

106TH CONGRESS  
2D SESSION

# H. R. 4770

To amend title XVIII of the Social Security Act to provide a prescription medicine benefit under the Medicare Program, to enhance the preventive benefits covered under such program, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

JUNE 27, 2000

Mr. GEPHARDT (for himself, Mr. HOEFFEL, Mr. BONIOR, Mr. RANGEL, Mr. DINGELL, Mr. STARK, Mr. BROWN of Ohio, Mr. MATSUI, Mr. COYNE, Mr. LEVIN, Mr. CARDIN, Mr. McDERMOTT, Mr. KLECZKA, Mr. LEWIS of Georgia, Mr. NEAL of Massachusetts, Mr. McNULTY, Mr. JEFFERSON, Mr. TANNER, Mr. BECERRA, Mrs. THURMAN, Mr. DOGGETT, Mr. WAXMAN, Mr. MARKEY, Mr. BOUCHER, Mr. PALLONE, Mr. STUPAK, Mr. ENGEL, Mr. GREEN of Texas, Mr. ALLEN, Mr. BACA, Mr. BENTSEN, Ms. BERKLEY, Mr. BISHOP, Mrs. CAPPS, Mr. BLAGOJEVICH, Mr. BLUMENAUER, Mr. BRADY of Pennsylvania, Ms. BROWN of Florida, Mr. CAPUANO, Mr. CLAY, Mrs. CLAYTON, Mr. CLEMENT, Mr. CONYERS, Mr. COSTELLO, Mr. CUMMINGS, Ms. DANNER, Mr. DAVIS of Illinois, Ms. DEGETTE, Mr. DELAHUNT, Ms. DELAURO, Mr. DIXON, Mr. DOYLE, Mr. EDWARDS, Mr. EVANS, Mr. FARR of California, Mr. FORBES, Mr. FRANK of Massachusetts, Mr. FROST, Mr. GONZALEZ, Mr. GUTIERREZ, Mr. HILLIARD, Ms. NORTON, Mr. HOYER, Mr. INSLEE, Mr. JACKSON of Illinois, Ms. JACKSON-LEE of Texas, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. KENNEDY of Rhode Island, Mr. KILDEE, Ms. KILPATRICK, Mr. KUCINICH, Mr. LAMPSON, Mr. LANTOS, Ms. LEE, Mrs. LOWEY, Mr. MCGOVERN, Mrs. MALONEY of New York, Mr. MEEHAN, Mr. MENENDEZ, Ms. MILLENDER-McDONALD, Mr. MOAKLEY, Mrs. NAPOLITANO, Mr. OBERSTAR, Mr. OLVER, Mr. ORTIZ, Mr. PASCRELL, Mr. PASTOR, Ms. PELOSI, Mr. PHELPS, Mr. POMEROY, Mr. REYES, Mr. RODRIGUEZ, Ms. ROYBAL-ALLARD, Ms. SANCHEZ, Mr. SANDLIN, Mr. SKELTON, Ms. SLAUGHTER, Mr. SNYDER, Mr. SPRATT, Ms. STABENOW, Mrs. JONES of Ohio, Mr. TURNER, Mr. UDALL of New Mexico, Mr. UNDERWOOD, Mr. WEYGAND, Mr. WEXLER, and Ms. WOOLSEY) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

# A BILL

To amend title XVIII of the Social Security Act to provide a prescription medicine benefit under the Medicare Program, to enhance the preventive benefits covered under such program, and for other purposes.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the  
 5 “Medicare Guaranteed and Defined Rx Benefit and  
 6 Health Provider Relief Act of 2000”.

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

Sec. 1. Short title; table of contents.

Sec. 2. Findings.

TITLE I—MEDICARE PRESCRIPTION MEDICINE BENEFIT  
PROGRAM

Sec. 101. Prescription medicine benefit program.

“PART D—PRESCRIPTION MEDICINE BENEFIT FOR THE AGED AND  
DISABLED

“Sec. 1860. Establishment of defined prescription medicine benefit pro-  
gram for the aged and disabled under the medicare pro-  
gram.

“Sec. 1860A. Scope of defined benefits; coverage of all medically necessary  
prescription medicines.

“Sec. 1860B. Payment of defined basic and catastrophic benefits.

“Sec. 1860C. Eligibility and enrollment.

“Sec. 1860D. Monthly premium; initial \$25 premium.

“Sec. 1860F. Prescription medicine insurance account.

“Sec. 1860G. Administration of benefits .

“Sec. 1860H. Incentive program to encourage employers to continue cov-  
erage .

“Sec. 1860I. Appropriations to cover government contributions.

“Sec. 1860J. Definitions.”.

Sec. 102. Medicaid buy-in of medicare prescription drug coverage for certain  
low-income individuals.

“Sec. 1860E. Special eligibility, enrollment, and copayment rules for low-income individuals.”.

Sec. 103. Offset for catastrophic prescription medicine benefit.

Sec. 104. GAO ongoing studies and reports on program; miscellaneous studies and reports.

## TITLE II—IMPROVEMENT IN BENEFICIARY SERVICES

### Subtitle A—Improvement of Medicare Coverage and Appeals Process

Sec. 201. Revisions to medicare appeals process.

Sec. 202. Provisions with respect to limitations on liability of beneficiaries.

Sec. 203. Waivers of liability for cost sharing amounts.

### Subtitle B—Establishment of Medicare Ombudsman

Sec. 211. Establishment of Medicare Ombudsman for Beneficiary Assistance and Advocacy.

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

### Subtitle A—Medicare+Choice Reforms

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

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

Sec. 303. Increasing minimum payment amount.

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

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

Sec. 306. Permitting higher negotiated rates in certain Medicare+Choice payment areas below national average.

Sec. 307. 10-year phase in of risk adjustment based on data from all settings.

### Subtitle B—Preservation of Medicare Coverage of Drugs and Biologicals

Sec. 311. Preservation of coverage of drugs and biologicals under part B of the medicare program.

Sec. 312. Comprehensive immunosuppressive medicine coverage for transplant patients.

### Subtitle C—Improvement of Certain Preventive Benefits

Sec. 321. Coverage of annual screening pap smear and pelvic exams.

## TITLE IV—ADJUSTMENTS TO PAYMENT PROVISIONS OF THE BALANCED BUDGET ACT

### Subtitle A—Payments for Inpatient Hospital Services

Sec. 401. Eliminating reduction in hospital market basket update for fiscal year 2001.

Sec. 402. Eliminating further reductions in indirect medical education (IME) for fiscal year 2001.

Sec. 403. Eliminating further reductions in disproportionate share hospital (DSH) payments.

Sec. 404. Increase base payment to Puerto Rico hospitals.

Subtitle B—Payments for Skilled Nursing Services

Sec. 411. Eliminating reduction in SNF market basket update for fiscal year 2001.

Sec. 412. Extension of moratorium on therapy caps.

Subtitle C—Payments for Home Health Services

Sec. 421. 1-year additional delay in application of 15 percent reduction on payment limits for home health services.

Sec. 422. Provision of full market basket update for home health services for fiscal year 2001.

Subtitle D—Rural Provider Provisions

Sec. 431. Elimination of reduction in hospital outpatient market basket increase.

Subtitle E—Other Providers

Sec. 441. Update in renal dialysis composite rate.

Subtitle F—Provision for Additional Adjustments

Sec. 451. Guarantee of additional adjustments to payments for providers from budget surplus.

1 **SEC. 2. FINDINGS.**

2 Congress makes the following findings:

3 (1) Prescription medicine coverage was not a  
4 standard part of health insurance when the medicare  
5 program under title XVIII of the Social Security Act  
6 was enacted in 1965. Since 1965, however, medicine  
7 coverage has become a key component of most pri-  
8 vate and public health insurance coverage, except for  
9 the medicare program.

10 (2) At least  $\frac{2}{3}$  of medicare beneficiaries have  
11 unreliable, inadequate, or no medicine coverage at  
12 all.

1           (3) Seniors who do not have medicine coverage  
2 typically pay, at a minimum, 15 percent more than  
3 people with coverage.

4           (4) Medicare beneficiaries at all income levels  
5 lack prescription medicine coverage, with more than  
6 ½ of such beneficiaries having incomes greater than  
7 150 percent of the poverty line.

8           (5) The number of private firms offering retiree  
9 health coverage is declining.

10          (6) Medigap premiums for medicines are too ex-  
11 pensive for most beneficiaries and are highest for  
12 older senior citizens, who need prescription medicine  
13 coverage the most and typically have the lowest in-  
14 comes.

15          (7) While the management of a medicare pre-  
16 scription medicine benefit program should mirror the  
17 practices employed by benefit administrators in de-  
18 livering prescription medicines, the Secretary of  
19 Health and Human Services should oversee that pro-  
20 gram to assure that a guaranteed and defined pre-  
21 scription drug benefit is provided to all medicare  
22 beneficiaries.

23          (8) All medicare beneficiaries should have ac-  
24 cess to a voluntary, reliable, affordable, dependable,  
25 and defined outpatient medicine benefit as part of

1 the medicare program that assists with the high cost  
2 of prescription medicines and protects them against  
3 excessive out-of-pocket costs.

4 **TITLE I—MEDICARE PRESCRIP-**  
5 **TION MEDICINE BENEFIT**  
6 **PROGRAM**

7 **SEC. 101. ESTABLISHMENT OF THE MEDICARE PRESCRIP-**  
8 **TION MEDICINE BENEFIT PROGRAM.**

9 (a) IN GENERAL.—Title XVIII of the Social Security  
10 Act (42 U.S.C. 1395 et seq.) is amended—

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

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

14 “PART D—PRESCRIPTION MEDICINE BENEFIT FOR THE  
15 AGED AND DISABLED

16 “ESTABLISHMENT OF DEFINED PRESCRIPTION MEDICINE  
17 BENEFIT PROGRAM FOR THE AGED AND DISABLED  
18 UNDER THE MEDICARE PROGRAM

19 “SEC. 1860. (a) IN GENERAL.—There is established  
20 as a part of the medicare program under this title a vol-  
21 untary insurance program to provide defined prescription  
22 medicine benefits, including pharmacy services, in accord-  
23 ance with the provisions of this part for individuals who  
24 are aged or disabled or have end-stage renal disease and  
25 who voluntarily elect to enroll under such program, to be

1 financed from premium payments by enrollees together  
2 with contributions from funds appropriated by the Federal  
3 Government.

4 “(b) NONINTERFERENCE BY THE SECRETARY.—In  
5 administering the prescription medicine benefit program  
6 established under this part, the Secretary may not—

7 “(1) require a particular formulary, institute a  
8 price structure for benefits, or in any way ration  
9 benefits;

10 “(2) interfere in any way with negotiations be-  
11 tween benefit administrators and medicine manufac-  
12 turers, or wholesalers; or

13 “(3) otherwise interfere with the competitive  
14 nature of providing a prescription medicine benefit  
15 using private benefit administrators, except as is re-  
16 quired to guarantee coverage of the defined benefit.

17 “SCOPE OF DEFINED BENEFITS; COVERAGE OF ALL  
18 MEDICALLY NECESSARY PRESCRIPTION MEDICINES

19 “SEC. 1860A. (a) IN GENERAL.—The benefits pro-  
20 vided to an individual enrolled in the insurance program  
21 under this part shall consist of—

22 “(1) payments made, in accordance with the  
23 provisions of this part, for covered prescription  
24 medicines (as specified in subsection (b)) dispensed  
25 by any pharmacy participating in the program under  
26 this part (and, in circumstances designated by the

1 benefit administrator, by a nonparticipating phar-  
2 macy), including any specifically named medicine  
3 prescribed for the individual by a qualified health  
4 care professional regardless of whether the medicine  
5 is included in a formulary established by the benefit  
6 administrator if such medicine is certified as medi-  
7 cally necessary by such health care professional (ex-  
8 cept that to the maximum extent possible the substi-  
9 tution and use of lower-cost generics shall be encour-  
10 aged); and

11 “(2) charging by pharmacies of the negotiated  
12 discount price—

13 “(A) for all covered prescription medicines,  
14 without regard to such basic benefit limitation;  
15 and

16 “(B) established with respect to any drugs  
17 or classes of drugs described in subparagraphs  
18 (A), (B), (D), (E), or (F) of section 1927(d)(2)  
19 that are available to individuals receiving bene-  
20 fits under this title.

21 “(b) COVERED PRESCRIPTION MEDICINES.—

22 “(1) IN GENERAL.—Covered prescription medi-  
23 cines, for purposes of this part, include all prescrip-  
24 tion medicines (as defined in section 1860J(1)), in-

1 including smoking cessation agents, except as other-  
2 wise provided in this subsection.

3 “(2) EXCLUSIONS FROM COVERAGE.—Covered  
4 prescription medicines shall not include drugs or  
5 classes of drugs described in subparagraphs (A)  
6 through (D) and (F) through (H) of section  
7 1927(d)(2) unless—

8 “(A) specifically provided otherwise by the  
9 Secretary with respect to a drug in any of such  
10 classes; or

11 “(B) a drug in any of such classes is cer-  
12 tified to be medically necessary by a health care  
13 professional.

14 “(3) NONDUPLICATION OF PRESCRIPTION  
15 MEDICINES COVERED UNDER PART A OR B.—A med-  
16 icine prescribed for an individual that would other-  
17 wise be a covered prescription medicine under this  
18 part shall not be so considered to the extent that  
19 payment for such medicine is available under part A  
20 or B (including all injectable drugs and biologicals  
21 for which payment was made or should have been  
22 made by a carrier under section 1861(s)(2) (A) or  
23 (B) as of the date of enactment of the Medicare  
24 Guaranteed and Defined Rx Benefit and Health  
25 Provider Relief Act of 2000). Medicines otherwise

1 covered under part A or B shall be covered under  
2 this part to the extent that benefits under part A or  
3 B are exhausted.

4 “(4) STUDY ON INCLUSION OF HOME INFUSION  
5 THERAPY SERVICES.—Not later than one year after  
6 the date of the enactment of the Medicare Guaranteed and Defined Rx Benefit and Health Provider  
7 Relief Act of 2000, the Secretary shall submit to  
8 Congress a legislative proposal for the delivery of  
9 home infusion therapy services under this title and  
10 for a system of payment for such a benefit that co-  
11 ordinates items and services furnished under part B  
12 and under this part.

14 “PAYMENT OF DEFINED BASIC AND CATASTROPHIC  
15 BENEFITS

16 “SEC. 1860B. (a) PAYMENT OF BENEFITS.—There  
17 shall be paid from the Prescription Medicine Insurance  
18 Account within the Supplementary Medical Insurance  
19 Trust Fund, in the case of each individual who is enrolled  
20 in the insurance program under this part and who pur-  
21 chases covered prescription medicines in a calendar year,  
22 the sum of the benefit amounts under subsections (b) and  
23 (c).

24 “(b) BASIC BENEFIT.—

25 “(1) IN GENERAL.—An amount (not exceeding  
26 50 percent of the annual limitation under paragraph

1 (3)) equal to the applicable government percentage  
2 (specified in paragraph (2)) of the negotiated price  
3 for each such covered prescription medicine or such  
4 higher percentage as is proposed under section  
5 1860G(d)(9).

6 “(2) APPLICABLE GOVERNMENT PERCENT-  
7 AGE.—The applicable government percentage speci-  
8 fied in this paragraph is 50 percent or such higher  
9 percentage as may be proposed under section  
10 1860G(d)(9), if the Secretary finds that such higher  
11 percentage will not increase aggregate costs to the  
12 Prescription Medicine Insurance Account.

