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**H. R. 4680**

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IN THE SENATE OF THE UNITED STATES

JUNE 29, 2000

Received and read the first time

JUNE 30, 2000

Read the second time and placed on the calendar

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**AN ACT**

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

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

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

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

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

Sec. 1. Short title; table of contents.

**TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT**

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

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

Sec. 103. Medicaid amendments.

Sec. 104. Medigap transition provisions.

Sec. 105. State Pharmaceutical Assistance Transition Commission.

Sec. 106. Demonstration project for disease management for severely chron-  
ically ill medicare beneficiaries.

**TITLE II—MODERNIZATION OF ADMINISTRATION OF MEDICARE**

**Subtitle A—Medicare Benefits Administration**

Sec. 201. Establishment of administration.

Sec. 202. Miscellaneous administrative provisions.

**Subtitle B—Oversight of Financial Sustainability of the Medicare Program**

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

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

Sec. 221. Revisions to medicare appeals process.

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

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

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

Sec. 225. Effective date of subtitle.

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

**Subtitle A—Medicare+Choice Reforms**

Sec. 301. Increase in national per capita Medicare+Choice growth percentage  
in 2001 and 2002.

Sec. 302. Permanently removing application of budget neutrality beginning in  
2002.

Sec. 303. Increasing minimum payment amount.

Sec. 304. Allowing movement to 50:50 percent blend in 2002.

Sec. 305. Increased update for payment areas with only one or no  
Medicare+Choice contracts.



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

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

13          “(b) GENERAL ELECTION PROCEDURES.—

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

25               “(2) ELECTION PERIODS.—

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

6                   “(i) annual coordinated election peri-  
7 ods; and

8                   “(ii) special election periods.

9 In applying the last sentence of section  
10 1851(e)(4) (relating to discontinuance of a  
11 Medicare+Choice election during the first year  
12 of eligibility) under this subparagraph, in the  
13 case of an election described in such section in  
14 which the individual had elected or is provided  
15 qualified prescription drug coverage at the time  
16 of such first enrollment, the individual shall be  
17 permitted to enroll in a prescription drug plan  
18 under this part at the time of the election of  
19 coverage under the original fee-for-service plan.

20           “(B) INITIAL ELECTION PERIODS.—

21                   “(i) INDIVIDUALS CURRENTLY COV-  
22 ERED.—In the case of an individual who is  
23 enrolled under part B as of November 1,  
24 2002, there shall be an initial election pe-  
25 riod of 6 months beginning on that date.

1           “(ii) INDIVIDUAL COVERED IN FU-  
2           TURE.—In the case of an individual who is  
3           first enrolled under part B after November  
4           1, 2002, there shall be an initial election  
5           period which is the same as the initial en-  
6           rollment period under section 1837(d).

7           “(C) ADDITIONAL SPECIAL ELECTION PE-  
8           RIODS.—The Medicare Benefits Administrator  
9           shall establish special election periods—

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

13           “(ii) in cases described in section  
14           1837(h) (relating to errors in enrollment),  
15           in the same manner as such section applies  
16           to part B; and

17           “(iii) in the case of an individual who  
18           meets such exceptional conditions (includ-  
19           ing conditions recognized under section  
20           1851(d)(4)(D)) as the Administrator may  
21           provide.

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

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

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

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

20                  “(1) GUARANTEED ISSUE.—

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

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

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

12 “(2) COMMUNITY-RATED PREMIUM.—

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



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

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

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

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

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

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

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

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

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

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

22 “(vi) VETERANS’ COVERAGE OF PRE-  
23 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 an  
12 election in the case of—

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

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

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

22           “(a) REQUIREMENTS.—

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

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

5           “(B) 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 this subparagraph  
16                 for the previous year, increased by the an-  
17                 nual percentage increase described in para-  
18                 graph (5) for the year involved.

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

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

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

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

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

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

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

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

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

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

19                  “(C) ASSURING STANDARD PAYMENT FOR  
20          COSTS AT INITIAL COVERAGE LIMIT.—The cov-  
21          erage is designed, based upon an actuarially  
22          representative pattern of utilization (as deter-  
23          mined under subsection (e)), to provide for the  
24          payment, with respect to costs incurred that are  
25          equal to the sum of the deductible under sub-

1 section (b)(1) and the initial coverage limit  
2 under subsection (b)(3), of an amount equal to  
3 at least such initial coverage limit multiplied by  
4 the percentage specified in subsection (b)(2).

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

9 “(d) ACCESS TO NEGOTIATED PRICES.—Under  
10 qualified prescription drug coverage offered by a PDP  
11 sponsor or a Medicare+Choice organization, the sponsor  
12 or organization shall provide beneficiaries with access to  
13 negotiated prices (including applicable discounts) used for  
14 payment for covered outpatient drugs, regardless of the  
15 fact that no benefits may be payable under the coverage  
16 with respect to such drugs because of the application of  
17 cost-sharing or an initial coverage limit (described in sub-  
18 section (b)(3)). Insofar as a State elects to provide medical  
19 assistance under title XIX for a drug based on the prices  
20 negotiated by a prescription drug plan under this part,  
21 the requirements of section 1927 shall not apply to such  
22 drugs.

23 “(e) ACTUARIAL VALUATION; DETERMINATION OF  
24 ANNUAL PERCENTAGE INCREASES.—

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

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

6                           “(i) an actuarial valuation of standard  
7                           coverage and of the reinsurance subsidy  
8                           payments under section 1860H;

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

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

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

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

23           “(f) COVERED OUTPATIENT DRUGS DEFINED.—

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

4           “(A) a drug that may be dispensed only  
5 upon a prescription and that is described in  
6 subparagraph (A)(i) or (A)(ii) of section  
7 1927(k)(2); or

8           “(B) a biological product described in  
9 clauses (i) through (iii) of subparagraph (B) of  
10 such section or insulin described in subpara-  
11 graph (C) of such section,

12 and such term includes any use of a covered out-  
13 patient drug for a medically accepted indication (as  
14 defined in section 1927(k)(6)).

15           “(2) EXCLUSIONS.—

16           “(A) IN GENERAL.—Such term does not  
17 include drugs or classes of drugs, or their med-  
18 ical uses, which may be excluded from coverage  
19 or otherwise restricted under section  
20 1927(d)(2), other than subparagraph (E) there-  
21 of (relating to smoking cessation agents) and  
22 except to the extent otherwise specifically pro-  
23 vided by the Medicare Benefits Administrator  
24 with respect to a drug in any of such classes.

1           “(B) AVOIDANCE OF DUPLICATE COV-  
2 ERAGE.—A drug prescribed for an individual  
3 that would otherwise be a covered outpatient  
4 drug under this part shall not be so considered  
5 if payment for such drug is available under part  
6 A or B (but shall be so considered if such pay-  
7 ment is not available because benefits under  
8 part A or B have been exhausted), without re-  
9 gard to whether the individual is entitled to  
10 benefits under part A or enrolled under part B.

11           “(3) APPLICATION OF FORMULARY RESTRIC-  
12 TIONS.—A drug prescribed for an individual that  
13 would otherwise be a covered outpatient drug under  
14 this part shall not be so considered under a plan if  
15 the plan excludes the drug under a formulary that  
16 meets the requirements of section 1860C(f)(2) (in-  
17 cluding providing an appeal process).

18           “(4) APPLICATION OF GENERAL EXCLUSION  
19 PROVISIONS.—A prescription drug plan or  
20 Medicare+Choice plan may exclude from qualified  
21 prescription drug coverage any covered outpatient  
22 drug—

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

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

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

5           “(5) STUDY ON INCLUSION OF DRUGS TREAT-  
6           ING MORBID OBESITY.—The Medicare Policy Advi-  
7           sory Board shall provide for a study on removing the  
8           exclusion under paragraph (2)(A) for coverage of  
9           agents used for weight loss in the case of morbidly  
10          obese individuals. The Board shall report to Con-  
11          gress on the results of the study not later than  
12          March 1, 2002.

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

15          “(a) GUARANTEED ISSUE COMMUNITY-RELATED  
16          PREMIUMS AND NONDISCRIMINATION.—For provisions re-  
17          quiring guaranteed issue, community-rated premiums, and  
18          nondiscrimination, see sections 1860A(c)(1), 1860A(c)(2),  
19          and 1860F(b).

20          “(b) DISSEMINATION OF INFORMATION.—

21               “(1) GENERAL INFORMATION.—A PDP sponsor  
22               shall disclose, in a clear, accurate, and standardized  
23               form to each enrollee with a prescription drug plan  
24               offered by the sponsor under this part at the time  
25               of enrollment and at least annually thereafter, the



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

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

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

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

10 “(D) Grievance and appeals procedures.

