

106TH CONGRESS
1ST SESSION

H. R. 3086

To direct the Secretary of Health and Human Services to make changes in payment methodologies under the Medicare Program under title XVIII of the Social Security Act, and to provide for short-term coverage of outpatient prescription drugs to Medicare beneficiaries who lose drug coverage under Medicare+Choice plans.

IN THE HOUSE OF REPRESENTATIVES

OCTOBER 14, 1999

Mrs. THURMAN (for herself and Mr. McDERMOTT) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To direct the Secretary of Health and Human Services to make changes in payment methodologies under the Medicare Program under title XVIII of the Social Security Act, and to provide for short-term coverage of outpatient prescription drugs to Medicare beneficiaries who lose drug coverage under Medicare+Choice plans.

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.**

2 This Act may be cited as the “Medicare Benefit Eq-
3 uity and Emergency Access to Prescription Drugs Act of
4 1999”.

5 **SEC. 2. FINDINGS.**

6 Congress finds as follows:

7 (1) American taxpayers should receive equal
8 Medicare services regardless of place of residence.

9 (2) Medicare managed care plans play a funda-
10 mental role in the health of our Nation’s seniors,
11 often providing coordinated care and access to phar-
12 maceuticals. The loss of Medicare managed care
13 plans and their services can be devastating to our
14 Nation’s Medicare-eligible seniors.

15 (3) For the second consecutive year, Medicare
16 managed care plans are abandoning hundreds of
17 thousands of medicare beneficiaries. The most recent
18 announcement of plan cancellations means that
19 within the past two years, 734,000 of the Nation’s
20 6,200,000 Medicare beneficiaries enrolled in man-
21 aged care plans will have been dropped from those
22 plans.

23 (4) In 1999, Medicare managed care plan with-
24 drawals affected nearly 407,000 Medicare bene-
25 ficiaries, and 51,276 beneficiaries in 79 counties

1 were left with no other Medicare managed care op-
2 tion.

3 (5) Beginning January 2000, another 327,000
4 enrollees will need to find alternative coverage, and
5 79,000 of these Medicare managed care participants
6 will have no other Medicare+Choice plan available.

7 (6) Medicare beneficiaries who have lost their
8 managed care option can enroll in Medicare fee-for-
9 service; however, Medicare fee-for-service does not
10 currently provide comprehensive outpatient pharma-
11 ceutical coverage.

12 (7) While all beneficiaries pay the same medi-
13 care part B premium as other program participants,
14 Medicare beneficiaries regularly pay managed care
15 plans varied amounts and receive very unequal serv-
16 ices and benefits.

17 (8) A growing body of data suggests that med-
18 ical practice and Medicare spending vary substan-
19 tially among the Nation's hospital referral regions,
20 even after adjustments for differences in regional
21 prices and illness rates, but there is little evidence
22 that greater spending brings better health.

23 (9) By adjusting Medicare reimbursement pay-
24 ment rates (adjusted for age, sex, severity of illness,
25 etc.) and lowering Medicare reimbursement pay-

1 ment to providers and regions where there are more
2 costly patterns of practice without better health out-
3 comes, Congress can provide more equitable and ef-
4 ficient health care for our Nation's 39,000,000
5 Medicare beneficiaries.

6 (10) Such a strategy will encourage a more re-
7 sponsible practice of medicine at the lowest cost to
8 the taxpayer and Medicare beneficiary, and will free
9 resources for improvements to the medicare pro-
10 gram.

11 **SEC. 3. MEDICARE CLINICAL PRACTICE AND PAYMENT PAT-**
12 **TERN ADJUSTMENT.**

13 (a) ESTABLISHMENT OF PRACTICE PROFILES.—

14 (1) IN GENERAL.—By not later than January
15 1, 2002, the Secretary of Health and Human Serv-
16 ices shall establish clinical profiles of the practice
17 and payment patterns of health care providers (in-
18 cluding both institutional providers and health care
19 professionals) furnishing items and services under
20 the medicare program under title XVIII of the So-
21 cial Security Act in order to determine how their
22 practice and payment patterns compare to each
23 other on a local, State, and national basis. In estab-
24 lishing such profiles, the Secretary shall take into
25 account differences in the case mix and severity of

1 patients served by such providers and shall take into
2 account, to the extent practicable, the medical out-
3 comes resulting from such practices.