13 “(3) ANNUAL LIMITATION IN BASIC BENEFIT.—

14 “(A) FOR 2003 THROUGH 2009.—For pur-  
15 poses of the basic benefit described in para-  
16 graph (1), the annual limitation under this  
17 paragraph is—

18 “(i) \$2,000 for each of 2003 and  
19 2004;

20 “(ii) \$3,000 for each of 2005 and  
21 2006;

22 “(iii) \$4,000 for each of 2007 and  
23 2008; and

24 “(iv) \$5,000 for 2009.

1           “(B) FOR 2010 AND SUBSEQUENT  
2 YEARS.—For purposes of paragraph (1), the  
3 annual limitation under this paragraph for  
4 2010 and each subsequent year is equal to the  
5 limitation for the preceding year adjusted by  
6 the annual percentage increase in average per  
7 capita aggregate expenditures for covered out-  
8 patient medicines in the United States for  
9 medicare beneficiaries, as estimated by the Sec-  
10 retary. Any amount determined under this sub-  
11 paragraph that is not a multiple of \$10 shall be  
12 rounded to the nearest multiple of \$10.

13           “(c) CATASTROPHIC BENEFIT.—

14           “(1) FOR 2003.—In the case of and with respect  
15 to out-of-pocket expenditures, the amount of such  
16 expenditures that exceeds the catastrophic benefit  
17 level established by the Secretary under paragraph  
18 (2) and increased in subsequent years by the annual  
19 percentage increase under paragraph (3).

20           “(2) ESTABLISHMENT OF CATASTROPHIC BEN-  
21 EFIT LEVEL.—The Chief Actuary shall estimate,  
22 over each five-year period, beginning with 2003, the  
23 amount of savings to the program under this title  
24 attributable to the operation of section 103 of the  
25 Medicare Guaranteed and Defined Rx Benefit and

1 Health Provider Relief Act of 2000. Based on such  
2 estimates, the Secretary shall establish the cata-  
3 strophic benefit level in a manner so that the aggre-  
4 gate amount of expenditures under this paragraph  
5 does not exceed the aggregate amount of such sav-  
6 ings, except that in 2003 and each year thereafter,  
7 the catastrophic benefit level may not be greater  
8 than \$4,000, as adjusted under paragraph (3).

9 “(3) INDEXING FOR OUTYEARS.—For a year  
10 beginning after 2003, the catastrophic benefit level  
11 shall be increased by annual percentage increase de-  
12 termined for the year involved under subsection  
13 (b)(3)(B).

14 “ELIGIBILITY AND ENROLLMENT

15 “SEC. 1860C. (a) ELIGIBILITY.—Every individual  
16 who, in or after 2003, is entitled to hospital insurance ben-  
17 efits under part A or enrolled in the medical insurance  
18 program under part B is eligible to enroll in the insurance  
19 program under this part, during an enrollment period pre-  
20 scribed in or under this section, in such manner and form  
21 as may be prescribed by regulations.

22 “(b) ENROLLMENT.—

23 “(1) IN GENERAL.—Each individual who satis-  
24 fies subsection (a) shall be enrolled (or eligible to en-  
25 roll) in the program under this part in accordance  
26 with the provisions of section 1837, as if that section

1 applied to this part, except as otherwise explicitly  
2 provided in this part.

3 “(2) SINGLE ENROLLMENT PERIOD.—Except as  
4 provided in section 1837(i) (as such section applies  
5 to this part), 1860E (relating to loss of coverage  
6 under the medicaid program), or 1860H(e) (relating  
7 to loss of employer or union coverage), or as other-  
8 wise explicitly provided, no individual shall be enti-  
9 tled to enroll in the program under this part at any  
10 time after the initial enrollment period without pen-  
11 alty, and in the case of all other late enrollments,  
12 the Secretary shall develop a late enrollment penalty  
13 for the individual that fully recovers the additional  
14 actuarial risk involved in providing coverage for the  
15 individual.

16 “(3) SPECIAL ENROLLMENT PERIOD IN 2003.—

17 “(A) IN GENERAL.—An individual who  
18 first satisfies subsection (a) in 2003 may, at  
19 any time on or before December 31, 2003—

20 “(i) enroll in the program under this  
21 part; and

22 “(ii) enroll or reenroll in such pro-  
23 gram after having previously declined or  
24 terminated enrollment in such program.

1           “(B) EFFECTIVE DATE OF COVERAGE.—

2           An individual who enrolls under the program  
3           under this part pursuant to subparagraph (A)  
4           shall be entitled to benefits under this part be-  
5           ginning on the first day of the month following  
6           the month in which such enrollment occurs.

7           “(c) PERIOD OF COVERAGE.—

8           “(1) IN GENERAL.—Except as otherwise pro-  
9           vided in this part, an individual’s coverage under the  
10          program under this part shall be effective for the pe-  
11          riod provided in section 1838, as if that section ap-  
12          plied to the program under this part.

13          “(2) PART D COVERAGE TERMINATED BY TER-  
14          MINATION OF COVERAGE UNDER PARTS A AND B.—

15          In addition to the causes of termination specified in  
16          section 1838, an individual’s coverage under this  
17          part shall be terminated when the individual retains  
18          coverage under neither the program under part A  
19          nor the program under part B, effective on the effec-  
20          tive date of termination of coverage under part A or  
21          (if later) under part B.

22          “MONTHLY PREMIUM; INITIAL \$25 PREMIUM

23          “SEC. 1860D. (a) ANNUAL ESTABLISHMENT OF  
24          GUARANTEED SINGLE RATE FOR ALL PARTICIPATING  
25          BENEFICIARIES.—

1           “(1) \$25 MONTHLY PREMIUM RATE IN 2003.—  
2           The monthly premium rate in 2003 for prescription  
3           medicine benefits under this part is \$25.

4           “(2) PREMIUM RATES IN SUBSEQUENT  
5           YEARS.—

6                   “(A) IN GENERAL.—The Secretary shall,  
7                   during September of 2003 and of each suc-  
8                   ceeding year, determine and promulgate a  
9                   monthly premium rate for the succeeding year  
10                  in accordance with the provisions of this para-  
11                  graph.

12                   “(B) DETERMINATION OF ANNUAL BEN-  
13                   EFIT COSTS.—The Secretary shall estimate an-  
14                   nually for the succeeding year the amount equal  
15                   to the total of the benefits (but not including  
16                   catastrophic benefits under section 1860B(c))  
17                   that will be payable from the Prescription Medi-  
18                   cine Insurance Account for prescription medi-  
19                   cines dispensed in such calendar year with re-  
20                   spect to enrollees in the program under this  
21                   part. In calculating such amount, the Secretary  
22                   shall include an appropriate amount for a con-  
23                   tingency margin.

24                   “(C) DETERMINATION OF MONTHLY PRE-  
25                   MIUM RATES.—

1           “(i) IN GENERAL.—The Secretary  
2           shall determine the monthly premium rate  
3           with respect to such enrollees for such suc-  
4           ceeding year, which shall be  $\frac{1}{12}$  of the  
5           share specified in clause (ii) of the amount  
6           determined under subparagraph (B), di-  
7           vided by the total number of such enroll-  
8           ees, and rounded (if such rate is not a  
9           multiple of 10 cents) to the nearest mul-  
10          tiple of 10 cents.

11           “(ii) ENROLLEE AND EMPLOYER PER-  
12          CENTAGE SHARES.—The share specified in  
13          this clause, for purposes of clause (i), shall  
14          be—

15                   “(I) one-half, in the case of pre-  
16                   miums paid by an individual enrolled  
17                   in the program under this part; and

18                   “(II) two-thirds, in the case of  
19                   premiums paid for such an individual  
20                   by a former employer (as defined in  
21                   section 1860H(f)(2)).

22           “(D) PUBLICATION OF ASSUMPTIONS.—  
23          The Secretary shall publish, together with the  
24          promulgation of the monthly premium rates for  
25          the succeeding year, a statement setting forth

1 the actuarial assumptions and bases employed  
2 in arriving at the amounts and rates deter-  
3 mined under this paragraph.

4 “(b) PAYMENT OF PREMIUMS.—

5 “(1) GENERALLY THROUGH DEDUCTION FROM  
6 SOCIAL SECURITY, RAILROAD RETIREMENT BENE-  
7 FITS, OR BENEFITS ADMINISTERED BY OPM.—

8 “(A) IN GENERAL.—In the case of an indi-  
9 vidual who is entitled to or receiving benefits as  
10 described in subsection (a), (b), or (d) of sec-  
11 tion 1840, premiums payable under this part  
12 shall be collected by deduction from such bene-  
13 fits at the same time and in the same manner  
14 as premiums payable under part B are collected  
15 pursuant to section 1840.

16 “(B) TRANSFERS OF DEDUCTION TO AC-  
17 COUNT.—The Secretary of the Treasury shall,  
18 from time to time, but not less often than quar-  
19 terly, transfer premiums collected pursuant to  
20 subparagraph (A) to the Prescription Medicine  
21 Insurance Account from the appropriate funds  
22 and accounts described in subsections (a)(2),  
23 (b)(2), and (d)(2) of section 1840, on the basis  
24 of the certifications described in such sub-  
25 sections. The amounts of such transfers shall be

1 appropriately adjusted to the extent that prior  
2 transfers were too great or too small.

3 “(2) OTHERWISE THROUGH DIRECT PAYMENTS  
4 BY ENROLLEE TO SECRETARY.—

5 “(A) IN THE CASE OF INADEQUATE DE-  
6 DUCTION.—An individual to whom paragraph  
7 (1) applies (other than an individual receiving  
8 benefits as described in section 1840(d)) and  
9 who estimates that the amount that will be  
10 available for deduction under such paragraph  
11 for any premium payment period will be less  
12 than the amount of the monthly premiums for  
13 such period may (under regulations) pay to the  
14 Secretary the estimated balance, or such great-  
15 er portion of the monthly premium as the indi-  
16 vidual chooses.

17 “(B) OTHER CASES.—An individual en-  
18 rolled in the insurance program under this part  
19 with respect to whom none of the preceding  
20 provisions of this subsection applies (or to  
21 whom section 1840(c) applies) shall pay pre-  
22 miums to the Secretary at such times and in  
23 such manner as the Secretary shall by regula-  
24 tions prescribe.

1           “(C) DEPOSIT OF PREMIUMS IN AC-  
2           COUNT.—Amounts paid to the Secretary under  
3           this paragraph shall be deposited in the Treas-  
4           ury to the credit of the Prescription Medicine  
5           Insurance Account in the Supplementary Med-  
6           ical Insurance Trust Fund.

7           “(c) CERTAIN LOW-INCOME INDIVIDUALS.—For  
8           rules concerning premiums for certain low-income individ-  
9           uals, see section 1860E.

10          “PRESCRIPTION MEDICINE INSURANCE ACCOUNT

11          “SEC. 1860F. (a) ESTABLISHMENT.—There is cre-  
12          ated within the Federal Supplemental Medical Insurance  
13          Trust Fund established by section 1841 an account to be  
14          known as the ‘Prescription Medicine Insurance Account’  
15          (in this section referred to as the ‘Account’).

16          “(b) AMOUNTS IN ACCOUNT.—

17                 “(1) IN GENERAL.—The Account shall consist  
18                 of—

19                         “(A) such amounts as may be deposited in,  
20                         or appropriated to, such fund as provided in  
21                         this part; and

22                         “(B) such gifts and bequests as may be  
23                         made as provided in section 201(i)(1).

24                 “(2) SEPARATION OF FUNDS.—Funds provided  
25                 under this part to the Account shall be kept sepa-

1 rate from all other funds within the Federal Supple-  
2 mental Medical Insurance Trust Fund.

3 “(c) PAYMENTS FROM ACCOUNT.—

4 “(1) IN GENERAL.—The Managing Trustee  
5 shall pay from time to time from the Account such  
6 amounts as the Secretary certifies are necessary to  
7 make the payments provided for by this part, and  
8 the payments with respect to administrative ex-  
9 penses in accordance with section 201(g).

10 “(2) TREATMENT IN RELATION TO PART B PRE-  
11 MIUM.—Amounts payable from the Account shall not  
12 be taken into account in computing actuarial rates  
13 or premium amounts under section 1839.

14 “ADMINISTRATION OF BENEFITS

15 “SEC. 1860G. (a) ADMINISTRATION.—

16 “(1) USE OF PRIVATE BENEFIT ADMINISTRA-  
17 TORS AS PROVIDED FOR UNDER PARTS A AND B.—  
18 The Secretary shall provide for administration of the  
19 benefits under this part through a contract with a  
20 private benefit administrator designated in accord-  
21 ance with subsection (c), for enrolled individuals re-  
22 siding in each service area designated pursuant to  
23 subsection (b) (other than such individuals enrolled  
24 in a Medicare+Choice program under part C), in ac-  
25 cordance with the provisions of this section.

1           “(2) GUARANTEE OF PROGRAM ADMINISTRA-  
2           TION.—In the case of a service area in which no pri-  
3           vate benefit administrator has entered into a con-  
4           tract with the Secretary under paragraph (1) for the  
5           administration of this part, the Secretary shall seek  
6           to enter into a contract with a fiscal intermediary  
7           under part A (with a contract under section 1816)  
8           or a carrier under part B (with a contract under  
9           section 1842) to administer this part in that service  
10          area in accordance with the provisions of subsection  
11          (d). If the Secretary is unable to enter into such a  
12          contract for that service area, the Secretary shall  
13          provide for the administration of this part in that  
14          service area in accordance with the provisions of  
15          subsection (d) through another benefit adminis-  
16          trator.

17          “(b) DESIGNATION OF GEOGRAPHIC SERVICE  
18          AREAS.—

19                 “(1) IN GENERAL.—The Secretary shall divide  
20                 the total geographic area served by the programs  
21                 under this title into an appropriate number of serv-  
22                 ice areas for purposes of administration of benefits  
23                 under this part.

24                 “(2) CONSIDERATIONS IN DETERMINING SERV-  
25                 ICE AREAS.—In determining or adjusting the num-

1 ber and boundaries of service areas under this sub-  
2 section, the Secretary shall seek to ensure that—

3 “(A) there is a reasonable level of competi-  
4 tion among entities eligible to contract to ad-  
5 minister the benefit program under this section  
6 for each area; and

7 “(B) the designation of areas is consistent  
8 with the goal of securing contracts under this  
9 section that use the volume purchasing power of  
10 enrollees to obtain the same or similar type of  
11 prescription medicine discounts as are afforded  
12 favored, large purchasers.

13 “(c) DESIGNATION OF BENEFIT ADMINISTRATOR.—

14 “(1) AWARD AND DURATION OF CONTRACT.—

15 “(A) COMPETITIVE AWARD.—Each con-  
16 tract for a service area shall be awarded com-  
17 petitively in accordance with section 5 of title  
18 41, United States Code, for a period (subject to  
19 subparagraph (B)) of not less than 2 nor more  
20 than 5 years.

21 “(B) REVIEW.—A contract for a service  
22 area shall be subject to an evaluation after a  
23 year and termination for cause.

24 “(2) ELIGIBLE BENEFIT ADMINISTRATORS.—

25 An entity shall not be eligible for consideration as a

1 benefit administrator responsible for administering  
2 the prescription medicine benefit program under this  
3 part in a service area unless it meets at least the fol-  
4 lowing criteria:

5 “(A) TYPE OF ENTITY.—The entity shall  
6 be capable of administering a prescription medi-  
7 cine benefit program, and may be a prescription  
8 medicine vendor, wholesale and retail pharmacy  
9 delivery system, health care provider or insurer,  
10 any other type of entity as the Secretary may  
11 specify, or a consortium of such entities.