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

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

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

12          “(c) ACCESS TO COVERED BENEFITS.—

13                 “(1) ASSURING PHARMACY ACCESS.—The PDP  
14                 sponsor of the prescription drug plan shall secure  
15                 the participation of sufficient numbers of pharmacies  
16                 (which may include mail order pharmacies) to en-  
17                 sure convenient access (including adequate emer-  
18                 gency access) for enrolled beneficiaries, in accord-  
19                 ance with standards established under section  
20                 1860D(e) that ensure such convenient access. Noth-  
21                 ing in this paragraph shall be construed as requiring  
22                 the participation of (or permitting the exclusion of)  
23                 all pharmacies in any area under a plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15           “(4) PUBLIC DISCLOSURE OF PHARMACEUTICAL  
16           PRICES FOR GENERIC EQUIVALENT DRUGS.—Each  
17           PDP sponsor shall provide that each pharmacy or  
18           other dispenser that arranges for the dispensing of  
19           a covered outpatient drug shall inform the bene-  
20           ficiary at the time of purchase of the drug of any  
21           differential between the price of the prescribed drug  
22           to the enrollee and the price of the lowest cost ge-  
23           neric drug that is therapeutically and pharmaceuti-  
24           cally equivalent and bioequivalent.

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

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

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

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

1 on the formulary is not as effective for the enrollee  
2 or has significant adverse effects for the enrollee.

3 “(g) CONFIDENTIALITY AND ACCURACY OF EN-  
4 ROLLEE RECORDS.—A PDP sponsor shall meet the re-  
5 quirements of section 1852(h) with respect to enrollees  
6 under this part in the same manner as such requirements  
7 apply to a Medicare+Choice organization with respect to  
8 enrollees under part C.

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

12 “(a) GENERAL REQUIREMENTS.—Each PDP sponsor  
13 of a prescription drug plan shall meet the following re-  
14 quirements:

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

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

21 “(A) IN GENERAL.—Subject to subpara-  
22 graph (B) and section 1860E(d)(2), the entity  
23 assumes full financial risk on a prospective  
24 basis for qualified prescription drug coverage  
25 that it offers under a prescription drug plan



1 and that is not covered under reinsurance  
2 under section 1860H.

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

7 “(3) SOLVENCY FOR UNLICENSED SPONSORS.—  
8 In the case of a sponsor that is not described in  
9 paragraph (1), the sponsor shall meet solvency  
10 standards established by the Medicare Benefits Ad-  
11 ministrator under subsection (d).

12 “(b) CONTRACT REQUIREMENTS.—

13 “(1) IN GENERAL.—The Medicare Benefits Ad-  
14 ministrator shall not permit the election under sec-  
15 tion 1860A of a prescription drug plan offered by a  
16 PDP sponsor under this part, and the sponsor shall  
17 not be eligible for payments under section 1860G or  
18 1860H, unless the Administrator has entered into a  
19 contract under this subsection with the sponsor with  
20 respect to the offering of such plan. Such a contract  
21 with a sponsor may cover more than one prescrip-  
22 tion drug plan. Such contract shall provide that the  
23 sponsor agrees to comply with the applicable require-  
24 ments and standards of this part and the terms and  
25 conditions of payment as provided for in this part.

1           “(2) NEGOTIATION REGARDING TERMS AND  
2           CONDITIONS.—The Medicare Benefits Administrator  
3           shall have the same authority to negotiate the terms  
4           and conditions of prescription drug plans under this  
5           part as the Director of the Office of Personnel Man-  
6           agement has with respect to health benefits plans  
7           under chapter 89 of title 5, United States Code. In  
8           negotiating the terms and conditions regarding pre-  
9           miums for which information is submitted under sec-  
10          tion 1860F(a)(2), the Administrator shall take into  
11          account the reinsurance subsidy payments under  
12          section 1860H and the adjusted community rate (as  
13          defined in section 1854(f)(3)) for the benefits cov-  
14          ered.

15          “(3) INCORPORATION OF CERTAIN  
16          MEDICARE+CHOICE CONTRACT REQUIREMENTS.—  
17          The following provisions of section 1857 shall apply,  
18          subject to subsection (c)(5), to contracts under this  
19          section in the same manner as they apply to con-  
20          tracts under section 1857(a):

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

23                 “(B) CONTRACT PERIOD AND EFFECTIVE-  
24                 NESS.—Paragraphs (1) through (3) and (5) of  
25                 section 1857(c).

1           “(C) PROTECTIONS AGAINST FRAUD AND  
2           BENEFICIARY PROTECTIONS.—Section 1857(d).

3           “(D) ADDITIONAL CONTRACT TERMS.—  
4           Section 1857(e); except that in applying section  
5           1857(e)(2) under this part—

6                   “(i) such section shall be applied sepa-  
7                   rately to costs relating to this part (from  
8                   costs under part C);

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

15                  “(iii) no fees shall be applied under  
16                  this subparagraph with respect to  
17                  Medicare+Choice plans.

18           “(E) INTERMEDIATE SANCTIONS.—Section  
19           1857(g).

20           “(F) PROCEDURES FOR TERMINATION.—  
21           Section 1857(h).

22           “(4) RULES OF APPLICATION FOR INTER-  
23           MEDIATE SANCTIONS.—In applying paragraph  
24           (3)(E)—

1           “(A) the reference in section  
2           1857(g)(1)(B) to section 1854 is deemed a ref-  
3           erence to this part; and

4           “(B) the reference in section  
5           1857(g)(1)(F) to section 1852(k)(2)(A)(ii) shall  
6           not be applied.

7           “(c) WAIVER OF CERTAIN REQUIREMENTS TO EX-  
8 PAND CHOICE.—

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

18          “(2) GROUNDS FOR APPROVAL.—The grounds  
19          for approval under this paragraph are the grounds  
20          for approval described in subparagraph (B), (C),  
21          and (D) of section 1855(a)(2), and also include the  
22          application by a State of any grounds other than  
23          those required under Federal law.

24          “(3) APPLICATION OF WAIVER PROCEDURES.—  
25          With respect to an application for a waiver (or a

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

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

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

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

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

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

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

1       quacy standards that an entity that does not meet  
2       the requirements of subsection (a)(1) must meet to  
3       qualify as a PDP sponsor under this part.

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

14              “(e) OTHER STANDARDS.—The Medicare Benefits  
15      Administrator shall establish by regulation other stand-  
16      ards (not described in subsection (d)) for PDP sponsors  
17      and plans consistent with, and to carry out, this part. The  
18      Administrator shall publish such regulations by October  
19      1, 2001. In order to carry out this requirement in a timely  
20      manner, the Administrator may promulgate regulations  
21      that take effect on an interim basis, after notice and pend-  
22      ing opportunity for public comment.

23              “(f) RELATION TO STATE LAWS.—

24                      “(1) IN GENERAL.—The standards established  
25      under this section shall supersede any State law or

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

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

9 “(A) Benefit requirements.

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

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

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

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

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

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

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

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

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

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



1 sponsor, in the manner described in (and in coordi-  
2 nation with) section 1851(c)(2).

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

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

12 “(1) CHOICE OF AT LEAST TWO PLANS IN EACH  
13 AREA.—

14 “(A) IN GENERAL.—The Medicare Bene-  
15 fits Administrator shall assure that each indi-  
16 vidual who is enrolled under part B and who is  
17 residing in an area has available, consistent  
18 with subparagraph (B), a choice of enrollment  
19 in at least two qualifying plans (as defined in  
20 paragraph (5)) in the area in which the indi-  
21 vidual resides, at least one of which is a pre-  
22 scription drug plan.

23 “(B) REQUIREMENT FOR DIFFERENT  
24 PLAN SPONSORS.—The requirement in subpara-  
25 graph (A) is not satisfied with respect to an

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

4 “(2) GUARANTEEING ACCESS TO COVERAGE.—

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

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

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

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

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

4           “(4) REPORTS.—The Medicare Benefits Admin-  
5           istrator shall, in each annual report to Congress  
6           under section 1807(f), include information on the  
7           exercise of authority under this subsection. The Ad-  
8           ministrator also shall include such recommendations  
9           as may be appropriate to minimize the exercise of  
10          such authority, including minimizing the assumption  
11          of financial risk.

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

17 **“SEC. 1860F. PREMIUMS.**

18          “(a) SUBMISSION OF PREMIUMS AND RELATED IN-  
19          FORMATION.—

20          “(1) IN GENERAL.—Each PDP sponsor shall  
21          submit to the Medicare Benefits Administrator in-  
22          formation of the type described in paragraph (2) in  
23          the same manner as information is submitted by a  
24          Medicare+Choice organization under section  
25          1854(a)(1).