4 (2) DISSEMINATION OF INFORMATION.—The
5 Secretary shall establish a method for disseminating
6 summary information to the public on the clinical
7 profiles established under paragraph (1). No infor-
8 mation that identifies (or permits the identification
9 of) an individual patient shall be disseminated.

10 (b) AUTHORITY TO MAKE PAYMENT ADJUST-
11 MENTS.—For items and services furnished on or after
12 January 1, 2003, the Secretary of Health and Human
13 Services may adjust the amount of the payments made
14 under the medicare program to such health care providers
15 in order to encourage their provision of services in a medi-
16 cally appropriate manner and to discourage significant de-
17 viations in underservice or overservice from generally ac-
18 cepted norms of medical practice. Such adjustments shall
19 be made on the basis of provider profiles established under
20 subsection (a) and shall be made only after—

21 (1) taking into account variations among pro-
22 viders in the case mix and severity of patients
23 served; and

1 (2) the Secretary determines that discouraging
2 particular patterns of overservice will not adversely
3 affect outcomes or quality of care.

4 (c) SCHEDULE TO REDUCE OVERPAYMENTS.—

5 (1) IN GENERAL.—For items and services fur-
6 nished on or after January 1, 2004, the Secretary
7 shall annually reduce overpayments to providers by
8 five percent of the overpayment amount (as defined
9 in paragraph (2)). Such reduction shall be adminis-
10 tered through a percentage reduction in the pro-
11 viders' applicable payment methodology.

12 (2) OVERPAYMENT AMOUNT DEFINED.—In this
13 subsection, the term “overpayment amount” means
14 a health care provider's payment profile minus the
15 median national payment profiles for similar health
16 care providers, adjusted for variations in case mix
17 and severity of patients served.

18 **SEC. 4. ADJUSTMENT IN MEDICARE+CHOICE PAYMENT**
19 **RATES TO OVERPAID COUNTIES.**

20 (a) IN GENERAL.—Section 1853(c)(1)(C) of the So-
21 cial Security Act (42 U.S.C. 1395w-23(c)(1)(C)) is
22 amended—

23 (1) in clause (ii), by striking “For a subsequent
24 year,” and inserting “Subject to clause (iii), for a
25 subsequent year,”; and

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

3 “(iii) In the case of a year beginning
4 after 1999 for which the Secretary deter-
5 mines there is an overpaid payment area
6 (as defined in paragraph (8)), the fol-
7 lowing:

8 “(I) In the case of such overpaid
9 payment area, 100.5 percent of the
10 annual Medicare+Choice capitation
11 rate under this paragraph for the area
12 for the previous year.

13 “(II) In the case of a payment
14 area that is not an overpaid payment
15 area, 102 percent of the annual
16 Medicare+Choice capitation rate
17 under this paragraph for the area for
18 the previous year.”.

19 (b) OVERPAID PAYMENT AREA DEFINED.—Section
20 1853(c) of such Act (42 U.S.C. 1395w-23(c)) is amended
21 by adding at the end the following new paragraph:

22 “(8) OVERPAID PAYMENT AREA DEFINED.—For
23 purposes of paragraph (1)(C)(iii), the term ‘overpaid
24 payment area’ means a Medicare+Choice payment
25 area for a year for which the annual per capita rate

1 of payment for such area exceeds the mean of the
2 annual per capita rates of payments for all
3 Medicare+Choice payment areas for that year by
4 more than two standard deviations, such mean de-
5 termined without regard to the number of Medicare
6 beneficiaries in such payment areas.”.