12 “(B) PERFORMANCE CAPABILITY.—The  
13 entity shall have sufficient expertise, personnel,  
14 and resources to perform effectively the benefit  
15 administration functions for such area.

16 “(C) FINANCIAL INTEGRITY.—The entity  
17 and its officers, directors, agents, and man-  
18 aging employees shall have a satisfactory record  
19 of professional competence and professional and  
20 financial integrity, and the entity shall have  
21 adequate financial resources to perform services  
22 under the contract without risk of insolvency.

23 “(3) PROPOSAL REQUIREMENTS.—

24 “(A) IN GENERAL.—An entity’s proposal  
25 for award or renewal of a contract under this

1 section shall include such material and informa-  
2 tion as the Secretary may require.

3 “(B) SPECIFIC INFORMATION.—A proposal  
4 described in subparagraph (A) shall—

5 “(i) include a detailed description of—

6 “(I) the schedule of negotiated  
7 prices that will be charged to enroll-  
8 ees;

9 “(II) how the entity will deter-  
10 medical errors that are related to pre-  
11 scription medicines; and

12 “(III) proposed contracts with  
13 local pharmacy providers designed to  
14 ensure access, including compensation  
15 for local pharmacists’ services;

16 “(ii) be accompanied by such informa-  
17 tion as the Secretary may require on the  
18 entity’s past performance; and

19 “(iii) disclose ownership and shared  
20 financial interests with other entities in-  
21 volved in the delivery of the benefit as pro-  
22 posed.

23 “(4) CRITERIA FOR COMPETITIVE SELEC-  
24 TION.—In awarding a contract competitively, the  
25 Secretary shall consider the comparative merits of

1 each of the applications by eligible entities, as deter-  
2 mined on the basis of the entities' past performance  
3 and other relevant factors, with respect to the fol-  
4 lowing:

5 “(A) the estimated total cost of the con-  
6 tract, taking into consideration the entity’s pro-  
7 posed fees and price and cost estimates, as eval-  
8 uated and adjusted by the Secretary in accord-  
9 ance with the provisions of the Federal Acquisi-  
10 tion Regulation concerning contracting by nego-  
11 tiation;

12 “(B) prior experience in administering a  
13 type of health insurance program;

14 “(C) effectiveness in containing costs  
15 through obtaining discounts from manufactur-  
16 ers, pricing incentives, utilization management,  
17 and drug utilization review;

18 “(D) the quality and efficiency of benefit  
19 management services with respect to such mat-  
20 ters as claims processing and benefits coordina-  
21 tion; record-keeping and reporting; maintenance  
22 of medical records confidentiality; and drug uti-  
23 lization review, patient information, customer  
24 satisfaction, and other activities supporting  
25 quality of care; and

1           “(E) such other factors as the Secretary  
2           deems necessary to evaluate the merits of each  
3           application.

4           “(5) FLEXIBILITY IN SECURING BEST BENEFIT  
5           ADMINISTRATOR.—In awarding contracts under this  
6           subsection, the Secretary may waive conflict of inter-  
7           est rules generally applicable to Federal acquisitions  
8           (subject to such safeguards as the Secretary may  
9           find necessary to impose) in circumstances where the  
10          Secretary finds that such waiver—

11           “(A) is not inconsistent with the purposes  
12           of the programs under this title and the best in-  
13           terests of enrolled individuals; and

14           “(B) will permit a sufficient level of com-  
15           petition for such contracts, promote efficiency  
16           of benefits administration, or otherwise serve  
17           the objectives of the program under this part.

18          If the Secretary waives such rules, the Secretary  
19          shall establish a special monitoring program to en-  
20          sure that beneficiaries served by the benefit adminis-  
21          trator have access to all necessary pharmaceuticals  
22          as prescribed.

23           “(6) MAXIMIZING COMPETITION AND SAV-  
24           INGS.—In awarding contracts under this section, the  
25          Secretary shall give consideration to the need to

1 maintain sufficient numbers of entities eligible and  
2 willing to administer benefits under this part to en-  
3 sure vigorous competition for such contracts, while  
4 also giving consideration to the need for a benefit  
5 administrator to have sufficient purchasing power to  
6 obtain appropriate cost savings.

7 “(d) FUNCTIONS OF BENEFIT ADMINISTRATOR.—A  
8 benefit administrator for a service area shall (or in the  
9 case of the function described in paragraph (9), may) per-  
10 form the following functions:

11 “(1) PARTICIPATION AGREEMENTS, PRICES,  
12 AND FEES.—

13 “(A) PRIVATELY NEGOTIATED PRICES.—  
14 Each benefit administrator shall establish,  
15 through negotiations with medicine manufactur-  
16 ers and wholesalers and pharmacies, a schedule  
17 of prices for covered prescription medicines.

18 “(B) AGREEMENTS WITH ANY WILLING  
19 PHARMACY.—Each benefit administrator shall  
20 enter into participation agreements under sub-  
21 section (e) with any willing pharmacy, that in-  
22 clude terms that—

23 “(i) secure the participation of suffi-  
24 cient numbers of pharmacies to ensure

1 convenient access (including adequate  
2 emergency access);

3 “(ii) permit the participation of any  
4 willing pharmacy in the service area that  
5 meets the participation requirements de-  
6 scribed in subsection (e); and

7 “(iii) allow for reasonable dispensing  
8 and consultation fees for pharmacies.

9 “(C) LISTS OF PRICES AND PARTICIPATING  
10 PHARMACIES.—Each benefit administrator shall  
11 ensure that the negotiated prices established  
12 under subparagraph (A) and the list of phar-  
13 macies with agreements under subsection (e)  
14 are regularly updated and readily available in  
15 the service area to health care professionals au-  
16 thorized to prescribe medicines, participating  
17 pharmacies, and enrolled individuals.

18 “(2) TRACKING OF COVERED ENROLLED INDI-  
19 VIDUALS.—In coordination with the Secretary, each  
20 benefit administrator shall maintain accurate, up-  
21 dated records of all enrolled individuals residing in  
22 the service area (other than individuals enrolled in  
23 a plan under part C).

24 “(3) PAYMENT AND COORDINATION OF BENE-  
25 FITS.—

1           “(A) PAYMENT.—Each benefit adminis-  
2           trator shall—

3                   “(i) administer claims for payment of  
4                   benefits under this part and encourage, to  
5                   the maximum extent possible, use of elec-  
6                   tronic means for the submissions of claims;

7                   “(ii) determine amounts of benefit  
8                   payments to be made; and

9                   “(iii) receive, disburse, and account  
10                  for funds used in making such payments,  
11                  including through the activities specified in  
12                  the provisions of this paragraph.

13           “(B) COORDINATION.—Each benefit ad-  
14           ministrators shall coordinate with the Secretary,  
15           other benefit administrators, pharmacies, and  
16           other relevant entities as necessary to ensure  
17           appropriate coordination of benefits with re-  
18           spect to enrolled individuals, including coordina-  
19           tion of access to and payment for covered pre-  
20           scription medicines according to an individual’s  
21           in-service area plan provisions, when such indi-  
22           vidual is traveling outside the home service  
23           area, and under such other circumstances as  
24           the Secretary may specify.

1           “(C) EXPLANATION OF BENEFITS.—Each  
2           benefit administrator shall furnish to enrolled  
3           individuals an explanation of benefits in accord-  
4           ance with section 1806(a), and a notice of the  
5           balance of benefits remaining for the current  
6           year, whenever prescription medicine benefits  
7           are provided under this part (except that such  
8           notice need not be provided more often than  
9           monthly).

10          “(4) REQUIREMENTS WITH RESPECT TO  
11          FORMULARIES.—If a benefit administrator uses a  
12          formulary to contain costs under this part, the ben-  
13          efit administrator shall—

14                 “(A) use a pharmacy and therapeutics  
15                 committee comprised of licensed practicing phy-  
16                 sicians, pharmacists, and other health care  
17                 practitioners to develop and manage the for-  
18                 mulary;

19                 “(B) include in the formulary at least 1  
20                 medicine from each therapeutic class and, if  
21                 available, a generic equivalent thereof; and

22                 “(C) disclose to current and prospective  
23                 enrollees and to participating providers and  
24                 pharmacies in the service area, the nature of  
25                 the formulary restrictions, including informa-

1           tion regarding the medicines included in the  
2           formulary and any difference in cost-sharing  
3           amounts.

4           “(5) COST AND UTILIZATION MANAGEMENT;  
5           QUALITY ASSURANCE.—Each benefit administrator  
6           shall have in place effective cost and utilization man-  
7           agement, drug utilization review, quality assurance  
8           measures, and systems to reduce medical errors, in-  
9           cluding at least the following, together with such ad-  
10          ditional measures as the Secretary may specify:

11                   “(A) DRUG UTILIZATION REVIEW.—A drug  
12                   utilization review program conforming to the  
13                   standards provided in section 1927(g)(2) (with  
14                   such modifications as the Secretary finds ap-  
15                   propriate).

16                   “(B) FRAUD AND ABUSE CONTROL.—Ac-  
17                   tivities to control fraud, abuse, and waste, in-  
18                   cluding prevention of diversion of pharma-  
19                   ceuticals to the illegal market.

20                   “(C) MEDICATION THERAPY MANAGE-  
21                   MENT.—

22                           “(i) IN GENERAL.—A program of  
23                           medicine therapy management and medica-  
24                           tion administration that is designed to as-  
25                           sure that covered outpatient medicines are

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

4 “(ii) ELEMENTS OF MEDICATION  
5 THERAPY MANAGEMENT.—Such program  
6 may include—

7 “(I) enhanced beneficiary under-  
8 standing of such appropriate use  
9 through beneficiary education, coun-  
10 seling, and other appropriate means;  
11 and

12 “(II) increased beneficiary adher-  
13 ence with prescription medication  
14 regimens through medication refill re-  
15 minders, special packaging, and other  
16 appropriate means.

17 “(iii) DEVELOPMENT OF PROGRAM IN  
18 COOPERATION WITH LICENSED PHAR-  
19 MACISTS.—The program shall be developed  
20 in cooperation with licensed pharmacists  
21 and physicians.

22 “(iv) CONSIDERATIONS IN PHARMACY  
23 FEES.—The benefit administrators shall  
24 take into account, in establishing fees for  
25 pharmacists and others providing services

1           under the medication therapy management  
2           program, the resources and time used in  
3           implementing the program.

4           “(6) EDUCATION AND INFORMATION ACTIVI-  
5           TIES.—Each benefit administrator shall have in  
6           place mechanisms for disseminating educational and  
7           informational materials to enrolled individuals and  
8           health care providers designed to encourage effective  
9           and cost-effective use of prescription medicine bene-  
10          fits and to ensure that enrolled individuals under-  
11          stand their rights and obligations under the pro-  
12          gram.

13          “(7) BENEFICIARY PROTECTIONS.—

14                 “(A) CONFIDENTIALITY OF HEALTH IN-  
15                 FORMATION.—Each benefit administrator shall  
16                 have in effect systems to safeguard the con-  
17                 fidentiality of health care information on en-  
18                 rolled individuals, which comply with section  
19                 1106 and with section 552a of title 5, United  
20                 States Code, and meet such additional stand-  
21                 ards as the Secretary may prescribe.

22                 “(B) GRIEVANCE AND APPEAL PROCE-  
23                 DURES.—Each benefit administrator shall have  
24                 in place such procedures as the Secretary may  
25                 specify for hearing and resolving grievances and

1 appeals, including expedited appeals, brought  
2 by enrolled individuals against the benefit ad-  
3 ministrator or a pharmacy concerning benefits  
4 under this part, which shall include procedures  
5 equivalent to those specified in subsections (f)  
6 and (g) of section 1852.

7 “(8) RECORDS, REPORTS, AND AUDITS OF BEN-  
8 EFIT ADMINISTRATORS.—

9 “(A) RECORDS AND AUDITS.—Each ben-  
10 efit administrator shall maintain adequate  
11 records, and afford the Secretary access to such  
12 records (including for audit purposes).

13 “(B) REPORTS.—Each benefit adminis-  
14 trator shall make such reports and submissions  
15 of financial and utilization data as the Sec-  
16 retary may require taking into account stand-  
17 ard commercial practices.

18 “(9) PROPOSAL FOR ALTERNATIVE COINSUR-  
19 ANCE AMOUNT.—

20 “(A) SUBMISSION.—Each benefit adminis-  
21 trator may submit a proposal for decreased  
22 beneficiary cost-sharing for generic prescription  
23 medicines, prescription medicines on the benefit  
24 administrator’s formulary, or prescription medi-  
25 cines obtained through mail order pharmacies.

1           “(B) CONTENTS.—The proposal submitted  
2           under subparagraph (A) shall contain evidence  
3           that such decreased cost-sharing would not re-  
4           sult in an increase in aggregate costs to the Ac-  
5           count, including an analysis of differences in  
6           projected drug utilization patterns by bene-  
7           ficiaries whose cost-sharing would be reduced  
8           under the proposal and those making the cost-  
9           sharing payments that would otherwise apply.

10           “(10) OTHER REQUIREMENTS.—Each benefit  
11           administrator shall meet such other requirements as  
12           the Secretary may specify.

13           “(e) PHARMACY PARTICIPATION AGREEMENTS.—

14           “(1) IN GENERAL.—A pharmacy that meets the  
15           requirements of this subsection shall be eligible to  
16           enter an agreement with a benefit administrator to  
17           furnish covered prescription medicines and phar-  
18           macists’ services to enrolled individuals residing in  
19           the service area.

20           “(2) TERMS OF AGREEMENT.—An agreement  
21           under this subsection shall include the following  
22           terms and requirements:

23           “(A) LICENSING.—The pharmacy and  
24           pharmacists shall meet (and throughout the

1 contract period will continue to meet) all appli-  
2 cable State and local licensing requirements.

3 “(B) LIMITATION ON CHARGES.—Phar-  
4 macies participating under this part shall not  
5 charge an enrolled individual more than the ne-  
6 gotiated price for an individual medicine as es-  
7 tablished under subsection (d)(1), regardless of  
8 whether such individual has attained the basic  
9 benefit limitation under section 1860B(b)(3),  
10 and shall not charge an enrolled individual  
11 more than the individual’s share of the nego-  
12 tiated price as determined under the provisions  
13 of this part.

14 “(C) PERFORMANCE STANDARDS.—The  
15 pharmacy and the pharmacist shall comply with  
16 performance standards relating to—

17 “(i) measures for quality assurance,  
18 reduction of medical errors, and participa-  
19 tion in the drug utilization review program  
20 described in subsection (d)(3)(A);

21 “(ii) systems to ensure compliance  
22 with the confidentiality standards applica-  
23 ble under subsection (d)(5)(A); and

1                   “(iii) other requirements as the Sec-  
2                   retary may impose to ensure integrity, effi-  
3                   ciency, and the quality of the program.

4                   “(D) DISCLOSURE OF PRICE OF GENERIC  
5                   MEDICINE.—A pharmacy participating under  
6                   this part that dispenses a prescription medicine  
7                   to a medicare beneficiary enrolled under this  
8                   part shall inform the beneficiary at the time of  
9                   purchase of the drug of any differential between  
10                  the price of the prescribed drug to the enrollee  
11                  and the price of the lowest cost generic drug  
12                  that is therapeutically and pharmaceutically  
13                  equivalent and bioequivalent.