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

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

5           “(B) Information on the actuarial value of  
6 the coverage.

7           “(C) Information on the monthly premium  
8 to be charged for the coverage, including an ac-  
9 tuarial certification of—

10           “(i) the actuarial basis for such pre-  
11 mium;

12           “(ii) the portion of such premium at-  
13 tributable to benefits in excess of standard  
14 coverage; and

15           “(iii) the reduction in such premium  
16 resulting from the reinsurance subsidy  
17 payments provided under section 1860H.

18           “(D) Such other information as the Medi-  
19 care Benefits Administrator may require to  
20 carry out this part.

21           “(3) REVIEW.—The Medicare Benefits Admin-  
22 istrator shall review the information filed under  
23 paragraph (2) for the purpose of conducting negotia-  
24 tions under section 1860D(b)(2).

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

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

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

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

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)(5)(A)(iii), determined without regard to  
17 any reduction effected under section  
18 1851(j)(5)(B).

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

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

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

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

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

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

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

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

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

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

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

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

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

17 “(e) RELATION TO MEDICAID PROGRAM.—

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

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

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

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

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

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

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

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

1 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           ministrators shall proportionally adjust the payments  
10          made under this section for a coverage year in such  
11          manner so that the total of the payments made for  
12          the year under this section is equal to 35 percent of  
13          the total payments described in paragraph (1)(B)  
14          during the year.

15          “(e) PAYMENT METHODS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 “(b) PAYMENTS FROM ACCOUNT.—

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

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

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

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

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

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

3 “(3) TREATMENT IN RELATION TO PART B PRE-  
4 MIUM.—Amounts payable from the Account shall not  
5 be taken into account in computing actuarial rates  
6 or premium amounts under section 1839.

7 “(c) DEPOSITS INTO ACCOUNT.—

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

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

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

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



1           “(1) COVERED OUTPATIENT DRUGS.—The term  
2           ‘covered outpatient drugs’ is defined in section  
3           1860B(f).

4           “(2) INITIAL COVERAGE LIMIT.—The term ‘ini-  
5           tial coverage limit’ means the such limit as estab-  
6           lished under section 1860B(b)(3), or, in the case of  
7           coverage that is not standard coverage, the com-  
8           parable limit (if any) established under the coverage.

9           “(3) MEDICARE PRESCRIPTION DRUG AC-  
10          COUNT.—The term ‘Medicare Prescription Drug Ac-  
11          count’ means the Account in the Federal Supple-  
12          mentary Medical Insurance Trust Fund created  
13          under section 1860I(a).

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

18          “(5) PRESCRIPTION DRUG PLAN.—The term  
19          ‘prescription drug plan’ means health benefits cov-  
20          erage that—

21                 “(A) is offered under a policy, contract, or  
22                 plan by a PDP sponsor pursuant to, and in ac-  
23                 cordance with, a contract between the Medicare  
24                 Benefits Administrator and the sponsor under  
25                 section 1860D(b);

1           “(B) provides qualified prescription drug  
2 coverage; and

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

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

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

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

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

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

20           “(3) any reference to a contract under section  
21 1857 included a reference to a contract under sec-  
22 tion 1860D(b); and

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

1 (b) CONFORMING AMENDMENTS TO FEDERAL SUP-  
2 PLEMENTARY MEDICAL INSURANCE TRUST FUND.—Sec-  
3 tion 1841 of the Social Security Act (42 U.S.C. 1395t)  
4 is amended—

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

6 (A) by striking “and” before “such  
7 amounts”; and

8 (B) by inserting before the period the fol-  
9 lowing: “and such amounts as may be deposited  
10 in, or appropriated to, the Medicare Prescrip-  
11 tion Drug Account established by section  
12 1860I”; and

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

18 (c) ADDITIONAL CONFORMING CHANGES.—

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

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

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

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

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

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

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

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

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

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

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

1 qualified prescription drug coverage through a  
2 Medicare+Choice plan, see section 1860G; and

3 “(B) providing a Medicare+Choice organi-  
4 zation with reinsurance subsidy payments for  
5 providing qualified prescription drug coverage  
6 under this part, see section 1860H.

7 “(5) SPECIFICATION OF SEPARATE AND STAND-  
8 ARD PREMIUM.—

9 “(A) IN GENERAL.—For purposes of ap-  
10 plying section 1854 and section 1860G(b)(2)(B)  
11 with respect to qualified prescription drug cov-  
12 erage offered under this subsection under a  
13 plan, the Medicare+Choice organization shall  
14 compute and publish the following:

15 “(i) SEPARATE PRESCRIPTION DRUG  
16 PREMIUM.—A premium for prescription  
17 drug benefits that constitute qualified pre-  
18 scription drug coverage that is separate  
19 from other coverage under the plan.

20 “(ii) PORTION OF COVERAGE ATTRIB-  
21 UTABLE TO STANDARD BENEFITS.—The  
22 ratio of the actuarial value of standard  
23 coverage to the actuarial value of the  
24 qualified prescription drug coverage offered  
25 under the plan.

1                   “(iii) PORTION OF PREMIUM ATTRIB-  
2                   UTABLE TO STANDARD BENEFITS.—A  
3                   standard premium equal to the product of  
4                   the premium described in clause (i) and  
5                   the ratio under clause (ii).

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

9                   “(B) REDUCTION OF PREMIUMS AL-  
10                  LOWED.—Nothing in this subsection shall be  
11                  construed as preventing a Medicare+Choice or-  
12                  ganization from reducing the amount of a pre-  
13                  mium charged for prescription drug coverage  
14                  because of the application of section  
15                  1854(f)(1)(A) to other coverage.

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

23                  “(6) TRANSITION IN INITIAL ENROLLMENT PE-  
24                  RIOD.—Notwithstanding any other provision of this  
25                  part, the annual, coordinated election period under

1 subsection (e)(3)(B) for 2003 shall be the 6-month  
2 period beginning with November 2002.

3 “(7) QUALIFIED PRESCRIPTION DRUG COV-  
4 ERAGE; STANDARD COVERAGE.—For purposes of  
5 this part, the terms ‘qualified prescription drug cov-  
6 erage’ and ‘standard coverage’ have the meanings  
7 given such terms in section 1860B.”.

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

10 (1) in subsection (a)(1)—

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

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

15 (C) by adding after and below subpara-  
16 graph (B) the following:

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

19 (2) in subsection (g)(1), by inserting “and sec-  
20 tion 1860A(e)(2)(B)” after “in this subsection”.

21 (c) EFFECTIVE DATE.—The amendments made by  
22 this section apply to coverage provided on or after January  
23 1, 2003.



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

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

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

6 (A) in subsection (a)—

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

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

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

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

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

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

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

22 “SPECIAL PROVISIONS RELATING TO MEDICARE  
23 PRESCRIPTION DRUG BENEFIT

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

1 under section 1902(a)(66) and receipt of any Federal fi-  
2 nancial assistance under section 1903(a), a State shall—

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

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

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

12 “(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE  
13 COSTS.—

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

22 “(A) For expenditures attributable to costs  
23 incurred during 2003, the otherwise applicable  
24 Federal matching rate shall be increased by 20

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

3           “(B) For expenditures attributable to costs  
4           incurred during 2004, the otherwise applicable  
5           Federal matching rate shall be increased by 40  
6           percent of the percentage otherwise payable  
7           (but for this subsection) by the State.

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

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

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

22          “(2) COORDINATION.—The State shall provide  
23          the Secretary with such information as may be nec-  
24          essary to properly allocate administrative expendi-

1 tures described in paragraph (1) that may otherwise  
2 be made for similar eligibility determinations.”.

3 (b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID  
4 RESPONSIBILITY FOR PREMIUM AND COST-SHARING SUB-  
5 SIDIES FOR DUALY ELIGIBLE INDIVIDUALS.—

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

11 (2) AMOUNT DESCRIBED.—Section 1935 of  
12 such Act, as inserted by subsection (a)(2), is amend-  
13 ed by adding at the end the following new sub-  
14 section:

15 “(c) FEDERAL ASSUMPTION OF MEDICAID PRE-  
16 SCRIPTION DRUG COSTS FOR DUALY-ELIGIBLE BENE-  
17 FICIARIES.—

18 “(1) IN GENERAL.—For purposes of section  
19 1903(a)(1), for a State that is one of the 50 States  
20 or the District of Columbia for a calendar quarter  
21 in a year (beginning with 2003) the amount com-  
22 puted under this subsection is equal to the product  
23 of the following:

24 “(A) MEDICARE SUBSIDIES.—The total  
25 amount of payments made in the quarter under

1 section 1860G (relating to premium and cost-  
2 sharing prescription drug subsidies for low-in-  
3 come medicare beneficiaries) that are attrib-  
4 utable to individuals who are residents of the  
5 State and are entitled to benefits with respect  
6 to prescribed drugs under the State plan under  
7 this title (including such a plan operating under  
8 a waiver under section 1115).