7 (c) ALLOCATION OF SAVINGS TO UNDERPAID COUN-
8 TIES.—For a contract year consisting of a calendar year
9 beginning on or after January 1, 2000, for which the Sec-
10 retary of Health and Human Services has determined
11 there is an overpaid payment area (as defined in section
12 1853(c)(8)), as added by subsection (b), the Secretary
13 shall adjust the annual per capita rate of payment for
14 Medicare+Choice payment areas described in section
15 1853(c)(1)(C)(iii)(II), as added by subsection (a), to in-
16 crease the blended capitation rate applicable to such areas
17 under section 1853(c)(1)(A) (in such pro rata manner as
18 the Secretary determines appropriate) by an aggregate
19 amount equal to the aggregate amount of reductions in
20 payments attributable to section 1853(c)(1)(C)(iii)(I), as
21 added by subsection (a).

1 **SEC. 5. PROVISION OF EMERGENCY OUTPATIENT PRE-**
2 **SCRIPTION DRUG COVERAGE FOR MEDICARE**
3 **BENEFICIARIES LOSING DRUG COVERAGE**
4 **UNDER MEDICARE+CHOICE PLANS.**

5 (a) TEMPORARY COVERAGE OF OUTPATIENT PRE-
6 SCRIPTON DRUGS FOR MEDICARE BENEFICIARIES LOS-
7 ING PRESCRIPTION DRUG COVERAGE UNDER
8 MEDICARE+CHOICE PLANS.—

9 (1) IN GENERAL.—The Secretary of Health and
10 Human Services shall provide for coverage of out-
11 patient prescription drugs to eligible Medicare bene-
12 ficiaries under this section. The Secretary shall pro-
13 vide for such coverage by entering into agreements
14 with eligible organizations to furnish such coverage.

15 (2) TERM OF EMERGENCY COVERAGE.—The
16 Secretary shall provide coverage of outpatient pre-
17 scription drugs to an eligible Medicare beneficiary
18 under this section for the 18-month period beginning
19 on the date the eligible Medicare beneficiary loses
20 coverage of outpatient prescription drugs under the
21 Medicare+Choice plan in which the beneficiary is
22 enrolled.

23 (3) COST-SHARING.—The Secretary shall im-
24 pose the following cost-sharing requirements under
25 coverage of outpatient prescription drugs furnished
26 under this section:

1 (A) Benefits under this section shall not
2 begin until the eligible medicare beneficiary has
3 met a \$50 deductible.

4 (B) The eligible Medicare beneficiary shall
5 pay coinsurance in the amount of 10 percent.

6 (4) PAYMENT.—The Secretary shall provide for
7 payment for such coverage under this section from
8 the Emergency Reserve Outpatient Prescription
9 Drug Account established under subsection (b).

10 (b) ACCOUNT FOR EMERGENCY OUTPATIENT PRE-
11 SCRIPTION DRUG BENEFIT IN SMI TRUST FUND.—

12 (1) ESTABLISHMENT.—There is hereby estab-
13 lished in the Federal Supplementary Medical Insur-
14 ance Trust Fund under section 1841 of the Social
15 Security Act (42 U.S.C. 1395t) an expenditure ac-
16 count to be known as the “Emergency Reserve Out-
17 patient Prescription Drug Account”.

18 (2) CREDITING OF FUNDS.—The Managing
19 Trustee shall credit to the Emergency Reserve Out-
20 patient Prescription Drug Account such amounts as
21 may be deposited in the Federal Supplementary
22 Medical Insurance Trust Fund as follows:

23 (A) Amounts appropriated to the account.

24 (B) Amounts equal to the annual out-
25 standing balance of the Health Care Fraud and

1 Abuse Control Account under section 1817(k)
2 of the Social Security Act (42 U.S.C. 1395i(k))
3 at the end of each fiscal year that the Secretary
4 determines may be made available to the Emer-
5 gency Reserve Outpatient Prescription Drug
6 Account.

7 (C) Amounts attributable to reductions in
8 payments to providers under section 3(e) of this
9 Act.

10 (3) USE OF FUNDS.—Funds credited to the
11 Outpatient Prescription Drug Account may only be
12 used to pay for outpatient prescription drugs fur-
13 nished under this section.