14                  “(f) FLEXIBILITY IN ASSIGNING WORKLOAD AMONG  
15                  BENEFIT ADMINISTRATORS.—During the period after the  
16                  Secretary has given notice of intent to terminate a con-  
17                  tract with a benefit administrator, the Secretary may  
18                  transfer responsibilities of the benefit administrator under  
19                  such contract to another benefit administrator.

20                  “(g) GUARANTEED ACCESS TO MEDICINES IN RURAL  
21                  AND HARD-TO-SERVE AREAS.—

22                  “(1) IN GENERAL.—The Secretary shall ensure  
23                  that all beneficiaries have guaranteed access to the  
24                  full range of pharmaceuticals under this part, and  
25                  shall give special attention to access, pharmacist

1 counseling, and delivery in rural and hard-to-serve  
2 areas, including through the use of incentives such  
3 as bonus payments to retail pharmacists in rural  
4 areas and extra payments to the benefit adminis-  
5 trator for the cost of rapid delivery of pharma-  
6 ceuticals, and any other actions necessary.

7 “(2) GAO REPORT.—Not later than 2 years  
8 after the implementation of this part the Comp-  
9 troller General of the United States shall submit to  
10 Congress a report on the access of medicare bene-  
11 ficiaries to pharmaceuticals and pharmacists’ serv-  
12 ices in rural and hard-to-serve areas under this part  
13 together with any recommendations of the Comp-  
14 troller General regarding any additional steps the  
15 Secretary may need to take to ensure the access of  
16 medicare beneficiaries to pharmaceuticals and phar-  
17 macists’ services in such areas under this part.

18 “(h) INCENTIVES FOR COST AND UTILIZATION MAN-  
19 AGEMENT AND QUALITY IMPROVEMENT.—The Secretary  
20 is authorized to include in a contract awarded under sub-  
21 section (c) such incentives for cost and utilization manage-  
22 ment and quality improvement as the Secretary may deem  
23 appropriate, including—

24 “(1) bonus and penalty incentives to encourage  
25 administrative efficiency;



1 tiree prescription medicine plan (as defined in subsection  
2 (f)(3)), a sponsor shall meet the following requirements:

3 “(1) ASSURANCES.—The sponsor shall—

4 “(A) annually attest, and provide such as-  
5 surances as the Secretary may require, that the  
6 coverage offered by the sponsor is a qualified  
7 retiree prescription medicine plan, and will re-  
8 main such a plan for the duration of the spon-  
9 sor’s participation in the program under this  
10 section; and

11 “(B) guarantee that it will give notice to  
12 the Secretary and covered retirees—

13 “(i) at least 120 days before termi-  
14 nating its plan; and

15 “(ii) immediately upon determining  
16 that the actuarial value of the prescription  
17 medicine benefit under the plan falls below  
18 the actuarial value of the insurance benefit  
19 under this part.

20 “(2) OTHER REQUIREMENTS.—The sponsor  
21 shall provide such information, and comply with  
22 such requirements, including information require-  
23 ments to ensure the integrity of the program, as the  
24 Secretary may find necessary to administer the pro-  
25 gram under this section.

1 “(c) INCENTIVE PAYMENT.—

2 “(1) IN GENERAL.—A sponsor that meets the  
3 requirements of subsection (b) with respect to a  
4 quarter in a calendar year shall have payment made  
5 by the Secretary on a quarterly basis to the appro-  
6 priate employment-based health plan of an incentive  
7 payment, in the amount determined as described in  
8 paragraph (2), for each retired individual (or  
9 spouse) who—

10 “(A) was covered under the sponsor’s  
11 qualified retiree prescription medicine plan dur-  
12 ing such quarter; and

13 “(B) was eligible for but was not enrolled  
14 in the insurance program under this part.

15 “(2) AMOUNT OF INCENTIVE.—The payment  
16 under this section with respect to each individual de-  
17 scribed in paragraph (1) for a month shall be equal  
18 to  $\frac{2}{3}$  of the monthly premium amount payable from  
19 the Prescription Medicine Insurance Account for an  
20 enrolled individual, as set for the calendar year pur-  
21 suant to section 1860D(a)(2).

22 “(3) PAYMENT DATE.—The incentive under  
23 this section with respect to a calendar quarter shall  
24 be payable as of the end of the next succeeding cal-  
25 endar quarter.

1       “(d) CIVIL MONEY PENALTIES.—A sponsor, health  
2 plan, or other entity that the Secretary determines has,  
3 directly or through its agent, provided information in con-  
4 nection with a request for an incentive payment under this  
5 section that the entity knew or should have known to be  
6 false shall be subject to a civil monetary penalty in an  
7 amount up to 3 times the total incentive amounts under  
8 subsection (e) that were paid (or would have been payable)  
9 on the basis of such information.

10       “(e) PART D ENROLLMENT FOR INDIVIDUALS  
11 WHOSE EMPLOYMENT-BASED RETIREE HEALTH COV-  
12 ERAGE ENDS.—

13               “(1) ELIGIBLE INDIVIDUALS.—An individual  
14 shall be given the opportunity to enroll in the pro-  
15 gram under this part during the period specified in  
16 paragraph (2) if—

17                       “(A) the individual declined enrollment in  
18 the program under this part at the time the in-  
19 dividual first satisfied section 1860C(a);

20                       “(B) at that time, the individual was cov-  
21 ered under a qualified retiree prescription medi-  
22 cine plan for which an incentive payment was  
23 paid under this section; and

24                       “(C)(i) the sponsor subsequently ceased to  
25 offer such plan; or

1           “(ii) the value of prescription medicine cov-  
2           erage under such plan became less than the  
3           value of the coverage under the program under  
4           this part.

5           “(2) SPECIAL ENROLLMENT PERIOD.—An indi-  
6           vidual described in paragraph (1) shall be eligible to  
7           enroll in the program under this part during the 6-  
8           month period beginning on the first day of the  
9           month in which—

10           “(A) the individual receives a notice that  
11           coverage under such plan has terminated (in  
12           the circumstance described in paragraph  
13           (1)(C)(i)) or notice that a claim has been de-  
14           nied because of such a termination; or

15           “(B) the individual received notice of the  
16           change in benefits (in the circumstance de-  
17           scribed in paragraph (1)(C)(ii)).

18           “(f) DEFINITIONS.—In this section:

19           “(1) EMPLOYMENT-BASED RETIREE HEALTH  
20           COVERAGE.—The term ‘employment-based retiree  
21           health coverage’ means health insurance or other  
22           coverage of health care costs for retired individuals  
23           (or for such individuals and their spouses and de-  
24           pendents) based on their status as former employees  
25           or labor union members.

1           “(2) EMPLOYER.—The term ‘employer’ has the  
2 meaning given to such term by section 3(5) of the  
3 Employee Retirement Income Security Act of 1974  
4 (except that such term shall include only employers  
5 of 2 or more employees).

6           “(3) QUALIFIED RETIREE PRESCRIPTION MEDI-  
7 CINE PLAN.—The term ‘qualified retiree prescription  
8 medicine plan’ means health insurance coverage in-  
9 cluded in employment-based retiree health coverage  
10 that—

11                   “(A) provides coverage of the cost of pre-  
12 scription medicines whose actuarial value to  
13 each retired beneficiary equals or exceeds the  
14 actuarial value of the benefits provided to an in-  
15 dividual enrolled in the program under this  
16 part; and

17                   “(B) does not deny, limit, or condition the  
18 coverage or provision of prescription medicine  
19 benefits for retired individuals based on age or  
20 any health status-related factor described in  
21 section 2702(a)(1) of the Public Health Service  
22 Act.

23           “(4) SPONSOR.—The term ‘sponsor’ has the  
24 meaning given the term ‘plan sponsor’ by section

1 3(16)(B) of the Employee Retirement Income Secu-  
2 rity Act of 1974.

3 “APPROPRIATIONS TO COVER GOVERNMENT  
4 CONTRIBUTIONS

5 “SEC. 1860I. (a) IN GENERAL.—There are author-  
6 ized to be appropriated from time to time, out of any mon-  
7 eys in the Treasury not otherwise appropriated, to the  
8 Prescription Medicine Insurance Account, a Government  
9 contribution equal to—

10 “(1) the aggregate premiums payable for a  
11 month pursuant to section 1860D(a)(2) by individ-  
12 uals enrolled in the program under this part; plus

13 “(2) one-half the aggregate premiums payable  
14 for a month pursuant to such section for such indi-  
15 viduals by former employers; plus

16 “(3) the benefits payable by reason of the appli-  
17 cation of section 1860B(e) (relating to catastrophic  
18 benefits).

19 “(b) APPROPRIATIONS TO COVER INCENTIVES FOR  
20 EMPLOYMENT-BASED RETIREE MEDICINE COVERAGE.—  
21 There are authorized to be appropriated to the Prescrip-  
22 tion Medicine Insurance Account from time to time, out  
23 of any moneys in the Treasury not otherwise appropriated  
24 such sums as may be necessary for payment of incentive  
25 payments under section 1860H(e).

## 1 “DEFINITIONS

2 “SEC. 1860J. As used in this part—

3 “(1) the term ‘prescription medicine’ means—

4 “(A) a drug that may be dispensed only  
5 upon a prescription, and that is described in  
6 subparagraph (A)(i), (A)(ii), or (B) of section  
7 1927(k)(2); and8 “(B) insulin certified under section 506 of  
9 the Federal Food, Drug, and Cosmetic Act, and  
10 needles, syringes, and disposable pumps for the  
11 administration of such insulin; and12 “(2) the term ‘benefit administrator’ means an  
13 entity which is providing for the administration of  
14 benefits under this part pursuant to 1860G.”.

15 (b) CONFORMING AMENDMENTS.—

16 (1) AMENDMENTS TO FEDERAL SUPPLE-  
17 MENTARY HEALTH INSURANCE TRUST FUND.—Sec-  
18 tion 1841 of the Social Security Act (42 U.S.C.  
19 1395t) is amended—

20 (A) in the last sentence of subsection (a)—

21 (i) by striking “and” after “section  
22 201(i)(1)”; and23 (ii) by inserting before the period the  
24 following: “, and such amounts as may be  
25 deposited in, or appropriated to, the Pre-

1           scription Medicine Insurance Account es-  
2           tablished by section 1860F”;

3           (B) in subsection (g), by inserting after  
4           “by this part,” the following: “the payments  
5           provided for under part D (in which case the  
6           payments shall come from the Prescription  
7           Medicine Insurance Account in the Supple-  
8           mentary Medical Insurance Trust Fund),”;

9           (C) in the first sentence of subsection (h),  
10          by inserting before the period the following:  
11          “and section 1860D(b)(4) (in which case the  
12          payments shall come from the Prescription  
13          Medicine Insurance Account in the Supple-  
14          mentary Medical Insurance Trust Fund)”;

15          (D) in the first sentence of subsection  
16          (i)—

17                 (i) by striking “and” after “section  
18                 1840(b)(1)”;

19                 (ii) by inserting before the period the  
20                 following: “, section 1860D(b)(2) (in which  
21                 case the payments shall come from the  
22                 Prescription Medicine Insurance Account  
23                 in the Supplementary Medical Insurance  
24                 Trust Fund)”.

1           (2) PRESCRIPTION MEDICINE OPTION UNDER  
2           MEDICARE+CHOICE PLANS.—

3           (A) ELIGIBILITY, ELECTION, AND ENROLL-  
4           MENT.—Section 1851 of the Social Security Act  
5           (42 U.S.C. 1395w–21) is amended—

6           (i) in subsection (a)(1)(A), by striking  
7           “parts A and B” inserting “parts A, B,  
8           and D”; and

9           (ii) in subsection (i)(1), by striking  
10           “parts A and B” and inserting “parts A,  
11           B, and D”.

12           (B) VOLUNTARY BENEFICIARY ENROLL-  
13           MENT FOR MEDICINE COVERAGE.—Section  
14           1852(a)(1)(A) of such Act (42 U.S.C. 1395w–  
15           22(a)(1)(A)) is amended by inserting “(and  
16           under part D to individuals also enrolled under  
17           that part)” after “parts A and B”.

18           (C) ACCESS TO SERVICES.—Section  
19           1852(d)(1) of such Act (42 U.S.C. 1395w–  
20           22(d)(1)) is amended—

21           (i) in subparagraph (D), by striking  
22           “and” at the end;

23           (ii) in subparagraph (E), by striking  
24           the period at the end and inserting “;  
25           and”; and

1 (iii) by adding at the end the fol-  
2 lowing new subparagraph:

3 “(F) the plan for prescription medicine  
4 benefits under part D guarantees coverage of  
5 any specifically named covered prescription  
6 medicine for an enrollee, when prescribed by a  
7 physician in accordance with the provisions of  
8 such part, regardless of whether such medicine  
9 would otherwise be covered under an applicable  
10 formulary or discount arrangement.”.

11 (D) PAYMENTS TO ORGANIZATIONS.—Sec-  
12 tion 1853(a)(1)(A) of such Act (42 U.S.C.  
13 1395w-23(a)(1)(A)) is amended—

14 (i) by inserting “determined sepa-  
15 rately for benefits under parts A and B  
16 and under part D (for individuals enrolled  
17 under that part)” after “as calculated  
18 under subsection (c)”;

19 (ii) by striking “that area, adjusted  
20 for such risk factors” and inserting “that  
21 area. In the case of payment for benefits  
22 under parts A and B, such payment shall  
23 be adjusted for such risk factors as”;

24 (iii) by inserting before the last sen-  
25 tence the following: “In the case of the

1 payments for benefits under part D, such  
2 payment shall initially be adjusted for the  
3 risk factors of each enrollee as the Sec-  
4 retary determines to be feasible and appro-  
5 priate. By 2006, the adjustments would be  
6 for the same risk factors applicable for  
7 benefits under parts A and B.”.

8 (E) CALCULATION OF ANNUAL MEDICARE  
9 +CHOICE CAPITATION RATES.—Section 1853(c)  
10 of such Act (42 U.S.C. 1395w–23(c)) is  
11 amended—

12 (i) in paragraph (1), in the matter  
13 preceding subparagraph (A), by inserting  
14 “for benefits under parts A and B” after  
15 “capitation rate”;

16 (ii) in paragraph (6)(A), by striking  
17 “rate of growth in expenditures under this  
18 title” and inserting “rate of growth in ex-  
19 penditures for benefits available under  
20 parts A and B”; and

21 (iii) by adding at the end the fol-  
22 lowing new paragraph:

23 “(8) PAYMENT FOR PRESCRIPTION MEDI-  
24 CINES.—The Secretary shall determine a capitation  
25 rate for prescription medicines—

1           “(A) dispensed in 2003, which is based on  
2           the projected national per capita costs for pre-  
3           scription medicine benefits under part D and  
4           associated claims processing costs for bene-  
5           ficiaries under the original medicare fee-for-  
6           service program; and

7           “(B) dispensed in each subsequent year,  
8           which shall be equal to the rate for the previous  
9           year updated by the Secretary’s estimate of the  
10          projected per capita rate of growth in expendi-  
11          tures under this title for prescription medicines  
12          for an individual enrolled under part D.”.

13           (F) LIMITATION ON ENROLLEE LIABIL-  
14          ITY.—Section 1854(e) of such Act (42 U.S.C.  
15          1395w–24(e)) is amended by adding at the end  
16          the following new paragraph:

17          “(5) SPECIAL RULE FOR PROVISION OF PART D  
18          BENEFITS.—In no event may a Medicare+Choice or-  
19          ganization include as part of a plan for prescription  
20          medicine benefits under part D the following re-  
21          quirements:

22           “(A) NO DEDUCTIBLE; NO COINSURANCE  
23          GREATER THAN 50 PERCENT.—A requirement  
24          that an enrollee pay a deductible, or a coinsur-  
25          ance percentage that exceeds 50 percent.