9 “(B) STATE MATCHING RATE.—A propor-  
10 tion computed by subtracting from 100 percent  
11 the Federal medical assistance percentage (as  
12 defined in section 1905(b)) applicable to the  
13 State and the quarter.

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

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

20 “(A) 2003 is 80 percent;

21 “(B) 2004 is 60 percent;

22 “(C) 2005 is 40 percent;

23 “(D) 2006 is 20 percent; or

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

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

5 “(d) ADDITIONAL PROVISIONS.—

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

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

24 (d) TREATMENT OF TERRITORIES.—

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

3           (A) in subsection (a) in the matter pre-  
4 ceding paragraph (1), by inserting “subject to  
5 subsection (e)” after “section 1903(a)”;

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

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

10       “(e) TREATMENT OF TERRITORIES.—

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

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

16           “(B) if the State establishes a plan de-  
17 scribed in paragraph (2) (for providing medical  
18 assistance with respect to the provision of pre-  
19 scription drugs to medicare beneficiaries), the  
20 amount otherwise determined under section  
21 1108(f) (as increased under section 1108(g))  
22 for the State shall be increased by the amount  
23 specified in paragraph (3).

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

1           “(A) provides medical assistance with re-  
2 spect to the provision of covered outpatient  
3 drugs (as defined in section 1860B(f)) to low-  
4 income medicare beneficiaries; and

5           “(B) assures that additional amounts re-  
6 ceived by the State that are attributable to the  
7 operation of this subsection are used only for  
8 such assistance.

9           “(3) INCREASED AMOUNT.—

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

13                   “(i) the aggregate amount specified in  
14 subparagraph (B); and

15                   “(ii) the amount specified in section  
16 1108(g)(1) for that State, divided by the  
17 sum of the amounts specified in such sec-  
18 tion for all such States.

19           “(B) AGGREGATE AMOUNT.—The aggre-  
20 gate amount specified in this subparagraph  
21 for—

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

23                   “(ii) a subsequent year, is equal to the  
24 aggregate amount specified in this sub-  
25 paragraph for the previous year increased



1           by annual percentage increase specified in  
2           section 1860B(b)(5) for the year involved.

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

7           (2)    CONFORMING    AMENDMENT.—Section  
8           1108(f) of such Act is amended by inserting “and  
9           section 1935(e)(1)(B)” after “Subject to subsection  
10          (g)”.

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

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

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

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

24                          (A) may not deny or condition the issuance  
25          or effectiveness of a medicare supplemental pol-

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

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

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

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

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

1 (A) enrolls in a prescription drug plan  
2 under part D of title XVIII of the Social Secu-  
3 rity Act; and

4 (B) at the time of such enrollment was en-  
5 rolled and terminates enrollment in a medicare  
6 supplemental policy which has a benefit pack-  
7 age classified as “H”, “I”, or “J” under the  
8 standards referred to in paragraph (1)(A) or  
9 terminates enrollment in a policy to which such  
10 standards do not apply but which provides ben-  
11 efits for prescription drugs.

12 (3) ENFORCEMENT.—The provisions of para-  
13 graph (1) shall be enforced as though they were in-  
14 cluded in section 1882(s) of the Social Security Act  
15 (42 U.S.C. 1395ss(s)).

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

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

22 (a) ESTABLISHMENT.—

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

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

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

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

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

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

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

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

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

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

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

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

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

1           (2) Protection of the financial interests of  
2 States so that States are not financially worse off as  
3 a result of the enactment of this title.

4           (d) REPORT.—By not later than July 1, 2001, the  
5 Commission shall submit to the President and the Con-  
6 gress a report that contains a detailed proposal (including  
7 specific legislative or administrative recommendations, if  
8 any) and such other recommendations as the Commission  
9 deems appropriate.

10          (e) SUPPORT.—The Secretary shall provide the Com-  
11 mission with the administrative support services necessary  
12 for the Commission to carry out its responsibilities under  
13 this section.

14          (f) TERMINATION.—The Commission shall terminate  
15 30 days after the date of submission of the report under  
16 subsection (d).

17 **SEC. 106. DEMONSTRATION PROJECT FOR DISEASE MAN-**  
18 **AGEMENT FOR SEVERELY CHRONICALLY ILL**  
19 **MEDICARE BENEFICIARIES.**

20          (a) IN GENERAL.—The Administrator of the Medi-  
21 care Benefits Administration (in this section referred to  
22 as the “Administrator”) shall conduct a demonstration  
23 project under this section (in this section referred to as  
24 the “project”) to demonstrate the impact on costs and  
25 health outcomes of applying disease management to medi-

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

5 (b) VOLUNTARY PARTICIPATION.—

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

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

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

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

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

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

19 (B) if the beneficiary—

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

1 under the plan because of the application  
2 of an initial coverage limit; or

3 (ii) is not enrolled in such a plan, for  
4 payment for all costs for prescription drugs  
5 without regard to whether or not they re-  
6 late to the chronic health condition,

7 except that the project may provide for modest  
8 cost-sharing with respect to prescription drug  
9 coverage.

10 (3) TREATMENT AS QUALIFYING COVERAGE  
11 FOR PURPOSES OF CONTINUOUS COVERAGE.—For  
12 purposes of applying section 1860A(c)(2)(C) of the  
13 Social Security Act, coverage under the project shall  
14 be treated as coverage under a prescription drug  
15 plan under part D of title XVIII of such Act.

16 (c) CONTRACTS WITH DISEASE MANAGEMENT ORGA-  
17 NIZATIONS.—

18 (1) IN GENERAL.—The Administrator shall  
19 carry out the project through contracts with up to  
20 three disease management organizations. The Ad-  
21 ministrator shall not enter into such a contract with  
22 an organization unless the organization dem-  
23 onstrates that it can produce improved health out-  
24 comes and reduce aggregate medicare expenditures  
25 consistent with paragraph (2).



1           (2) CONTRACT PROVISIONS.—Under such  
2 contracts—

3           (A) such an organization shall be required  
4 to provide for prescription drug coverage de-  
5 scribed in subsection (b)(2)(B);

6           (B) such an organization shall be paid a  
7 fee negotiated and established by the Adminis-  
8 trator in a manner so that (taking into account  
9 savings in expenditures under parts A and B of  
10 the medicare program) there will be a net re-  
11 duction in expenditures under the medicare pro-  
12 gram as a result of the project; and

13           (C) such an organization shall guarantee,  
14 through an appropriate arrangement with a re-  
15 insurance company or otherwise, the net reduc-  
16 tion in expenditures described in subparagraph  
17 (B).

18           (3) PAYMENTS.—Payments to such organiza-  
19 tions shall be made in appropriate proportion from  
20 the Trust Funds established under title XVIII of the  
21 Social Security Act.

22           (d) DURATION.—The project shall last for not longer  
23 than 3 years.

24           (e) REPORT.—The Administrator shall submit to  
25 Congress an interim report on the project not later than

1 2 years after the date it is first implemented and a final  
2 report on the project not later than 6 months after the  
3 date of its completion. Such reports shall include informa-  
4 tion on the impact of the project on costs and health out-  
5 comes and recommendations on the cost-effectiveness of  
6 extending or expanding the project.

7 **TITLE II—MODERNIZATION OF**  
8 **ADMINISTRATION OF MEDICARE**

9 **Subtitle A—Medicare Benefits**

10 **Administration**

11 **SEC. 201. ESTABLISHMENT OF ADMINISTRATION.**

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

15 “MEDICARE BENEFITS ADMINISTRATION

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

20 “(b) ADMINISTRATOR AND DEPUTY ADMINIS-  
21 TRATOR.—

22 “(1) ADMINISTRATOR.—

23 “(A) IN GENERAL.—The Medicare Bene-  
24 fits Administration shall be headed by an Ad-  
25 ministrator (in this section referred to as the  
26 ‘Administrator’) who shall be appointed by the

1 President, by and with the advice and consent  
2 of the Senate. The Administrator shall be in di-  
3 rect line of authority to the Secretary.

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

8 “(C) TERM OF OFFICE.—The Adminis-  
9 trator shall be appointed for a term of 5 years.  
10 In any case in which a successor does not take  
11 office at the end of an Administrator’s term of  
12 office, that Administrator may continue in of-  
13 fice until the entry upon office of such a suc-  
14 cessor. An Administrator appointed to a term of  
15 office after the commencement of such term  
16 may serve under such appointment only for the  
17 remainder of such term.