14 (e) DEFINITIONS.—In this section:

15 (1) ELIGIBLE MEDICARE BENEFICIARY.—The
16 term “eligible Medicare beneficiary” means an
17 individual—

18 (A) who is enrolled in a Medicare+Choice
19 plan under part C of title XVIII of the Social
20 Security Act;

21 (B) who requires outpatient prescription
22 drugs for an extended period of time for the
23 treatment of a condition, as determined by a
24 physician; and

1 (C)(i) whose enrollment in such plan is ter-
2 minated or may not be renewed for the next
3 contract year because the plan has been termi-
4 nated or will not be offered in such contract
5 year; or

6 (ii) whose coverage of outpatient prescrip-
7 tion drugs under such plan has been termi-
8 nated, significantly reduced, or no longer pro-
9 vides for the coverage of a particular outpatient
10 prescription drug required as specified under
11 subparagraph (B).

12 (2) COVERED OUTPATIENT DRUG.—

13 (A) IN GENERAL.—Except as provided in
14 subparagraph (B), the term “covered outpatient
15 drug” means any of the following products:

16 (i) A drug which may be dispensed
17 only upon prescription, and—

18 (I) which is approved for safety
19 and effectiveness as a prescription
20 drug under section 505 of the Federal
21 Food, Drug, and Cosmetic Act;

22 (II)(aa) which was commercially
23 used or sold in the United States be-
24 fore the date of enactment of the
25 Drug Amendments of 1962 or which

1 is identical, similar, or related (within
2 the meaning of section 310.6(b)(1) of
3 title 21 of the Code of Federal Regu-
4 lations) to such a drug, and (bb)
5 which has not been the subject of a
6 final determination by the Secretary
7 that it is a “new drug” (within the
8 meaning of section 201(p) of the Fed-
9 eral Food, Drug, and Cosmetic Act)
10 or an action brought by the Secretary
11 under section 301, 302(a), or 304(a)
12 of such Act to enforce section 502(f)
13 or 505(a) of such Act; or

14 (III)(aa) which is described in
15 section 107(c)(3) of the Drug Amend-
16 ments of 1962 and for which the Sec-
17 retary has determined there is a com-
18 pelling justification for its medical
19 need, or is identical, similar, or re-
20 lated (within the meaning of section
21 310.6(b)(1) of title 21 of the Code of
22 Federal Regulations) to such a drug,
23 and (bb) for which the Secretary has
24 not issued a notice of an opportunity
25 for a hearing under section 505(e) of

1 the Federal Food, Drug, and Cos-
2 metic Act on a proposed order of the
3 Secretary to withdraw approval of an
4 application for such drug under such
5 section because the Secretary has de-
6 termined that the drug is less than ef-
7 fective for all conditions of use pre-
8 scribed, recommended, or suggested in
9 its labeling.

10 (ii) A biological product which—

11 (I) may only be dispensed upon
12 prescription;

13 (II) is licensed under section 351
14 of the Public Health Service Act; and

15 (III) is produced at an establish-
16 ment licensed under such section to
17 produce such product.

18 (iii) Insulin approved under appro-
19 priate Federal law.

20 (iv) A prescribed drug or biological
21 product that would meet the requirements
22 of clause (i) or (ii) but that is available
23 over-the-counter in addition to being avail-
24 able upon prescription.

1 (B) EXCLUSION.—The term “covered out-
2 patient drug” does not include any product—

3 (i) except as provided in subparagraph
4 (A)(iv), which may be distributed to indi-
5 viduals without a prescription;

6 (ii) when furnished as part of, or as
7 incident to, a diagnostic service or any
8 other item or service for which payment
9 may be made under title XVIII of the So-
10 cial Security Act; or

11 (iii) that is a therapeutically equiva-
12 lent replacement for a product described in
13 clause (i) or (ii), as determined by the Sec-
14 retary.

15 (3) ELIGIBLE ORGANIZATION.—The term “eligi-
16 ble organization” means any organization that the
17 Secretary determines to be appropriate, including—

18 (A) pharmaceutical benefit management
19 companies;

20 (B) wholesale and retail pharmacist deliv-
21 ery systems;

22 (C) insurers;

23 (D) other organizations; or

24 (E) any combination of the entities de-
25 scribed in subparagraphs (A) through (D).

1 (4) SECRETARY.—The term “Secretary” means
2 the Secretary of Health and Human Services.

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