1           “(B) MANDATORY INCLUSION OF CATA-  
2           STROPHIC BENEFIT.—A requirement that the  
3           catastrophic benefit level under the plan be  
4           greater than such level established under sec-  
5           tion 1860B(c).”.

6           (G) REQUIREMENT FOR ADDITIONAL BEN-  
7           EFITS.—Section 1854(f)(1) of such Act (42  
8           U.S.C. 1395w–24(f)(1)) is amended by adding  
9           at the end the following new sentence: “Such  
10          determination shall be made separately for ben-  
11          efits under parts A and B and for prescription  
12          medicine benefits under part D.”.

13          (H) PROTECTIONS AGAINST FRAUD AND  
14          BENEFICIARY PROTECTIONS.—Section 1857(d)  
15          of such Act (42 U.S.C. 1395w–27(d)) is amend-  
16          ed by adding at the end the following new para-  
17          graph:

18          “(6) AVAILABILITY OF NEGOTIATED PRICES.—  
19          Each contract under this section shall provide that  
20          enrollees who exhaust prescription medicine benefits  
21          under the plan will continue to have access to pre-  
22          scription medicines at negotiated prices equivalent to  
23          the total combined cost of such medicines to the  
24          plan and the enrollee prior to such exhaustion of  
25          benefits.”.

1 (3) EXCLUSIONS FROM COVERAGE.—

2 (A) APPLICATION TO PART D.—Section  
3 1862(a) of the Social Security Act (42 U.S.C.  
4 1395y(a)) is amended in the matter preceding  
5 paragraph (1) by striking “part A or part B”  
6 and inserting “part A, B, or D”.

7 (B) PRESCRIPTION MEDICINES NOT EX-  
8 CLUDED FROM COVERAGE IF APPROPRIATELY  
9 PRESCRIBED.—Section 1862(a)(1) of such Act  
10 (42 U.S.C. 1395y(a)(1)) is amended—

11 (i) in subparagraph (H), by striking  
12 “and” at the end;

13 (ii) in subparagraph (I), by striking  
14 the semicolon at the end and inserting “,  
15 and”; and

16 (iii) by adding at the end the fol-  
17 lowing new subparagraph:

18 “(J) in the case of prescription medicines  
19 covered under part D, which are not prescribed  
20 in accordance with such part;”.

21 **SEC. 102. MEDICAID BUY-IN OF MEDICARE PRESCRIPTION**  
22 **MEDICINE COVERAGE FOR CERTAIN LOW-IN-**  
23 **COME INDIVIDUALS.**

24 (a) STATE OPTION TO BUY-IN DUALY ELIGIBLE  
25 INDIVIDUALS.—

1           (1) COVERAGE OF PREMIUMS AS MEDICAL AS-  
2           SISTANCE.—Section 1905(a) of the Social Security  
3           Act (42 U.S.C. 1396d) is amended in the second  
4           sentence of the flush matter at the end by striking  
5           “premiums under part B” the first place it appears  
6           and inserting “premiums under parts B and D”.

7           (2) STATE COMMITMENT TO CONTINUE PAR-  
8           TICIPATION IN PART D AFTER BENEFIT LIMIT EX-  
9           CEEDED.—Section 1902(a) of such Act (42 U.S.C.  
10          1396a) is amended—

11                   (A) by striking “and” at the end of para-  
12                   graph (64);

13                   (B) by striking the period at the end of  
14                   paragraph (65)(B) and inserting “; and”; and

15                   (C) by adding at the end the following new  
16                   paragraph:

17                   “(66) provide that in the case of any individual  
18                   whose eligibility for medical assistance is not limited  
19                   to medicare or medicare medicine cost-sharing and  
20                   for whom the State elects to pay premiums under  
21                   part D of title XVIII pursuant to section 1860E, the  
22                   State will purchase all prescription medicines for  
23                   such individual in accordance with the provisions of  
24                   such part D, without regard to whether the basic

1 benefit limitation for such individual under section  
2 1860B(b)(3) has been reached.”.

3 (b) GOVERNMENT PAYMENT OF MEDICARE MEDI-  
4 CINE COST-SHARING REQUIRED FOR QUALIFIED MEDI-  
5 CARE BENEFICIARIES.—Section 1905(p)(3) of the Social  
6 Security Act (42 U.S.C. 1396d(p)(3)) is amended—

7 (1) in subparagraph (A)—

8 (A) in clause (i), by striking “and” at the  
9 end;

10 (B) in clause (ii), by inserting “and” at  
11 the end; and

12 (C) by adding at the end the following new  
13 clause:

14 “(iii) premiums under section  
15 1860D.”; and

16 (2) in subparagraph (D)—

17 (A) by inserting “(i)” after “(D)”; and

18 (B) by adding at the end the following:

19 “(ii) PART D COST-SHARING.—The dif-  
20 ference between the amount that is paid under  
21 section 1860B and the amount that would be  
22 paid under such section if any reference to ‘50  
23 percent’ therein were deemed a reference to  
24 ‘100 percent’ (or, if the Secretary approves a

1 higher percentage under such section, if such  
2 percentage were deemed to be 100 percent).”.

3 (c) GOVERNMENT PAYMENT OF MEDICARE MEDI-  
4 CINE COST-SHARING REQUIRED FOR MEDICARE BENE-  
5 FICIARIES WITH INCOMES BETWEEN 100 AND 150 PER-  
6 CENT OF POVERTY LINE.—

7 (1) STATE PLAN REQUIREMENT.—Section  
8 1902(a)(10)(E) of the Social Security Act (42  
9 U.S.C. 1396a(a)(10)(E)) is amended—

10 (A) in clause (iii), by striking “and” at the  
11 end; and

12 (B) by adding at the end the following new  
13 clause:

14 “(v) for making medical assistance avail-  
15 able for medicare medicine cost-sharing (as de-  
16 fined in section 1905(x)(2)) for qualified medi-  
17 care medicine beneficiaries described in section  
18 1905(x)(1); and”.

19 (2) 100 PERCENT FEDERAL MATCHING OF  
20 STATE MEDICAL ASSISTANCE COSTS FOR MEDICARE  
21 MEDICINE COST-SHARING.—Section 1903(a) of the  
22 Social Security Act (42 U.S.C. 1396b(a)) is  
23 amended—

24 (A) by redesignating paragraph (7) as  
25 paragraph (8); and

1 (B) by inserting after paragraph (6) the  
2 following new paragraph:

3 “(7) except in the case of amounts expended for  
4 an individual whose eligibility for medical assistance  
5 is not limited to medicare or medicare medicine cost-  
6 sharing, an amount equal to 100 percent of amounts  
7 as expended as medicare medicine cost-sharing for  
8 qualified medicare medicine beneficiaries (as defined  
9 in section 1905(x)); plus”.

10 (3) ADDITIONAL FUNDS FOR MEDICARE MEDI-  
11 CINE COST-SHARING IN TERRITORIES.—Section  
12 1108 of the Social Security Act (42 U.S.C. 1308) is  
13 amended—

14 (A) in subsection (f), by striking “sub-  
15 section (g),” and inserting “subsections (g) and  
16 (h)”;

17 (B) by adding at the end the following new  
18 subsection:

19 “(h) ADDITIONAL MEDICAID PAYMENTS TO TERRI-  
20 TORIES FOR MEDICARE MEDICINE COST-SHARING.—

21 “(1) IN GENERAL.—In the case of a territory  
22 that develops and implements a plan described in  
23 paragraph (2) (for providing medical assistance with  
24 respect to the provision of prescription drugs to  
25 medicare beneficiaries), the amount otherwise deter-

1       mined under subsection (f) (as increased under sub-  
2       section (g)) for the State shall be increased by the  
3       amount specified in paragraph (3).

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

6               “(A) provides medical assistance with re-  
7       spect to the provision of some or all medicare  
8       medicine cost sharing (as defined in section  
9       1905(x)(2)) to low-income medicare bene-  
10      ficiaries; and

11              “(B) assures that additional amounts re-  
12      ceived by the State that are attributable to the  
13      operation of this subsection are used only for  
14      such assistance.

15              “(3) INCREASED AMOUNT.—

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

19              “(i) the aggregate amount specified in  
20      subparagraph (B); and

21              “(ii) the amount specified in sub-  
22      section (g)(1) for that State, divided by the  
23      sum of the amounts specified in such sec-  
24      tion for all such States.

1           “(B) AGGREGATE AMOUNT.—The aggre-  
2           gate amount specified in this subparagraph  
3           for—

4                   “(i) 2003, is equal to \$25,000,000; or

5                   “(ii) a subsequent year, is equal to the  
6           aggregate amount specified in this sub-  
7           paragraph for the previous year increased  
8           by annual percentage increase specified in  
9           section 1860B(b)(3)(B) for the year in-  
10          volved.”.

11           (4) DEFINITIONS OF ELIGIBLE BENEFICIARIES  
12          AND COVERAGE.—Section 1905 of the Social Secu-  
13          rity Act (42 U.S.C. 1396d) is amended by adding  
14          at the end the following new subsection:

15          “(x)(1) The term ‘qualified medicare medicine bene-  
16          ficiary’ means an individual—

17                   “(A) who is enrolled or enrolling under part D  
18                  of title XVIII;

19                   “(B) whose income (as determined under sec-  
20                  tion 1612 for purposes of the supplemental security  
21                  income program, except as provided in subsection  
22                  (p)(2)(D)) is above 100 percent but below 150 per-  
23                  cent of the official poverty line (as referred to in  
24                  subsection (p)(2)) applicable to a family of the size  
25                  involved; and

1           “(C) whose resources (as determined under sec-  
2           tion 1613 for purposes of the supplemental security  
3           income program) do not exceed twice the maximum  
4           amount of resources that an individual may have  
5           and obtain benefits under that program.

6           “(2) The term ‘medicare medicine cost-sharing’  
7           means the following costs incurred with respect to a quali-  
8           fied medicare medicine beneficiary, without regard to  
9           whether the costs incurred were for items and services for  
10          which medical assistance is otherwise available under the  
11          plan:

12           “(A) In the case of a qualified medicare medi-  
13          cine beneficiary whose income (as determined under  
14          paragraph (1)) is less than 135 percent of the offi-  
15          cial poverty line—

16                   “(i) premiums under section 1860D; and

17                   “(ii) the difference between the amount  
18                   that is paid under section 1860B and the  
19                   amount that would be paid under such section  
20                   if any reference to ‘50 percent’ therein were  
21                   deemed a reference to ‘100 percent’ (or, if the  
22                   Secretary approves a higher percentage under  
23                   such section, if such percentage were deemed to  
24                   be 100 percent).

1           “(B) In the case of a qualified medicare medi-  
2           cine beneficiary whose income (as determined under  
3           paragraph (1)) is at least 135 percent but less than  
4           150 percent of the official poverty line, a percentage  
5           of premiums under section 1860D, determined on a  
6           linear sliding scale ranging from 100 percent for in-  
7           dividuals with incomes at 135 percent of such line  
8           to 0 percent for individuals with incomes at 150 per-  
9           cent of such line.

10          “(3) In the case of any State which is providing med-  
11          ical assistance to its residents under a waiver granted  
12          under section 1115, the Secretary shall require the State  
13          to meet the requirement of section 1902(a)(10)(E) in the  
14          same manner as the State would be required to meet such  
15          requirement if the State had in effect a plan approved  
16          under this title.”.

17          (d) MEDICAID MEDICINE PRICE REBATES UNAVAIL-  
18          ABLE WITH RESPECT TO MEDICINES PURCHASED  
19          THROUGH MEDICARE BUY-IN.—Section 1927 of the So-  
20          cial Security Act (42 U.S.C. 1396r–8) is amended by add-  
21          ing at the end the following new subsection:

22          “(1) MEDICINES PURCHASED THROUGH MEDICARE  
23          BUY-IN.—The provisions of this section shall not apply  
24          to prescription medicines purchased under part D of title  
25          XVIII pursuant to an agreement with the Secretary under

1 section 1860E (including any medicines so purchased  
2 after the limit under section 1860B(b)(3) has been exceed-  
3 ed).”.

4 (e) AMENDMENTS TO MEDICARE PART D.—Part D  
5 of title XVIII of the Social Security Act (as added by sec-  
6 tion 2) is amended by inserting after section 1860D the  
7 following new section:

8 “SPECIAL ELIGIBILITY, ENROLLMENT, AND COPAYMENT  
9 RULES FOR LOW-INCOME INDIVIDUALS

10 “SEC. 1860E. (a) STATE OPTIONS FOR COVERAGE:  
11 CONTINUATION OF MEDICAID COVERAGE OR ENROLL-  
12 MENT UNDER THIS PART.—

13 “(1) IN GENERAL.—The Secretary shall, at the  
14 request of a State, enter into an agreement with the  
15 State under which all individuals described in para-  
16 graph (2) are enrolled in the program under this  
17 part, without regard to whether any such individual  
18 has previously declined the opportunity to enroll in  
19 such program.

20 “(2) ELIGIBILITY GROUPS.—The individuals de-  
21 scribed in this paragraph, for purposes of paragraph  
22 (1), are individuals who satisfy section 1860C(a)  
23 and who are—

24 “(A) in a coverage group or groups per-  
25 mitted under section 1843 (as selected by the  
26 State and specified in the agreement); or

1           “(B) qualified medicare medicine bene-  
2           ficiaries (as defined in section 1905(x)(1)).

3           “(3) COVERAGE PERIOD.—The period of cov-  
4           erage under this part of an individual enrolled under  
5           an agreement under this subsection shall be as fol-  
6           lows:

7           “(A) INDIVIDUALS ELIGIBLE (AT STATE  
8           OPTION) FOR PART B BUY-IN.—In the case of  
9           an individual described in subsection (a)(2)(A),  
10          the coverage period shall be the same period  
11          that applies (or would apply) pursuant to sec-  
12          tion 1843(d).

13          “(B) QUALIFIED MEDICARE MEDICINE  
14          BENEFICIARIES.—In the case of an individual  
15          described in subsection (a)(2)(B)—

16                 “(i) the coverage period shall begin on  
17                 the latest of—

18                         “(I) January 1, 2003;

19                         “(II) the first day of the third  
20                         month following the month in which  
21                         the State agreement is entered into;  
22                         or

23                         “(III) the first day of the first  
24                         month following the month in which

1 the individual satisfies section  
2 1860C(a); and

3 “(ii) the coverage period shall end on  
4 the last day of the month in which the in-  
5 dividual is determined by the State to have  
6 become ineligible for medicare medicine  
7 cost-sharing.

8 “(4) ENROLLMENT FOR LOW-INCOME SUBSIDY  
9 THROUGH OTHER MEANS.—

10 “(A) FLEXIBILITY IN ENROLLMENT PROC-  
11 ESS.—With respect to low-income individuals  
12 residing in a State enrolling under this part on  
13 or after January 1, 2003, the Secretary shall  
14 provide for determinations of whether the indi-  
15 vidual is eligible for a subsidy and the amount  
16 of such individual’s income to be made under  
17 arrangements with appropriate entities other  
18 than State medicaid agencies.

19 “(B) USE OF CERTAIN INFORMATION.—  
20 Arrangements with entities under subparagraph  
21 (A) shall provide for —

22 “(i) the use of existing Federal gov-  
23 ernment databases to identify eligibility;  
24 and

1                   “(ii) the use of information obtained  
2                   under section 154 of the Social Security  
3                   Act Amendments of 1994 for newly eligible  
4                   medicare beneficiaries, and the application  
5                   of such information with respect to other  
6                   medicare beneficiaries.