18 “(D) GENERAL AUTHORITY.—The Admin-  
19 istrator shall be responsible for the exercise of  
20 all powers and the discharge of all duties of the  
21 Administration, and shall have authority and  
22 control over all personnel and activities thereof.

23 “(E) RULEMAKING AUTHORITY.—The Ad-  
24 ministrator may prescribe such rules and regu-  
25 lations as the Administrator determines nec-

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

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

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

1           “(2) DEPUTY ADMINISTRATOR.—

2                   “(A) IN GENERAL.—There shall be a Dep-  
3           puty Administrator of the Medicare Benefits Ad-  
4           ministration who shall be appointed by the  
5           President, by and with the advice and consent  
6           of the Senate.

7                   “(B) COMPENSATION.—The Deputy Ad-  
8           ministrators shall be paid at the rate of basic  
9           pay payable for level IV of the Executive Sched-  
10          ule under section 5315 of title 5, United States  
11          Code.

12                   “(C) TERM OF OFFICE.—The Deputy Ad-  
13          ministrators shall be appointed for a term of 5  
14          years. In any case in which a successor does not  
15          take office at the end of a Deputy Administra-  
16          tor’s term of office, such Deputy Administrator  
17          may continue in office until the entry upon of-  
18          fice of such a successor. A Deputy Adminis-  
19          trator appointed to a term of office after the  
20          commencement of such term may serve under  
21          such appointment only for the remainder of  
22          such term.

23                   “(D) DUTIES.—The Deputy Administrator  
24          shall perform such duties and exercise such  
25          powers as the Administrator shall from time to

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

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

14          “(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

15                 “(1) DUTIES.—

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

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

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

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

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

1           ficiaries under this title, the Administrator may  
2           not—

3                   “(i) require a particular formulary or  
4                   institute a price structure for the reim-  
5                   bursement of covered outpatient drugs;

6                   “(ii) interfere in any way with nego-  
7                   tiations between PDP sponsors and  
8                   Medicare+Choice organizations and drug  
9                   manufacturers, wholesalers, or other sup-  
10                  pliers of covered outpatient drugs; and

11                  “(iii) otherwise interfere with the  
12                  competitive nature of providing such cov-  
13                  erage through such sponsors and organiza-  
14                  tions.

15                  “(D) ANNUAL REPORTS.—Not later March  
16                  31 of each year, the Administrator shall submit  
17                  to Congress and the President a report on the  
18                  administration of parts C and D during the  
19                  previous fiscal year.

20                  “(2) STAFF.—

21                   “(A) IN GENERAL.—The Administrator,  
22                   with the approval of the Secretary, may employ,  
23                   without regard to chapter 31 of title 5, United  
24                   States Code, such officers and employees as are  
25                   necessary to administer the activities to be car-



1           ried out through the Medicare Benefits Admin-  
2           istration.

3                   “(B) FLEXIBILITY WITH RESPECT TO COM-  
4           PENSATION.—

5                           “(i) IN GENERAL.—The staff of the  
6           Medicare Benefits Administration shall,  
7           subject to clause (ii), be paid without re-  
8           gard to the provisions of chapter 51 and  
9           chapter 53 of such title (relating to classi-  
10          fication and schedule pay rates).

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

17                           “(C) LIMITATION ON FULL-TIME EQUIVA-  
18          LENT STAFFING FOR CURRENT HCFA FUNC-  
19          TIONS BEING TRANSFERRED.—The Adminis-  
20          trator may not employ under this paragraph a  
21          number of full-time equivalent employees, to  
22          carry out functions that were previously con-  
23          ducted by the Health Care Financing Adminis-  
24          tration and that are conducted by the Adminis-  
25          trator by reason of this section, that exceeds

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

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

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

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

1 care Benefits Administration requires to carry  
2 out the duties described in paragraph (1).

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

12 “(d) OFFICE OF BENEFICIARY ASSISTANCE.—

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

23 “(2) DISSEMINATION OF INFORMATION ON  
24 BENEFITS AND APPEALS RIGHTS.—

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

9                   “(i) Benefits, and limitations on pay-  
10                  ment (including cost-sharing, stop-loss pro-  
11                  visions, and formulary restrictions) under  
12                  parts C and D.

13                  “(ii) Benefits, and limitations on pay-  
14                  ment under parts A and B, including in-  
15                  formation on medicare supplemental poli-  
16                  cies under section 1882.

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

22           “(B) DISSEMINATION OF APPEALS RIGHTS  
23           INFORMATION.—The Office of Beneficiary As-  
24           sistance shall disseminate to medicare bene-  
25           ficiaries in the manner provided under subpara-

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

8 “(3) MEDICARE OMBUDSMAN.—

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

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

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

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

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

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

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

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

1 medical Ombudsman programs, and with State-  
2 and community-based consumer organizations,  
3 to—

4 “(i) provide information about the  
5 medicare program; and

6 “(ii) conduct outreach to educate  
7 medicare beneficiaries with respect to man-  
8 ners in which problems under the medicare  
9 program may be resolved or avoided.

10 “(e) MEDICARE POLICY ADVISORY BOARD.—

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

20 “(2) REPORTS.—

21 “(A) IN GENERAL.—With respect to mat-  
22 ters of the administration of parts C and D, the  
23 Board shall submit to Congress and to the Ad-  
24 ministrator of the Medicare Benefits Adminis-  
25 tration such reports as the Board determines

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

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

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

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

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



1 rates under that section to  
2 Medicare+Choice organizations offering  
3 Medicare+Choice plans that accounts for  
4 variations in per capita costs based on  
5 health status and other demographic fac-  
6 tors.

7 “(iv) DISEASE MANAGEMENT PRO-  
8 GRAMS.—Recommendations on the incor-  
9 poration of disease management programs  
10 under parts C and D.

11 “(v) RURAL ACCESS.—Recommendations  
12 to improve competition and access to  
13 plans under parts C and D in rural areas.

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

22 “(3) DUTY OF ADMINISTRATOR OF MEDICARE  
23 BENEFITS ADMINISTRATION.—With respect to any  
24 report submitted by the Board under paragraph  
25 (2)(A), not later than 90 days after the report is

1 submitted, the Administrator of the Medicare Bene-  
2 fits Administration shall submit to Congress and the  
3 President an analysis of recommendations made by  
4 the Board in such report. Each such analysis shall  
5 be published in the Federal Register.

6 “(4) MEMBERSHIP.—

7 “(A) APPOINTMENT.—Subject to the suc-  
8 ceeding provisions of this paragraph, the Board  
9 shall consist of seven members to be appointed  
10 as follows:

11 “(i) Three members shall be ap-  
12 pointed by the President.

13 “(ii) Two members shall be appointed  
14 by the Speaker of the House of Represent-  
15 atives, with the advice of the chairman and  
16 the ranking minority member of the Com-  
17 mittees on Ways and Means and on Com-  
18 merce of the House of Representatives.

19 “(iii) Two members shall be appointed  
20 by the President pro tempore of the Senate  
21 with the advice of the chairman and the  
22 ranking minority member of the Senate  
23 Committee on Finance.

24 “(B) QUALIFICATIONS.—The members  
25 shall be chosen on the basis of their integrity,

1           impartiality, and good judgment, and shall be  
2           individuals who are, by reason of their edu-  
3           cation and experience in health care benefits  
4           management, exceptionally qualified to perform  
5           the duties of members of the Board.

6           “(C) PROHIBITION ON INCLUSION OF FED-  
7           ERAL EMPLOYEES.—No officer or employee of  
8           the United States may serve as a member of  
9           the Board.

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

17          “(6) TERMS OF OFFICE.—

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

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

23                         “(i) one shall be appointed for a term  
24                         of 1 year;

1                   “(ii) three shall be appointed for  
2                   terms of 2 years; and

3                   “(iii) three shall be appointed for  
4                   terms of 3 years.

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

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

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

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

23                  “(9) DIRECTOR AND STAFF.—

1           “(A) APPOINTMENT OF DIRECTOR.—The  
2 Board shall have a Director who shall be ap-  
3 pointed by the Chair.

4           “(B) IN GENERAL.—With the approval of  
5 the Board, the Director may appoint, without  
6 regard to chapter 31 of title 5, United States  
7 Code, such additional personnel as the Director  
8 considers appropriate.

9           “(C) FLEXIBILITY WITH RESPECT TO COM-  
10 PENSATION.—

11           “(i) IN GENERAL.—The Director and  
12 staff of the Board shall, subject to clause  
13 (ii), be paid without regard to the provi-  
14 sions of chapter 51 and chapter 53 of such  
15 title (relating to classification and schedule  
16 pay rates).

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

23           “(D) ASSISTANCE FROM THE ADMINIS-  
24 TRATOR OF THE MEDICARE BENEFITS ADMINIS-  
25 TRATION.—The Administrator of the Medicare

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

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

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

16          (b) EFFECTIVE DATE.—

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

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

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

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

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

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

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

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

21           “Administrator of the Health Care Financing  
22      Administration.”.

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

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

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

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

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

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

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



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

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

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

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

1 rate of growth in the gross domestic product for  
2 the same period.

3 “(2) PUBLICATION.—Each report submitted  
4 under paragraph (1) shall be published by the Com-  
5 mittee on Ways and Means as a public document  
6 and shall be made available by such Committee on  
7 the Internet.”.

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

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

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

### 17 **SEC. 221. REVISIONS TO MEDICARE APPEALS PROCESS.**

18 (a) CONDUCT OF RECONSIDERATIONS OF DETER-  
19 MINATIONS BY INDEPENDENT CONTRACTORS.—Section  
20 1869 of the Social Security Act (42 U.S.C. 1395ff) is  
21 amended to read as follows:

22 “DETERMINATIONS; APPEALS

23 “SEC. 1869. (a) INITIAL DETERMINATIONS.—The  
24 Secretary shall promulgate regulations and make initial  
25 determinations with respect to benefits under part A or

1 part B in accordance with those regulations for the fol-  
2 lowing:

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

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

7 “(3) Any other initial determination with re-  
8 spect to a claim for benefits under such parts, in-  
9 cluding an initial determination by the Secretary  
10 that payment may not be made, or may no longer  
11 be made, for an item or service under such parts, an  
12 initial determination made by a utilization and qual-  
13 ity control peer review organization under section  
14 1154(a)(2), and an initial determination made by an  
15 entity pursuant to a contract with the Secretary to  
16 administer provisions of this title or title XI.

17 “(b) APPEAL RIGHTS.—

18 “(1) IN GENERAL.—

19 “(A) RECONSIDERATION OF INITIAL DE-  
20 TERMINATION.—Subject to subparagraph (D),  
21 any individual dissatisfied with any initial de-  
22 termination under subsection (a) shall be enti-  
23 tled to reconsideration of the determination,  
24 and, subject to subparagraphs (D) and (E), a  
25 hearing thereon by the Secretary to the same

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

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

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

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

1           “(iii) PROHIBITION ON PAYMENT FOR  
2           REPRESENTATION.—If a person furnishes  
3           services or items to an individual and rep-  
4           resents the individual under this section,  
5           the person may not impose any financial li-  
6           ability on such individual in connection  
7           with such representation.

8           “(iv) REQUIREMENTS FOR REP-  
9           RESENTATIVES OF A BENEFICIARY.—The  
10          provisions of section 205(j) and section  
11          206 (regarding representation of claim-  
12          ants) shall apply to representation of an  
13          individual with respect to appeals under  
14          this section in the same manner as they  
15          apply to representation of an individual  
16          under those sections.

17          “(C) SUCCESSION OF RIGHTS IN CASES OF  
18          ASSIGNMENT.—The right of an individual to an  
19          appeal under this section with respect to an  
20          item or service may be assigned to the provider  
21          of services or supplier of the item or service  
22          upon the written consent of such individual  
23          using a standard form established by the Sec-  
24          retary for such an assignment.

25          “(D) TIME LIMITS FOR APPEALS.—

1           “(i) RECONSIDERATIONS.—Reconsid-  
2           eration under subparagraph (A) shall be  
3           available only if the individual described  
4           subparagraph (A) files notice with the Sec-  
5           retary to request reconsideration by not  
6           later than 180 days after the individual re-  
7           ceives notice of the initial determination  
8           under subsection (a) or within such addi-  
9           tional time as the Secretary may allow.

10           “(ii) HEARINGS CONDUCTED BY THE  
11           SECRETARY.—The Secretary shall establish  
12           in regulations time limits for the filing of  
13           a request for a hearing by the Secretary in  
14           accordance with provisions in sections 205  
15           and 206.

16           “(E) AMOUNTS IN CONTROVERSY.—

17           “(i) IN GENERAL.—A hearing (by the  
18           Secretary) shall not be available to an indi-  
19           vidual under this section if the amount in  
20           controversy is less than \$100, and judicial  
21           review shall not be available to the indi-  
22           vidual if the amount in controversy is less  
23           than \$1,000.

24           “(ii) AGGREGATION OF CLAIMS.—In  
25           determining the amount in controversy, the

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

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

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

13 “(F) EXPEDITED PROCEEDINGS.—

14 “(i) EXPEDITED DETERMINATION.—

15 In the case of an individual who—

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

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

1 of services plans to discharge the indi-  
2 vidual from the provider of services,  
3 the individual may request, in writing or  
4 orally, an expedited determination or an  
5 expedited reconsideration of an initial de-  
6 termination made under subsection (a), as  
7 the case may be, and the Secretary shall  
8 provide such expedited determination or  
9 expedited reconsideration.

10 “(ii) EXPEDITED HEARING.—In a  
11 hearing by the Secretary under this sec-  
12 tion, in which the moving party alleges  
13 that no material issues of fact are in dis-  
14 pute, the Secretary shall make an expe-  
15 dited determination as to whether any such  
16 facts are in dispute and, if not, shall  
17 render a decision expeditiously.

18 “(G) REOPENING AND REVISION OF DE-  
19 TERMINATIONS.—The Secretary may reopen or  
20 revise any initial determination or reconsidered  
21 determination described in this subsection  
22 under guidelines established by the Secretary in  
23 regulations.

24 “(2) REVIEW OF COVERAGE DETERMINA-  
25 TIONS.—



1           “(A) NATIONAL COVERAGE DETERMINA-  
2           TIONS.—

3           “(i) IN GENERAL.—Review of any na-  
4           tional coverage determination shall be sub-  
5           ject to the following limitations:

6                   “(I) Such a determination shall  
7                   not be reviewed by any administrative  
8                   law judge.

9                   “(II) Such a determination shall  
10                  not be held unlawful or set aside on  
11                  the ground that a requirement of sec-  
12                  tion 553 of title 5, United States  
13                  Code, or section 1871(b) of this title,  
14                  relating to publication in the Federal  
15                  Register or opportunity for public  
16                  comment, was not satisfied.

17                  “(III) Upon the filing of a com-  
18                  plaint by an aggrieved party, such a  
19                  determination shall be reviewed by the  
20                  Departmental Appeals Board of the  
21                  Department of Health and Human  
22                  Services. In conducting such a review,  
23                  the Departmental Appeals Board shall  
24                  review the record and shall permit dis-  
25                  covery and the taking of evidence to

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

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

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

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

1 of items or services is covered under such parts, the  
2 following limitations apply:

3 “(i) Upon the filing of a complaint by an  
4 aggrieved party, such a determination shall be  
5 reviewed by an administrative law judge of the  
6 Social Security Administration. The administra-  
7 tive law judge shall review the record and shall  
8 permit discovery and the taking of evidence to  
9 evaluate the reasonableness of the determina-  
10 tion. In reviewing such a determination, the ad-  
11 ministrative law judge shall defer only to the  
12 reasonable findings of fact, reasonable interpre-  
13 tations of law, and reasonable applications of  
14 fact to law by the Secretary.

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

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

21 “(C) NO MATERIAL ISSUES OF FACT IN DIS-  
22 PUTE.—In the case of review of a determination  
23 under subparagraph (A)(i)(III) or (B)(i) where the  
24 moving party alleges that there are no material  
25 issues of fact in dispute, and alleges that the only

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

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

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

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

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

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

1           such 90-day period with respect to national  
2           coverage of such items or services.

3           “(IV) Issue a notice that states that  
4           the Secretary has not completed a review  
5           of the request for a national coverage de-  
6           termination and that includes an identi-  
7           fication of the remaining steps in the Sec-  
8           retary’s review process and a deadline by  
9           which the Secretary will complete the re-  
10          view and take an action described in sub-  
11          clause (I), (II), or (III).

12          “(ii) In the case of an action described in  
13          clause (i)(IV), if the Secretary fails to take an  
14          action referred to in such clause by the deadline  
15          specified by the Secretary under such clause,  
16          then the Secretary is deemed to have taken an  
17          action described in clause (i)(III) as of the  
18          deadline.

19          “(iii) When issuing a determination under  
20          clause (i), the Secretary shall include an expla-  
21          nation of the basis for the determination. An  
22          action taken under clause (i) (other than sub-  
23          clause (IV)) is deemed to be a national coverage  
24          determination for purposes of review under sub-  
25          paragraph (A).