7           “(b) SPECIAL PART D ENROLLMENT OPPORTUNITY  
8 FOR INDIVIDUALS LOSING MEDICAID ELIGIBILITY.—In  
9 the case of an individual who—

10                   “(1) satisfies section 1860C(a); and

11                   “(2) loses eligibility for benefits under the State  
12                   plan under title XIX after having been enrolled  
13                   under such plan or having been determined eligible  
14                   for such benefits;

15 the Secretary shall provide an opportunity for enrollment  
16 under the program under this part during the period that  
17 begins on the date that such individual loses such eligi-  
18 bility and ends on the date specified by the Secretary.

19           “(c) DEFINITION.—For purposes of this section, the  
20 term ‘State’ has the meaning given such term under sec-  
21 tion 1101(a) for purposes of title XIX.”.

22           (f) REMOVAL OF SUNSET DATE FOR COST-SHARING  
23 IN MEDICARE PART B PREMIUMS FOR CERTAIN QUALI-  
24 FYING INDIVIDUALS.—

1           (1) IN GENERAL.—Section 1902(a)(10)(E)(iv)  
2 of the Social Security Act (42 U.S.C.  
3 1396a(a)(10)(E)(iv)) is amended to read as  
4 follows—

5                   “(iv) subject to section 1905(p)(4),  
6 for making medical assistance available for  
7 medicare cost-sharing described in section  
8 1905(p)(3)(A)(ii) for individuals who  
9 would be qualified medicare beneficiaries  
10 described in section 1905(p)(1) but for the  
11 fact that their income exceeds the income  
12 level established by the State under section  
13 1905(p)(2) and is at least 120 percent, but  
14 less than 135 percent, of the official pov-  
15 erty line (referred to in such section) for a  
16 family of the size involved and who are not  
17 otherwise eligible for medical assistance  
18 under the State plan;”.

19           (2) RELOCATION OF PROVISION REQUIRING 100  
20 PERCENT FEDERAL MATCHING OF STATE MEDICAL  
21 ASSISTANCE COSTS FOR CERTAIN QUALIFYING INDI-  
22 VIDUALS.—Section 1903(a) of the Social Security  
23 Act (42 U.S.C. 1396b(a)), as amended by subsection  
24 (c)(3), is amended—

1 (A) by redesignating paragraph (8) as  
2 paragraph (9); and

3 (B) by inserting after paragraph (7) the  
4 following new paragraph:

5 “(8) an amount equal to 100 percent of  
6 amounts expended as medicare cost-sharing de-  
7 scribed in section 1903(a)(10)(E)(iv) for individuals  
8 described in such section; plus”.

9 (3) REPEAL OF SECTION 1933.—Section 1933 is  
10 repealed.

11 (4) EFFECTIVE DATE.—The amendments made  
12 by this subsection shall take effect on January 1,  
13 2003.

14 **SEC. 103. OFFSET FOR CATASTROPHIC PRESCRIPTION**  
15 **MEDICINE BENEFIT.**

16 If the mid-summer 2000 budget estimate prepared by  
17 the Director of the Congressional Budget Office results  
18 in a higher level of projected on-budget surplus over the  
19 ten fiscal year period beginning with fiscal year 2001 than  
20 the projected on-budget surplus in the estimate prepared  
21 by the Director in March, 2000, there shall be transferred  
22 out of any moneys in the Treasury not otherwise appro-  
23 priated in a fiscal year (beginning with fiscal year 2003)  
24 to the Prescription Medicine Insurance Account (created  
25 in the Federal Supplemental Medical Insurance Trust

1 Fund established by section 1841 of the Social Security  
2 Act (42 U.S.C. 1395t)) such sums as are necessary to off-  
3 set the costs attributable to the operation of section  
4 1860B(a)(2) of the Social Security Act (as added by sec-  
5 tion 3) (relating to catastrophic benefit payment amounts)  
6 in that fiscal year.

7 **SEC. 104. GAO ONGOING STUDIES AND REPORTS ON PRO-**  
8 **GRAM; MISCELLANEOUS REPORTS.**

9 (a) ONGOING STUDY.—The Comptroller General of  
10 the United States shall conduct an ongoing study and  
11 analysis of the prescription medicine benefit program  
12 under part D of the Medicare program under title XVIII  
13 of the Social Security Act (as added by section 3 of this  
14 Act), including an analysis of each of the following:

15 (1) The extent to which the administering enti-  
16 ties have —achieved volume-based discounts similar  
17 to the favored —price paid by other large purchasers.

18 (2) Whether access to the benefits under such  
19 program are in fact available to all beneficiaries,  
20 with special attention given to access for bene-  
21 ficiaries living in rural and hard-to-serve areas.

22 (3) The success of such program in reducing  
23 medication error and adverse medicine reactions and  
24 improving quality of care, and whether it is probable  
25 that the program has resulted in savings through re-

1       duced hospitalizations and morbidity due to medica-  
2       tion errors and adverse medicine reactions.

3           (4) Whether patient medical record confiden-  
4       tiality is being maintained and safe-guarded.

5           (5) Such other issues as the Comptroller Gen-  
6       eral may consider.

7       (b) REPORTS.—The Comptroller General shall issue  
8       such reports on the results of the ongoing study described  
9       in (a) as the Comptroller General shall deem appropriate  
10      and shall notify Congress on a timely basis of significant  
11      problems in the operation of the part D prescription medi-  
12      cine program and the need for legislative adjustments and  
13      improvements.

14      (c) MISCELLANEOUS STUDIES AND REPORTS.—

15           (1) STUDY ON METHODS TO ENCOURAGE ADDI-  
16      TIONAL RESEARCH ON BREAKTHROUGH PHARMA-  
17      CEUTICALS.—

18           (A) IN GENERAL.—The Secretary of  
19      Health and Human Services shall seek the ad-  
20      vice of the Secretary of the Treasury on pos-  
21      sible tax and trade law changes to encourage  
22      increased original research on new pharma-  
23      ceutical breakthrough products designed to ad-  
24      dress disease and illness.

1 (B) REPORT.—Not later than January 1,  
2 2003, the Secretary shall submit to Congress a  
3 report on such study. The report shall include  
4 recommended methods to encourage the phar-  
5 maceutical industry to devote more resources to  
6 research and development of new covered prod-  
7 ucts than it devotes to overhead expenses.

8 (2) STUDY ON PHARMACEUTICAL SALES PRAC-  
9 TICES AND IMPACT ON COSTS AND QUALITY OF  
10 CARE.—

11 (A) IN GENERAL.—The Secretary of  
12 Health and Human Services shall conduct a  
13 study on the methods used by the pharma-  
14 ceutical industry to advertise and sell to con-  
15 sumers and educate and sell to providers.

16 (B) REPORT.—Not later than January 1,  
17 2003, the Secretary shall submit to Congress a  
18 report on such study. The report shall include  
19 the estimated direct and indirect costs of the  
20 sales methods used, the quality of the informa-  
21 tion conveyed, and whether such sales efforts  
22 leads (or could lead) to inappropriate pre-  
23 scribing. Such report may include legislative  
24 and regulatory recommendations to encourage

1 more appropriate education and prescribing  
2 practices.

3 (3) STUDY ON COST OF PHARMACEUTICAL RE-  
4 SEARCH.—

5 (A) IN GENERAL.—The Secretary of  
6 Health and Human Services shall conduct a  
7 study on the costs of, and needs for, the phar-  
8 maceutical research and the role that the tax-  
9 payer provides in encouraging such research.

10 (B) REPORT.—Not later than January 1,  
11 2003, the Secretary shall submit to Congress a  
12 report on such study. The report shall include  
13 a description of the full-range of taxpayer-as-  
14 sisted programs impacting pharmaceutical re-  
15 search, including tax, trade, government re-  
16 search, and regulatory assistance. The report  
17 may also include legislative and regulatory rec-  
18 ommendations that are designed to ensure that  
19 the taxpayer's investment in pharmaceutical re-  
20 search results in the availability of pharma-  
21 ceuticals at reasonable prices.

22 (4) REPORT ON PHARMACEUTICAL PRICES IN  
23 MAJOR FOREIGN NATIONS.—Not later than January  
24 1, 2003, the Secretary of Health and Human Serv-  
25 ices shall submit to Congress a report on the retail

1 price of major pharmaceutical products in various  
2 developed nations, compared to prices for the same  
3 or similar products in the United States. The report  
4 shall include a description of the principal reasons  
5 for any price differences that may exist.

6 **TITLE II—IMPROVEMENT IN**  
7 **BENEFICIARY SERVICES**

8 **Subtitle A—Improvement of Medi-**  
9 **care Coverage and Appeals**  
10 **Process**

11 **SEC. 201. REVISIONS TO MEDICARE APPEALS PROCESS.**

12 (a) CONDUCT OF RECONSIDERATIONS OF DETER-  
13 MINATIONS BY INDEPENDENT CONTRACTORS.—Section  
14 1869 of the Social Security Act (42 U.S.C. 1395ff) is  
15 amended to read as follows:

16 “DETERMINATIONS; APPEALS

17 “SEC. 1869. (a) INITIAL DETERMINATIONS.—The  
18 Secretary shall promulgate regulations and make initial  
19 determinations with respect to benefits under part A or  
20 part B in accordance with those regulations for the fol-  
21 lowing:

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

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

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

11          “(b) APPEAL RIGHTS.—

12                 “(1) IN GENERAL.—

13                         “(A) RECONSIDERATION OF INITIAL DE-  
14                         TERMINATION.—Subject to subparagraph (D),  
15                         any individual dissatisfied with any initial de-  
16                         termination under subsection (a) shall be enti-  
17                         tled to reconsideration of the determination,  
18                         and, subject to subparagraphs (D) and (E), a  
19                         hearing thereon by the Secretary to the same  
20                         extent as is provided in section 205(b) and to  
21                         judicial review of the Secretary’s final decision  
22                         after such hearing as is provided in section  
23                         205(g).

24                         “(B) REPRESENTATION BY PROVIDER OR  
25                         SUPPLIER.—

1           “(i) IN GENERAL.—Sections 206(a),  
2           1102, and 1871 shall not be construed as  
3           authorizing the Secretary to prohibit an in-  
4           dividual from being represented under this  
5           section by a person that furnishes or sup-  
6           plies the individual, directly or indirectly,  
7           with services or items, solely on the basis  
8           that the person furnishes or supplies the  
9           individual with such a service or item.

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

20           “(iii) PROHIBITION ON PAYMENT FOR  
21           REPRESENTATION.—If a person furnishes  
22           services or items to an individual and rep-  
23           resents the individual under this section,  
24           the person may not impose any financial li-

1 ability on such individual in connection  
2 with such representation.

3 “(iv) REQUIREMENTS FOR REP-  
4 REPRESENTATIVES OF A BENEFICIARY.—The  
5 provisions of section 205(j) and section  
6 206 (regarding representation of claim-  
7 ants) shall apply to representation of an  
8 individual with respect to appeals under  
9 this section in the same manner as they  
10 apply to representation of an individual  
11 under those sections.

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

20 “(D) TIME LIMITS FOR APPEALS.—

21 “(i) RECONSIDERATIONS.—Reconsid-  
22 eration under subparagraph (A) shall be  
23 available only if the individual described in  
24 subparagraph (A) files notice with the Sec-  
25 retary to request reconsideration by not

1 later than 180 days after the individual re-  
2 ceives notice of the initial determination  
3 under subsection (a) or within such addi-  
4 tional time as the Secretary may allow.

5 “(ii) HEARINGS CONDUCTED BY THE  
6 SECRETARY.—The Secretary shall establish  
7 in regulations time limits for the filing of  
8 a request for a hearing by the Secretary in  
9 accordance with provisions in sections 205  
10 and 206.

11 “(E) AMOUNTS IN CONTROVERSY.—

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

19 “(ii) AGGREGATION OF CLAIMS.—In  
20 determining the amount in controversy, the  
21 Secretary, under regulations, shall allow 2  
22 or more appeals to be aggregated if the ap-  
23 peals involve—

24 “(I) the delivery of similar or re-  
25 lated services to the same individual

1 by one or more providers of services  
2 or suppliers, or

3 “(II) common issues of law and  
4 fact arising from services furnished to  
5 2 or more individuals by one or more  
6 providers of services or suppliers.

7 “(F) EXPEDITED PROCEEDINGS.—

8 “(i) EXPEDITED DETERMINATION.—

9 In the case of an individual who—

10 “(I) has received notice by a pro-  
11 vider of services that the provider of  
12 services plans to terminate services  
13 provided to an individual and a physi-  
14 cian certifies that failure to continue  
15 the provision of such services is likely  
16 to place the individual’s health at sig-  
17 nificant risk, or

18 “(II) has received notice by a  
19 provider of services that the provider  
20 of services plans to discharge the indi-  
21 vidual from the provider of services,  
22 the individual may request, in writing or  
23 orally, an expedited determination or an  
24 expedited reconsideration of an initial de-  
25 termination made under subsection (a), as

1           the case may be, and the Secretary shall  
2           provide such expedited determination or  
3           expedited reconsideration.

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

12          “(G) REOPENING AND REVISION OF DE-  
13          TERMINATIONS.—The Secretary may reopen or  
14          revise any initial determination or reconsidered  
15          determination described in this subsection  
16          under guidelines established by the Secretary in  
17          regulations.

18          “(2) REVIEW OF COVERAGE DETERMINA-  
19          TIONS.—

20                  “(A) NATIONAL COVERAGE DETERMINA-  
21          TIONS.—

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

1           “(I) Such a determination shall  
2 not be reviewed by any administrative  
3 law judge.

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

12           “(III) Upon the filing of a com-  
13 plaint by an aggrieved party, such a  
14 determination shall be reviewed by the  
15 Departmental Appeals Board of the  
16 Department of Health and Human  
17 Services. In conducting such a review,  
18 the Departmental Appeals Board shall  
19 review the record and shall permit dis-  
20 covery and the taking of evidence to  
21 evaluate the reasonableness of the de-  
22 termination. In reviewing such a de-  
23 termination, the Departmental Ap-  
24 peals Board shall defer only to the  
25 reasonable findings of fact, reasonable

1 interpretations of law, and reasonable  
2 applications of fact to law by the Sec-  
3 retary.

4 “(IV) A decision of the Depart-  
5 mental Appeals Board constitutes a  
6 final agency action and is subject to  
7 judicial review.

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

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

22 “(i) Upon the filing of a complaint by an  
23 aggrieved party, such a determination shall be  
24 reviewed by an administrative law judge of the  
25 Social Security Administration. The administra-

1           tive law judge shall review the record and shall  
2           permit discovery and the taking of evidence to  
3           evaluate the reasonableness of the determina-  
4           tion. In reviewing such a determination, the ad-  
5           ministrative law judge shall defer only to the  
6           reasonable findings of fact, reasonable interpre-  
7           tations of law, and reasonable applications of  
8           fact to law by the Secretary.

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

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

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

24          “(D) PENDING NATIONAL COVERAGE DETER-  
25          MINATIONS.—

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

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

14                   “(II) Issue a national noncoverage de-  
15                   termination.

16                   “(III) Issue a determination that no  
17                   national coverage or noncoverage deter-  
18                   mination is appropriate as of the end of  
19                   such 90-day period with respect to national  
20                   coverage of such items or services.