1           “(E) ANNUAL REPORT ON NATIONAL COVERAGE  
2 DETERMINATIONS.—

3           “(i) IN GENERAL.—Not later than Decem-  
4 ber 1 of each year, beginning in 2001, the Sec-  
5 retary shall submit to Congress a report that  
6 sets forth a detailed compilation of the actual  
7 time periods that were necessary to complete  
8 and fully implement national coverage deter-  
9 minations that were made in the previous fiscal  
10 year for items, services, or medical devices not  
11 previously covered as a benefit under this title,  
12 including, with respect to each new item, serv-  
13 ice, or medical device, a statement of the time  
14 taken by the Secretary to make the necessary  
15 coverage, coding, and payment determinations,  
16 including the time taken to complete each sig-  
17 nificant step in the process of making such de-  
18 terminations.

19           “(ii) PUBLICATION OF REPORTS ON THE  
20 INTERNET.—The Secretary shall publish each  
21 report submitted under clause (i) on the medi-  
22 care Internet site of the Department of Health  
23 and Human Services.

24           “(3) PUBLICATION ON THE INTERNET OF DECI-  
25 SIONS OF HEARINGS OF THE SECRETARY.—Each de-

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

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

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

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

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

1       “(c) CONDUCT OF RECONSIDERATIONS BY INDE-  
2 PENDENT CONTRACTORS.—

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

10           “(2) QUALIFIED INDEPENDENT CON-  
11 TRACTOR.—For purposes of this subsection, the  
12 term ‘qualified independent contractor’ means an en-  
13 tity or organization that is independent of any orga-  
14 nization under contract with the Secretary that  
15 makes initial determinations under subsection (a),  
16 and that meets the requirements established by the  
17 Secretary consistent with paragraph (3).

18           “(3) REQUIREMENTS.—Any qualified inde-  
19 pendent contractor entering into a contract with the  
20 Secretary under this subsection shall meet the fol-  
21 lowing requirements:

22           “(A) IN GENERAL.—The qualified inde-  
23 pendent contractor shall perform such duties  
24 and functions and assume such responsibilities  
25 as may be required under regulations of the



1 Secretary promulgated to carry out the provi-  
2 sions of this subsection, and such additional du-  
3 ties, functions, and responsibilities as provided  
4 under the contract.

5 “(B) DETERMINATIONS.—The qualified  
6 independent contractor shall determine, on the  
7 basis of such criteria, guidelines, and policies  
8 established by the Secretary and published  
9 under subsection (d)(2)(D), whether payment  
10 shall be made for items or services under part  
11 A or part B and the amount of such payment.  
12 Such determination shall constitute the conclu-  
13 sive determination on those issues for purposes  
14 of payment under such parts for fiscal inter-  
15 mediaries, carriers, and other entities whose de-  
16 terminations are subject to review by the con-  
17 tractor; except that payment may be made if—

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

20 “(ii) in the case of inpatient hospital  
21 services or extended care services, the  
22 qualified independent contractor deter-  
23 mines that additional time is required in  
24 order to arrange for postdischarge care,  
25 but payment may be continued under this

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

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

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

16 “(C) DEADLINES FOR DECISIONS.—

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

1           “(ii) CONSEQUENCES OF FAILURE TO  
2 MEET DEADLINE.—In the case of a failure  
3 by the qualified independent contractor to  
4 mail the notice of the decision by the end  
5 of the period described in clause (i), the  
6 party requesting the reconsideration or ap-  
7 peal may request a hearing before an ad-  
8 ministrative law judge, notwithstanding  
9 any requirements for a reconsidered deter-  
10 mination for purposes of the party’s right  
11 to such hearing.

12           “(iii) EXPEDITED RECONSIDER-  
13 ATIONS.—The qualified independent con-  
14 tractor shall perform an expedited recon-  
15 sideration under subsection (b)(1)(F) of a  
16 notice from a provider of services or sup-  
17 plier that payment may not be made for an  
18 item or service furnished by the provider of  
19 services or supplier, of a decision by a pro-  
20 vider of services to terminate services fur-  
21 nished to an individual, or in accordance  
22 with the following:

23           “(I) DEADLINE FOR DECISION.—  
24           Notwithstanding section 216(j), not  
25           later than 1 day after the date the

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

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

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

1           “(i) PHYSICIANS.—No physician  
2 under the employ of a qualified inde-  
3 pendent contractor may review—

4                   “(I) determinations regarding  
5 health care services furnished to a pa-  
6 tient if the physician was directly re-  
7 sponsible for furnishing such services;  
8 or

9                   “(II) determinations regarding  
10 health care services provided in or by  
11 an institution, organization, or agen-  
12 cy, if the physician or any member of  
13 the physician’s family has, directly or  
14 indirectly, a significant financial inter-  
15 est in such institution, organization,  
16 or agency.

17           “(ii) PHYSICIAN’S FAMILY DE-  
18 SCRIBED.—For purposes of this para-  
19 graph, a physician’s family includes the  
20 physician’s spouse (other than a spouse  
21 who is legally separated from the physician  
22 under a decree of divorce or separate  
23 maintenance), children (including step-  
24 children and legally adopted children),  
25 grandchildren, parents, and grandparents.

1           “(E) EXPLANATION OF DETERMINA-  
2           TIONS.—Any determination of a qualified inde-  
3           pendent contractor shall be in writing, and shall  
4           include a detailed explanation of the determina-  
5           tion as well as a discussion of the pertinent  
6           facts and applicable regulations applied in mak-  
7           ing such determination.

8           “(F) NOTICE REQUIREMENTS.—Whenever  
9           a qualified independent contractor makes a de-  
10          termination under this subsection, the qualified  
11          independent contractor shall promptly notify  
12          such individual and the entity responsible for  
13          the payment of claims under part A or part B  
14          of such determination.

15          “(G) DISSEMINATION OF INFORMATION.—  
16          Each qualified independent contractor shall,  
17          using the methodology established by the Sec-  
18          retary under subsection (d)(4), make available  
19          all determinations of such qualified independent  
20          contractors to fiscal intermediaries (under sec-  
21          tion 1816), carriers (under section 1842), peer  
22          review organizations (under part B of title XI),  
23          Medicare+Choice organizations offering  
24          Medicare+Choice plans under part C, and  
25          other entities under contract with the Secretary

1 to make initial determinations under part A or  
2 part B or title XI.

3 “(H) ENSURING CONSISTENCY IN DETER-  
4 MINATIONS.—Each qualified independent con-  
5 tractor shall monitor its determinations to en-  
6 sure the consistency of its determinations with  
7 respect to requests for reconsideration of simi-  
8 lar or related matters.

9 “(I) DATA COLLECTION.—

10 “(i) IN GENERAL.—Consistent with  
11 the requirements of clause (ii), a qualified  
12 independent contractor shall collect such  
13 information relevant to its functions, and  
14 keep and maintain such records in such  
15 form and manner as the Secretary may re-  
16 quire to carry out the purposes of this sec-  
17 tion and shall permit access to and use of  
18 any such information and records as the  
19 Secretary may require for such purposes.

20 “(ii) TYPE OF DATA COLLECTED.—  
21 Each qualified independent contractor  
22 shall keep accurate records of each deci-  
23 sion made, consistent with standards es-  
24 tablished by the Secretary for such pur-  
25 pose. Such records shall be maintained in

1 an electronic database in a manner that  
2 provides for identification of the following:

3 “(I) Specific claims that give rise  
4 to appeals.

5 “(II) Situations suggesting the  
6 need for increased education for pro-  
7 viders of services, physicians, or sup-  
8 pliers.

9 “(III) Situations suggesting the  
10 need for changes in national or local  
11 coverage policy.

12 “(IV) Situations suggesting the  
13 need for changes in local medical re-  
14 view policies.

15 “(iii) ANNUAL REPORTING.—Each  
16 qualified independent contractor shall sub-  
17 mit annually to the Secretary (or otherwise  
18 as the Secretary may request) records  
19 maintained under this paragraph for the  
20 previous year.

21 “(J) HEARINGS BY THE SECRETARY.—The  
22 qualified independent contractor shall (i) pre-  
23 pare such information as is required for an ap-  
24 peal of its reconsidered determination to the  
25 Secretary for a hearing, including as necessary,



1 explanations of issues involved in the deter-  
2 mination and relevant policies, and (ii) partici-  
3 pate in such hearings as required by the Sec-  
4 retary.

5 “(4) NUMBER OF QUALIFIED INDEPENDENT  
6 CONTRACTORS.—The Secretary shall enter into con-  
7 tracts with not fewer than 12 qualified independent  
8 contractors under this subsection.