21                   “(IV) Issue a notice that states that  
22                   the Secretary has not completed a review  
23                   of the request for a national coverage de-  
24                   termination and that includes an identi-  
25                   fication of the remaining steps in the Sec-

1           retary’s review process and a deadline by  
2           which the Secretary will complete the re-  
3           view and take an action described in sub-  
4           clause (I), (II), or (III).

5           “(ii) In the case of an action described in  
6           clause (i)(IV), if the Secretary fails to take an  
7           action referred to in such clause by the deadline  
8           specified by the Secretary under such clause,  
9           then the Secretary is deemed to have taken an  
10          action described in clause (i)(III) as of the  
11          deadline.

12          “(iii) When issuing a determination under  
13          clause (i), the Secretary shall include an expla-  
14          nation of the basis for the determination. An  
15          action taken under clause (i) (other than sub-  
16          clause (IV)) is deemed to be a national coverage  
17          determination for purposes of review under sub-  
18          paragraph (A).

19          “(E) ANNUAL REPORT ON NATIONAL COVERAGE  
20          DETERMINATIONS.—

21                 “(i) IN GENERAL.—Not later than Decem-  
22                 ber 1 of each year, beginning in 2001, the Sec-  
23                 retary shall submit to Congress a report that  
24                 sets forth a detailed compilation of the actual  
25                 time periods that were necessary to complete

1 and fully implement national coverage deter-  
2 minations that were made in the previous fiscal  
3 year for items, services, or medical devices not  
4 previously covered as a benefit under this title,  
5 including, with respect to each new item, serv-  
6 ice, or medical device, a statement of the time  
7 taken by the Secretary to make the necessary  
8 coverage, coding, and payment determinations,  
9 including the time taken to complete each sig-  
10 nificant step in the process of making such de-  
11 terminations.

12 “(ii) PUBLICATION OF REPORTS ON THE  
13 INTERNET.—The Secretary shall publish each  
14 report submitted under clause (i) on the medi-  
15 care Internet site of the Department of Health  
16 and Human Services.

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

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

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

12                   “(A) Individuals entitled to benefits under  
13                   part A, or enrolled under part B, or both, who  
14                   are in need of the items or services that are the  
15                   subject of the coverage determination.

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

19          “(c) CONDUCT OF RECONSIDERATIONS BY INDE-  
20          PENDENT CONTRACTORS.—

21                   “(1) IN GENERAL.—The Secretary shall enter  
22                   into contracts with qualified independent contractors  
23                   to conduct reconsiderations of initial determinations  
24                   made under paragraphs (2) and (3) of subsection  
25                   (a). Contracts shall be for an initial term of three

1 years and shall be renewable on a triennial basis  
2 thereafter.

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

11 “(3) REQUIREMENTS.—Any qualified inde-  
12 pendent contractor entering into a contract with the  
13 Secretary under this subsection shall meet the fol-  
14 lowing requirements:

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

23 “(B) DETERMINATIONS.—The qualified  
24 independent contractor shall determine, on the  
25 basis of such criteria, guidelines, and policies

1 established by the Secretary and published  
2 under subsection (d)(2)(D), whether payment  
3 shall be made for items or services under part  
4 A or part B and the amount of such payment.  
5 Such determination shall constitute the conclu-  
6 sive determination on those issues for purposes  
7 of payment under such parts for fiscal inter-  
8 mediaries, carriers, and other entities whose de-  
9 terminations are subject to review by the con-  
10 tractor; except that payment may be made if—

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

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

1 to notification by the qualified independent  
2 contractor under this subsection;

3 “(iii) such determination is changed  
4 as the result of any hearing by the Sec-  
5 retary or judicial review of the decision  
6 under this section; or

7 “(iv) such payment is authorized  
8 under section 1861(v)(1)(G).

9 “(C) DEADLINES FOR DECISIONS.—

10 “(i) DETERMINATIONS.—The quali-  
11 fied independent contractor shall conduct  
12 and conclude a determination under sub-  
13 paragraph (B) or an appeal of an initial  
14 determination, and mail the notice of the  
15 decision by not later than the end of the  
16 45-day period beginning on the date a re-  
17 quest for reconsideration has been timely  
18 filed.

19 “(ii) CONSEQUENCES OF FAILURE TO  
20 MEET DEADLINE.—In the case of a failure  
21 by the qualified independent contractor to  
22 mail the notice of the decision by the end  
23 of the period described in clause (i), the  
24 party requesting the reconsideration or ap-  
25 peal may request a hearing before an ad-

1           ministrative law judge, notwithstanding  
2           any requirements for a reconsidered deter-  
3           mination for purposes of the party's right  
4           to such hearing.

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

16           “(I) DEADLINE FOR DECISION.—

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

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

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

16 “(D) LIMITATION ON INDIVIDUAL REVIEW-  
17 ING DETERMINATIONS.—

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

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

1                   “(II) determinations regarding  
2                   health care services provided in or by  
3                   an institution, organization, or agen-  
4                   cy, if the physician or any member of  
5                   the physician’s family has, directly or  
6                   indirectly, a significant financial inter-  
7                   est in such institution, organization,  
8                   or agency.

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

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

1           “(F) NOTICE REQUIREMENTS.—Whenever  
2 a qualified independent contractor makes a de-  
3 termination under this subsection, the qualified  
4 independent contractor shall promptly notify  
5 such individual and the entity responsible for  
6 the payment of claims under part A or part B  
7 of such determination.

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

21           “(H) ENSURING CONSISTENCY IN DETER-  
22 MINATIONS.—Each qualified independent con-  
23 tractor shall monitor its determinations to en-  
24 sure the consistency of its determinations with

1 respect to requests for reconsideration of simi-  
2 lar or related matters.

3 “(I) DATA COLLECTION.—

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

14 “(ii) TYPE OF DATA COLLECTED.—

15 Each qualified independent contractor  
16 shall keep accurate records of each deci-  
17 sion made, consistent with standards es-  
18 tablished by the Secretary for such pur-  
19 pose. Such records shall be maintained in  
20 an electronic database in a manner that  
21 provides for identification of the following:

22 “(I) Specific claims that give rise  
23 to appeals.

24 “(II) Situations suggesting the  
25 need for increased education for pro-

1                   viders of services, physicians, or sup-  
2                   pliers.

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

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

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

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

24                  “(4) NUMBER OF QUALIFIED INDEPENDENT  
25                  CONTRACTORS.—The Secretary shall enter into con-

1 tracts with not fewer than 12 qualified independent  
2 contractors under this subsection.

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

19 “(d) ADMINISTRATIVE PROVISIONS.—

20 “(1) OUTREACH.—The Secretary shall perform  
21 such outreach activities as are necessary to inform  
22 individuals entitled to benefits under this title and  
23 providers of services and suppliers with respect to  
24 their rights of, and the process for, appeals made  
25 under this section. The Secretary shall use the toll-

1 free telephone number maintained by the Secretary  
2 (1-800-MEDICAR(E)) (1-800-633-4227) to pro-  
3 vide information regarding appeal rights and re-  
4 spond to inquiries regarding the status of appeals.

5 “(2) GUIDANCE FOR RECONSIDERATIONS AND  
6 HEARINGS.—

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

18 “(B) DEADLINES FOR ADMINISTRATIVE  
19 ACTION.—

20 “(i) HEARING BY ADMINISTRATIVE  
21 LAW JUDGE.—

22 “(I) IN GENERAL.—Except as  
23 provided in subclause (II), an admin-  
24 istrative law judge shall conduct and  
25 conclude a hearing on a decision of a

1 qualified independent contractor  
2 under subsection (c) and render a de-  
3 cision on such hearing by not later  
4 than the end of the 90-day period be-  
5 ginning on the date a request for  
6 hearing has been timely filed.

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

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

24 “(iii) CONSEQUENCES OF FAILURE TO  
25 MEET DEADLINES.—In the case of a fail-

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

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

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

1           “(D) PUBLICATION OF MEDICARE COV-  
2 ERAGE POLICIES ON THE INTERNET.—The Sec-  
3 retary shall publish national and local coverage  
4 policies under this title on an Internet site  
5 maintained by the Secretary.

6           “(E) EFFECT OF FAILURE TO PUBLISH  
7 POLICIES.—

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

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

23           “(3) CONTINUING EDUCATION REQUIREMENT  
24 FOR QUALIFIED INDEPENDENT CONTRACTORS AND  
25 ADMINISTRATIVE LAW JUDGES.—

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

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

1 oversight of qualified independent contractors  
2 and, in consultation with the Commissioner of  
3 Social Security, administrative law judges  
4 through a central office of the Department of  
5 Health and Human Services. Such administra-  
6 tion and oversight may not be delegated to re-  
7 gional offices of the Department.

8 “(4) DISSEMINATION OF DETERMINATIONS.—

9 The Secretary shall establish a methodology under  
10 which qualified independent contractors shall carry  
11 out subsection (c)(3)(G).

12 “(5) SURVEY.—Not less frequently than every 5

13 years, the Secretary shall conduct a survey of a valid  
14 sample of individuals entitled to benefits under this  
15 title, providers of services, and suppliers to deter-  
16 mine the satisfaction of such individuals or entities  
17 with the process for appeals of determinations pro-  
18 vided for under this section and education and train-  
19 ing provided by the Secretary with respect to that  
20 process. The Secretary shall submit to Congress a  
21 report describing the results of the survey, and shall  
22 include any recommendations for administrative or  
23 legislative actions that the Secretary determines ap-  
24 propriate.

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

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

19          (c) CONFORMING AMENDMENT TO REVIEW BY THE  
20          PROVIDER REIMBURSEMENT REVIEW BOARD.—Section  
21          1878(g) of the Social Security Act (42 U.S.C. 1395oo(g))  
22          is amended by adding at the end the following new para-  
23          graph:

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

4 **SEC. 202. PROVISIONS WITH RESPECT TO LIMITATIONS ON**  
5 **LIABILITY OF BENEFICIARIES.**

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

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

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

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

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

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

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

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

11           “(i) improperly submitted by the provider  
12 of services or supplier; or

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

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

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

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

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

1 qualified independent contractor under section 1869,  
2 as determined by the Secretary) the records required  
3 to review the determination.

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

22 “(m) An individual who is entitled to benefits under  
23 this title and is furnished an item or service is not liable  
24 for payment of cost sharing amounts of more than \$50  
25 with respect to such benefits unless the individual has

1 been informed in advance of being furnished the item or  
2 service of the estimated amount of the cost sharing for  
3 the item or service using a standard form established by  
4 the Secretary.”.

5           (2) CONFORMING AMENDMENT.—Section  
6       1870(a) of the Social Security Act (42 U.S.C.  
7       1395gg(a)) is amended by striking “Any payment  
8       under this title” and inserting “Except as provided  
9       in section 1879(i), any payment under this title”.

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

14           (1) in paragraph (1), by striking “and” at the  
15       end;

16           (2) by redesignating paragraph (2) as para-  
17       graph (3); and

18           (3) by inserting after paragraph (1) the fol-  
19       lowing new paragraph:

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

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

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

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

8 **SEC. 203. WAIVERS OF LIABILITY FOR COST SHARING**  
9 **AMOUNTS.**

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

14                   “(i) the waiver is offered as a part of  
15 a supplemental insurance policy or retiree  
16 health plan;

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

21                   “(iii) the person waives the coinsur-  
22 ance and deductible amount after the bene-  
23 ficiary informs the person that payment of  
24 the coinsurance or deductible amount

1           would pose a financial hardship for the in-  
2           dividual; or

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

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

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

13                   **Subtitle B—Establishment of**  
14                   **Medicare Ombudsman**

15           **SEC. 211. ESTABLISHMENT OF MEDICARE OMBUDSMAN**  
16                   **FOR BENEFICIARY ASSISTANCE AND ADVOCACY.**  
17                   **CACY.**

18           (a) IN GENERAL.—Within the Health Care Financ-  
19 ing Administration of the Department of Health and  
20 Human Services, there shall be a Medicare Ombudsman,  
21 appointed by the Secretary of Health and Human Services  
22 from among individuals with expertise and experience in  
23 the fields of health care and advocacy, to carry out the  
24 duties described in subsection (b).

25           (b) DUTIES.—The Medicare Ombudsman shall—

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

4           (2) provide assistance with respect to com-  
5           plaints, grievances, and requests referred to in  
6           clause (i), including—

7                   (A) assistance in collecting relevant infor-  
8                   mation for such beneficiaries, to seek an appeal  
9                   of a decision or determination made by a fiscal  
10                  intermediary, carrier, Medicare+Choice organi-  
11                  zation, a benefit administrator responsible for  
12                  administering the prescription medicine benefit  
13                  program under part D of title XVIII of the So-  
14                  cial Security Act, or the Secretary;

15                  (B) assistance to such beneficiaries with  
16                  any problems arising from disenrollment from a  
17                  Medicare+Choice plan under part C of title  
18                  XVIII of such Act or a benefit administrator  
19                  responsible for administering such prescription  
20                  medicine benefit program; and

21                  (C) submit annual reports to Congress and  
22                  the Secretary, and include in such reports rec-  
23                  ommendations for improvement in the adminis-  
24                  tration of this title as the Medicare Ombuds-  
25                  man determines appropriate.

1 (c) COORDINATION WITH STATE OMBUDSMAN PRO-  
2 GRAMS AND CONSUMER ORGANIZATIONS.—The Medicare  
3 Ombudsman shall, to the extent appropriate, coordinate  
4 with State medical Ombudsman programs, and with  
5 State- and community-based consumer organizations, to—

6 (1) provide information about the medicare pro-  
7 gram; and

8 (2) conduct outreach to educate medicare bene-  
9 ficiaries with respect to manners in which problems  
10 under the medicare program may be resolved or  
11 avoided.

12 (d) DEFINITIONS.—In this section:

13 (1) The term “medicare beneficiary” means an  
14 individual entitled to benefits under part A of title  
15 XVIII of the Social Security Act, or enrolled under  
16 part B of such title, or both.

17 (2) The term “medicare program” means the  
18 insurance program established under title XVIII of  
19 the Social Security Act.

20 (3) The term “fiscal intermediary” has the  
21 meaning given such term under section 1816(a) of  
22 the Social Security Act (42 U.S.C. 1395h(a)).

23 (4) The term “carrier” has the meaning given  
24 such term under section 1842(f) of the Social Secu-  
25 rity Act (42 U.S.C. 1395u(f)).

1           (5) The term “Medicare+Choice organization”  
 2           has the meaning given such term under section  
 3           1859(a)(1) of the Social Security Act (42 U.S.C.  
 4           1395w–29(a)(1)).

5           (6) The term “Secretary” means the Secretary  
 6           of Health and Human Services.

7   **TITLE     III—MEDICARE+CHOICE**  
 8   **REFORMS; PRESERVATION OF**  
 9   **MEDICARE   PART   B   DRUG**  
 10 **BENEFIT**

11   **Subtitle A—Medicare+Choice**  
 12   **Reforms**

13 **SEC.   301.   INCREASE   IN   NATIONAL   PER   CAPITA**  
 14           **MEDICARE+CHOICE   GROWTH   PERCENTAGE**  
 15           **IN 2001 AND 2002.**

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

18           (1) in clause (iv), by striking “for 2001, 0.5  
 19           percentage points” and inserting “for 2001, 0 per-  
 20           centage points”; and

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

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

3 Section 1853(c) of the Social Security Act (42 U.S.C.  
4 1395w-23(c)) is amended—

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

8 (2) in paragraph (5), by inserting “(before  
9 2002)” after “for each year”.