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

25 “(d) ADMINISTRATIVE PROVISIONS.—

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

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

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

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

1                   “(i) HEARING BY ADMINISTRATIVE  
2                   LAW JUDGE.—

3                   “(I) IN GENERAL.—Except as  
4                   provided in subclause (II), an admin-  
5                   istrative law judge shall conduct and  
6                   conclude a hearing on a decision of a  
7                   qualified independent contractor  
8                   under subsection (c) and render a de-  
9                   cision on such hearing by not later  
10                  than the end of the 90-day period be-  
11                  ginning on the date a request for  
12                  hearing has been timely filed.

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

19                  “(ii) DEPARTMENTAL APPEALS BOARD  
20                  REVIEW.—The Departmental Appeals  
21                  Board of the Department of Health and  
22                  Human Services shall conduct and con-  
23                  clude a review of the decision on a hearing  
24                  described in subparagraph (B) and make a  
25                  decision or remand the case to the admin-

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

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

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

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

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

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

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

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

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

1 published format consistent with subpara-  
2 graph (C).

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

6 “(A) IN GENERAL.—The Secretary shall  
7 provide to each qualified independent con-  
8 tractor, and, in consultation with the Commis-  
9 sioner of Social Security, to administrative law  
10 judges that decide appeals of reconsiderations  
11 of initial determinations or other decisions or  
12 determinations under this section, such con-  
13 tinuing education with respect to policies of the  
14 Secretary under this title or part B of title XI  
15 as is necessary for such qualified independent  
16 contractors and administrative law judges to  
17 make informed decisions with respect to ap-  
18 peals.

19 “(B) MONITORING OF DECISIONS BY  
20 QUALIFIED INDEPENDENT CONTRACTORS AND  
21 ADMINISTRATIVE LAW JUDGES.—The Secretary  
22 shall monitor determinations made by all quali-  
23 fied independent contractors and administrative  
24 law judges under this section and shall provide  
25 continuing education and training to such quali-

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

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

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

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

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

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

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



1 is amended by adding at the end the following new para-  
2 graph:

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

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

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

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

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

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

22 “(2) in the case of payments made to the indi-  
23 vidual by the Secretary with respect to any claim  
24 under paragraph (1), the individual shall be liable  
25 for repayment of such amount only up to the

1 amount of payment received by the individual from  
2 the Secretary.

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

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

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

13 “(i) improperly submitted by the provider  
14 of services or supplier; or

15 “(ii) rejected by an entity under contract  
16 with the Secretary to review or pay claims for  
17 services and items furnished under this title, in-  
18 cluding an entity under contract with the Sec-  
19 retary under section 1857.

20 “(2) The limitation on liability under paragraph (1)  
21 shall not apply if the individual signs a waiver provided  
22 by the Secretary under subsection (l) of protections under  
23 this paragraph, except that any such waiver shall not  
24 apply in the case of a denial of a claim for noncompliance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1           fiary informs the person that payment of  
2           the coinsurance or deductible amount  
3           would pose a financial hardship for the in-  
4           dividual; or

5                   “(iv) the person determines that the  
6           coinsurance and deductible amount would  
7           not justify the costs of collection.”.

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

12                   “(4) In this section, the term ‘remuneration’ in-  
13           cludes the meaning given such term in section  
14           1128A(i)(6).”.

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

18           Section 1878(f)(1) of such Act (42 U.S.C.  
19 1395oo(f)(1)) is amended—

20                   (1) in the first sentence, by striking “unless the  
21           Secretary, on his own motion, and within 60 days  
22           after the provider of services is notified of the  
23           Board’s decision, reverses, affirms, or modifies the  
24           Board’s decision”;

1           (2) in the second sentence, by striking “, or of  
2           any reversal, affirmance, or modification by the Sec-  
3           retary,” and “or of any reversal, affirmance, or  
4           modification by the Secretary”; and

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

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

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

10 **TITLE III—MEDICARE+CHOICE**  
11 **REFORMS; PRESERVATION OF**  
12 **MEDICARE PART B DRUG**  
13 **BENEFIT**  
14 **Subtitle A—Medicare+Choice**  
15 **Reforms**

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

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

21           (1) in clause (iv), by striking “for 2001, 0.5  
22           percentage points” and inserting “for 2001, 0 per-  
23           centage points”; and



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 (1) by striking “(ii) For a subsequent year”  
21 and inserting “(ii)(I) Subject to subclause (II), for  
22 a subsequent year”; and

23 (2) by adding at the end the following new sub-  
24 clause:

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

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

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

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

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

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

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

1           “(i) IN GENERAL.—For each year be-  
2           ginning with 2004, in the case of a  
3           Medicare+Choice payment area for which  
4           the Medicare+Choice capitation rate under  
5           this paragraph would otherwise be less  
6           than the United States per capita cost  
7           (USPCC), as calculated by the Secretary,  
8           a Medicare+Choice organization may ne-  
9           gotiate with the Medicare Benefits Admin-  
10          istrator an annual per capita rate that—

11                   “(I) reflects an annual rate of in-  
12                   crease up to the rate of increase speci-  
13                   fied in clause (ii);

14                   “(II) takes into account audited  
15                   current data supplied by the organiza-  
16                   tion on its adjusted community rate  
17                   (as defined in section 1854(f)(3)); and

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

21           “(ii) MAXIMUM RATE DESCRIBED.—  
22           The rate of increase specified in this clause  
23           for a year is the rate of inflation in private  
24           health insurance for the year involved, as  
25           projected by the Medicare Benefits Admin-

1           istrator, and includes such adjustments as  
2           may be necessary—

3                   “(I) to reflect the demographic  
4                   characteristics in the population under  
5                   this title; and

6                   “(II) to eliminate the costs of  
7                   prescription drugs.

8                   “(iii) ADJUSTMENTS FOR OVER OR  
9                   UNDER PROJECTIONS.—If subparagraph is  
10                  applied to an organization and payment  
11                  area for a year, in applying this subpara-  
12                  graph for a subsequent year the provisions  
13                  of paragraph (6)(C) shall apply in the  
14                  same manner as such provisions apply  
15                  under this paragraph.”.

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

18           Section 1853(a)(3)(C)(ii) of the Social Security Act  
19 (42 U.S.C. 1395w-23(c)(1)(C)(ii)) is amended—

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

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

24                   “and, beginning in 2004, insofar as such  
25                   risk adjustment is based on data from all

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

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

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

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

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

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

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

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

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

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

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

1           (1) the delivery of health care services to Medi-  
2           care beneficiaries with cancer;

3           (2) total Medicare expenditures, including an  
4           estimate of the number of patients who would, as a  
5           result of the payment reduction, receive chemo-  
6           therapy in a hospital rather than in a physician's of-  
7           fice;

8           (3) the delivery of dialysis services;

9           (4) the delivery of vaccines;

10          (5) the administration in physician offices of  
11          drugs other than cancer therapy drugs; and

12          (6) the effect on the delivery of drug therapies  
13          by hospital outpatient departments of changing the  
14          average wholesale price as the basis for Medicare  
15          pass-through payments to such departments, as in-  
16          cluded in the Medicare, Medicaid, and SCHIP Bal-  
17          anced Budget Refinement Act of 1999.

18          (c) PAYMENT FOR RELATED PROFESSIONAL SERV-  
19          ICES.—The study shall also include a review of the extent  
20          to which other payment methodologies under part B of  
21          the medicare program, if any, intended to reimburse phy-  
22          sician and other suppliers of drugs and biologicals de-  
23          scribed in subsection (a) for costs incurred in handling,  
24          storing and administering such drugs and biologicals are  
25          inadequate to cover such costs and whether an additional



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

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

8 (1) Identification of possible bases for deter-  
9 mining the average acquisition cost of drugs, such as  
10 surveys of wholesaler catalog prices, and determina-  
11 tion of the advantages, disadvantages, and costs (to  
12 the government and public) of each possible ap-  
13 proach.

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

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

19 (e) COORDINATION WITH BBRA STUDY.—The  
20 Comptroller General shall conduct the study under this  
21 section in coordination with the study provided for under  
22 section 213(a) of the Medicare, Medicaid, and SCHIP  
23 Balanced Budget Refinement Act of 1999 (113 Stat.  
24 1501A–350), as enacted into law by section 1000(a)(6)  
25 of Public Law 106–113.

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

Passed the House of Representatives June 28, 2000.

Attest:

JEFF TRANDAHL,

*Clerk.*



**Calendar No. 655**

106TH CONGRESS  
2D SESSION

**H. R. 4680**

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**AN ACT**

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

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JUNE 30, 2000

Read the second time and placed on calendar