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

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

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

17 (2) by adding at the end the following new sub-  
18 clause:

19 “(II) For 2002 for any of the 50  
20 States and the District of Columbia,  
21 \$450.”.

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

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

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

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

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

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

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

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

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

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

23 “(II) During 2002, 2003, 2004, and  
24 2005, in the case of a Medicare+Choice  
25 payment area in which there is no more  
26 than 1 contract entered into under this

1 part as of July 1 before the beginning of  
 2 the year, 102.5 percent of the annual  
 3 Medicare+Choice capitation rate under  
 4 this paragraph for the area for the pre-  
 5 vious year.”.

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

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

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

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

17 (2) by adding at the end the following new sub-  
 18 paragraph:

19 “(D) PERMITTING HIGHER RATES  
 20 THROUGH NEGOTIATION.—

21 “(i) IN GENERAL.—For each year be-  
 22 ginning with 2004, in the case of a  
 23 Medicare+Choice payment area for which  
 24 the Medicare+Choice capitation rate under  
 25 this paragraph would otherwise be less

1 than the United States per capita cost  
2 (USPCC), as calculated by the Secretary,  
3 a Medicare+Choice organization may ne-  
4 gotiate with the Medicare Benefits Admin-  
5 istrator an annual per capita rate that—

6 “(I) reflects an annual rate of in-  
7 crease up to the rate of increase speci-  
8 fied in clause (ii);

9 “(II) takes into account audited  
10 current data supplied by the organiza-  
11 tion on its adjusted community rate  
12 (as defined in section 1854(f)(3)); and

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

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

23 “(I) to reflect the demographic  
24 characteristics in the population under  
25 this title; and

1                   “(II) to eliminate the costs of  
2                   prescription drugs.

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

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

13                  Section 1853(a)(3)(C)(ii) of the Social Security Act  
14 (42 U.S.C. 1395w-23(c)(1)(C)(ii)) is amended—

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

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

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

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

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

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

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

18 **SEC. 312. COMPREHENSIVE IMMUNOSUPPRESSIVE DRUG**  
19 **COVERAGE FOR TRANSPLANT PATIENTS.**

20 (a) REVISION OF MEDICARE COVERAGE FOR IM-  
21 MUNOSUPPRESSIVE DRUGS.—

22 (1) IN GENERAL.—Section 1861(s)(2)(J) of the  
23 Social Security Act (42 U.S.C. 1395x(s)(2)(J)) (as  
24 amended by section 227(a) of the Medicare, Med-  
25 icaid, and SCHIP Balanced Budget Refinement Act

1 of 1999 (113 Stat. 1501A–354), as enacted into law  
2 by section 1000(a)(6) of Public Law 106–113) is  
3 amended by striking “, to an individual who re-  
4 ceives” and all that follows before the semicolon at  
5 the end and inserting “to an individual who has re-  
6 ceived an organ transplant”.

7 (2) CONFORMING AMENDMENTS.—

8 (A) Section 1832 of the Social Security  
9 Act (42 U.S.C. 1395k) (as amended by section  
10 227(b) of the Medicare, Medicaid, and SCHIP  
11 Balanced Budget Refinement Act of 1999 (113  
12 Stat. 1501A–354), as enacted into law by sec-  
13 tion 1000(a)(6) of Public Law 106–113) is  
14 amended—

15 (i) by striking subsection (b); and

16 (ii) by redesignating subsection (c) as  
17 subsection (b).

18 (B) Subsections (c) and (d) of section 227  
19 of the Medicare, Medicaid, and SCHIP Bal-  
20 anced Budget Refinement Act of 1999 (113  
21 Stat. 1501A–355), as enacted into law by sec-  
22 tion 1000(a)(6) of Public Law 106–113, are re-  
23 pealed.

1           (3) EFFECTIVE DATE.—The amendments made  
2           by this subsection shall apply to drugs furnished on  
3           or after the date of enactment of this Act.

4           (b) EXTENSION OF CERTAIN SECONDARY PAYER RE-  
5           QUIREMENTS.—Section 1862(b)(1)(C) of the Social Secu-  
6           rity Act (42 U.S.C. 1395y(b)(1)(C)) is amended by adding  
7           at the end the following: “With regard to immuno-  
8           suppressive drugs furnished on or after the date of enact-  
9           ment of the Medicare Guaranteed and Defined Rx Benefit  
10          and Health Provider Relief Act of 2000, this subpara-  
11          graph shall be applied without regard to any time limita-  
12          tion.”.

13          (c) ESTABLISHMENT OF PART D CATASTROPHIC  
14          LIMIT ON PART B COPAYMENTS FOR IMMUNO-  
15          SUPPRESSIVE DRUGS.—Section 1833 of the Social Secu-  
16          rity Act (42 U.S.C. 1395l) is amended by inserting after  
17          subsection (o) the following new subsection:

18          “(p) LIMITATION ON AMOUNT OF DEDUCTIBLES AND  
19          COINSURANCE FOR IMMUNOSUPPRESSIVE DRUGS FOR  
20          CERTAIN BENEFICIARIES.—With respect to 2003 and  
21          each subsequent year, no deductibles and coinsurance ap-  
22          plicable to immunosuppressive drugs (as described in sec-  
23          tion 1861(s)(2)(J)) in a year under this part shall be im-  
24          posed to the extent that the individual has incurred ex-  
25          penditures in that year for out-of-pocket expenditures for

1 immunosuppressive drugs in excess of the catastrophic  
2 benefit level provided for under section 1860B(c).”.

3           **Subtitle C—Improvement of**  
4           **Certain Preventive Benefits**

5 **SEC. 321. COVERAGE OF ANNUAL SCREENING PAP SMEAR**  
6           **AND PELVIC EXAMS.**

7           (a) IN GENERAL.—

8                   (1) ANNUAL SCREENING PAP SMEAR.—Section  
9           1861(nn)(1) of the Social Security Act (42 U.S.C.  
10           1395x(nn)(1)) is amended by striking “if the indi-  
11           vidual involved has not had such a test during the  
12           preceding 3 years, or during the preceding year in  
13           the case of a woman described in paragraph (3).”  
14           and inserting “if the woman involved has not had  
15           such a test during the preceding year.”.

16                   (2) ANNUAL SCREENING PELVIC EXAM.—Sec-  
17           tion 1861(nn)(2) of such Act (42 U.S.C.  
18           1395x(nn)(2)) is amended by striking “during the  
19           preceding 3 years, or during the preceding year in  
20           the case of a woman described in paragraph (3),”  
21           and inserting “during the preceding year,”.

22                   (3) CONFORMING AMENDMENT.—Section  
23           1861(nn) of such Act (42 U.S.C. 1395x(nn)) is  
24           amended by striking paragraph (3).

1 (b) EFFECTIVE DATE.—The amendments made by  
 2 subsection (a) apply to items and services furnished on  
 3 or after January 1, 2001.

4 **TITLE IV—ADJUSTMENTS TO**  
 5 **PAYMENT PROVISIONS OF**  
 6 **THE BALANCED BUDGET ACT**  
 7 **Subtitle A—Payments for Inpatient**  
 8 **Hospital Services**

9 **SEC. 401. ELIMINATING REDUCTION IN HOSPITAL MARKET**  
 10 **BASKET UPDATE FOR FISCAL YEAR 2001.**

11 Section 1886(b)(3)(B)(i)(XVI) of the Social Security  
 12 Act (42 U.S.C. 1395ww(b)(3)(B)(i)(XVI)) is amended by  
 13 striking “minus 1.1 percentage points for hospitals (other  
 14 than sole community hospitals) in all areas, and the mar-  
 15 ket basket percentage increase for sole community hos-  
 16 pitals,” and inserting “for hospitals in all areas,”.

17 **SEC. 402. ELIMINATING FURTHER REDUCTIONS IN INDI-**  
 18 **RECT MEDICAL EDUCATION (IME) FOR FIS-**  
 19 **CAL YEAR 2001.**

20 Section 1886(d)(5)(B)(ii) of the Social Security Act  
 21 (42 U.S.C. 1395ww(d)(5)(B)(ii)(V)) is amended—

22 (1) in subclause (IV)—

23 (A) by striking “fiscal year 2000” and in-  
 24 serting “each of fiscal years 2000 and 2001”;

25 and

- 1 (B) by adding “and” at the end;  
 2 (2) by striking subclause (V); and  
 3 (3) by redesignating subclause (VI) as sub-  
 4 clause (V).

5 **SEC. 403. ELIMINATING FURTHER REDUCTIONS IN DIS-**  
 6 **PROPORTIONATE SHARE HOSPITAL (DSH)**  
 7 **PAYMENTS.**

8 (a) MEDICARE PAYMENTS.—Section  
 9 1886(d)(5)(F)(ix) of the Social Security Act (42 U.S.C.  
 10 1395ww(d)(5)(F)(ix)) is amended—

- 11 (1) in subclause (III), by striking “and 2001”;  
 12 (2) by redesignating subclauses (IV) and (V) as  
 13 subclauses (V) and (VI), respectively; and  
 14 (3) by inserting after subclause (III) the fol-  
 15 lowing new subclause:

16 “(IV) during fiscal year 2001, such additional  
 17 payment amount shall be reduced by 0 percent;”.

18 (b) FREEZE IN MEDICAID DSH ALLOTMENTS FOR  
 19 FISCAL YEAR 2001.—Notwithstanding section 1923(f)(2)  
 20 of the Social Security Act (42 U.S.C. 1396r-4(f)(2)), the  
 21 DSH allotment under such section for a State for fiscal  
 22 year 2001 shall be the same as the DSH allotment under  
 23 such section for fiscal year 2000.

1 **SEC. 404. INCREASE BASE PAYMENT TO PUERTO RICO HOS-**  
2 **PITALS.**

3 Section 1886(d)(9)(A) of the Social Security Act (42  
4 U.S.C. 1395ww(d)(9)(A)) is amended—

5 (1) in clause (i), by striking “October 1, 1997,  
6 50 percent (” and inserting “October 1, 2000, 25  
7 percent (for discharges between October 1, 1997 and  
8 September 30, 2000, 50 percent,”; and

9 (2) in clause (ii), in the matter preceding sub-  
10 clause (I), by striking “after October 1, 1997, 50  
11 percent (” and inserting “after October 1, 2000, 75  
12 percent (for discharges between October 1, 1997,  
13 and September 30, 2000, 50 percent,”.

14 **Subtitle B—Payments for Skilled**  
15 **Nursing Services**

16 **SEC. 411. ELIMINATING REDUCTION IN SNF MARKET BAS-**  
17 **KET UPDATE FOR FISCAL YEAR 2001.**

18 Section 1888(e)(4)(E) of the Social Security Act (42  
19 U.S.C. 1395yy(e)(4)(E)) is amended—

20 (1) by redesignating subclauses (II) and (III)  
21 as subclauses (III) and (IV) respectively;

22 (2) in subclause (III) as redesignated, by strik-  
23 ing “for each of fiscal years 2001 and 2002,” and  
24 inserting “for fiscal year 2002,”; and

25 (3) by inserting after subclause (I) the fol-  
26 lowing new subclause:

1                   “(II) for fiscal year 2001, the  
 2                   rate computed for fiscal year 2000 in-  
 3                   creased by the skilled nursing facility  
 4                   market basket percentage increase for  
 5                   fiscal year 2000.”.

6 **SEC. 412. EXTENSION OF MORATORIUM ON THERAPY CAPS.**

7           Section 1833(g) of the Social Security Act (42 U.S.C.  
 8 1395l(g)) is amended in paragraph (4) by striking “2000  
 9 and 2001.” and inserting “2000 through 2002.”.

10                   **Subtitle C—Payments for Home**  
 11                   **Health Services**

12 **SEC. 421. 1-YEAR ADDITIONAL DELAY IN APPLICATION OF**  
 13                   **15 PERCENT REDUCTION ON PAYMENT LIM-**  
 14                   **ITS FOR HOME HEALTH SERVICES.**

15           Section 1895(b)(3)(A)(i) of the Social Security Act  
 16 (42 U.S.C. 1395fff(b)(3)(A)(i)) is amended—

17                   (1) by redesignating subparagraph (II) as sub-  
 18                   paragraph (III);

19                   (2) by inserting in subparagraph (III), as redес-  
 20                   ignated, “24 months” following “periods beginning”;  
 21                   and

22                   (3) by inserting after subclause (I) the fol-  
 23                   lowing new subclause:

24                                   “(II) For the 12-month period  
 25                                   beginning after the period described

1 in subclause (I), such amount (or  
 2 amounts) shall be equal to the amount  
 3 (or amounts) determined under sub-  
 4 clause (I), updated under subpara-  
 5 graph (B).”.

6 **SEC. 422. PROVISION OF FULL MARKET BASKET UPDATE**  
 7 **FOR HOME HEALTH SERVICES FOR FISCAL**  
 8 **YEAR 2001.**

9 Section 1861(v)(1)(L)(x) of the Social Security Act  
 10 (42 U.S.C. 1395x(v)(1)(L)(x)) is amended—

11 (1) by striking “2001,”; and

12 (2) by adding at the end the following: “With  
 13 respect to cost reporting periods beginning during  
 14 fiscal year 2001, the update to any limit under this  
 15 subparagraph shall be the home health market bas-  
 16 ket.”.

17 **Subtitle D—Rural Provider**  
 18 **Provisions**

19 **SEC. 431. ELIMINATION OF REDUCTION IN HOSPITAL OUT-**  
 20 **PATIENT MARKET BASKET INCREASE.**

21 Section 1833(t)(3)(C)(iii) of the Social Security Act  
 22 (42 U.S.C. 1395l(t)(3)(C)(iii)) is amended by striking “re-  
 23 duced by 1 percentage point for such factor for services  
 24 furnished in each of 2000, 2001, and 2002” and inserting  
 25 “reduced by 1 percentage point for such factor for services

1 furnished in 2000 and reduced (except in the case of hos-  
2 pitals located in a rural area, as defined for purposes of  
3 section 1886(d)) by 1 percentage point for such factor for  
4 services furnished in each of 2001 and 2002.”

## 5 **Subtitle E—Other Providers**

### 6 **SEC. 441. UPDATE IN RENAL DIALYSIS COMPOSITE RATE.**

7 The last sentence of section 1881(b)(7) of the Social  
8 Security Act (42 U.S.C. 1395rr(b)(7)) is amended by  
9 striking “for such services furnished on or after January  
10 1, 2001, by 1.2 percent” and inserting “for such services  
11 furnished on or after January 1, 2001, by 2.4 percent”.

## 12 **Subtitle F—Provision for** 13 **Additional Adjustments**

### 14 **SEC. 451. GUARANTEE OF ADDITIONAL ADJUSTMENTS TO** 15 **PAYMENTS FOR PROVIDERS FROM BUDGET** 16 **SURPLUS.**

17 Notwithstanding any other provision of law, from  
18 amounts estimated to be in excess social security surpluses  
19 estimated under the Balanced Budget and Emergency  
20 Deficit Control Act of 1985 for the 5 fiscal year and 10  
21 fiscal year periods beginning in fiscal year 2001, there  
22 shall be made available for further adjustments to pay-  
23 ment policies established by the Balanced Budget Act of  
24 1997, amounts that would provide for additional improve-  
25 ments to the medicare and medicaid programs carried out

1 under titles XVIII and XIX of the Social Security Act and  
2 payments to providers of services and suppliers furnishing  
3 items and services for which payments is made under  
4 those programs in the aggregate amounts over such 5 fis-  
5 cal year and 10 fiscal year periods of \$11,000,000, and  
6 \$21,000,000, respectively.

○