106TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPT. 106–703
Part 1

MEDICARE RX 2000 ACT

JUNE 27, 2000.—Committed to the Committee of the Whole House on the state of the Union and ordered to be printed

Mr. ARCHER, from the Committee on Ways and Means, submitted the following

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 4680]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 4680) to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

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79–006

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

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

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

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

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

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

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

"PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

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

"(a) PROVISION OF QUALIFIED PRESCRIPTION DRUG COVERAGE THROUGH ENROLLMENT IN PLANS.—Subject to the succeeding provisions of this part, each individual who is enrolled under part B is entitled to obtain qualified prescription drug coverage (described in section 1860B(a)) as follows:

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

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

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

"(b) GENERAL ELECTION PROCEDURES.—

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

"(2) ELECTION PERIODS.—

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

"(i) annual coordinated election periods; and

"(ii) special election periods.

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

"(B) INITIAL ELECTION PERIODS.—

"(i) INDIVIDUALS CURRENTLY COVERED.—In the case of an individual who is enrolled under part B as of November 1, 2002, there shall be an initial election period of 6 months beginning on that date.

"(ii) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who is first enrolled under part B after November 1, 2002, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

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

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

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

"(iii) in the case of an individual who meets such exceptional conditions (including conditions recognized under section 1851(d)(4)(D)) as the Administrator may provide.

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

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

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

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

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

"(1) GUARANTEED ISSUE.—

"(A) IN GENERAL.—An eligible individual who is eligible to elect qualified prescription drug coverage under a prescription drug plan or Medicare+Choice plan at a time during which elections are accepted under this part with respect to the plan shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

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

"(2) COMMUNITY-RATED PREMIUM.—

"(A) IN GENERAL.—In the case of an individual who maintains (as determined under subparagraph (C)) continuous prescription drug coverage since first qualifying to elect prescription drug coverage under this part, a PDP sponsor or Medicare+Choice organization offering a prescription drug plan or Medicare+Choice plan that provides qualified prescription drug coverage and in which the individual is enrolled may not deny, limit, or condition the coverage or provision of covered prescription drug benefits or increase the premium under the plan based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act or any other factor.

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

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

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

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

"(iii) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any outpatient prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan as defined in section 1860H(f)(1).

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

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

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

"(D) CERTIFICATION.—For purposes of carrying out this paragraph, the certifications of the type described in sections 2701(e) of the Public Health Service Act and in section 9801(e) of the Internal Revenue Code shall also

include a statement for the period of coverage of whether the individual involved had prescription drug coverage described in subparagraph (C).

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

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

"(d) EFFECTIVE DATE OF ELECTIONS.—

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

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

"(3) TERMINATION.—The Medicare Benefits Administrator shall provide for the termination of an election in the case of—

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

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

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

"(a) REQUIREMENTS.—

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

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

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

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

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

"(B) DISAPPROVAL AUTHORITY.—The Medicare Benefits Administrator shall review the offering of qualified prescription drug coverage under this part or part C. If the Administrator finds that, in the case of a qualified prescription drug coverage under a prescription drug plan or a Medicare+Choice plan, that the organization or sponsor offering the coverage is purposefully engaged in activities intended to result in favorable selection of those eligible medicare beneficiaries obtaining coverage through the plan, the Administrator may terminate the contract with the sponsor or organization under this part or part C.

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

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

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

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

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

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

"(2) LIMITS ON COST-SHARING.—The coverage has cost-sharing (for costs above the annual deductible specified in paragraph (1) and up to the initial coverage limit under paragraph (3)) that is equal to 50 percent or that is actuarially con-

sistent (using processes established under subsection (e)) with an average expected payment of 50 percent of such costs.

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

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

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

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

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

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

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

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

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

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

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

"(i) incurred costs shall only include costs incurred for the annual deductible (described in paragraph (1)), cost-sharing (described in paragraph (2)), and amounts for which benefits are not provided because of the application of the initial coverage limit described in paragraph (3); and

"(ii) such costs shall be treated as incurred without regard to whether the individual or another person, including a State program or other third-party coverage, has paid for such costs.

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

"(c) ALTERNATIVE COVERAGE REQUIREMENTS.—A prescription drug plan or Medicare+Choice plan may provide a different prescription drug benefit design from the standard coverage described in subsection (b) so long as the following requirements are met:

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

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

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

"(C) ASSURING STANDARD PAYMENT FOR COSTS AT INITIAL COVERAGE LIMIT.—The coverage is designed, based upon an actuarially representative pattern of utilization (as determined under subsection (e)), to provide for the payment, with respect to costs incurred that are equal to the sum of the deductible under subsection (b)(1) and the initial coverage limit under subsection (b)(3), of an amount equal to at least such initial coverage limit multiplied by the percentage specified in subsection (b)(2).

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

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

cause of the application of cost-sharing or an initial coverage limit (described in subsection (b)(3)). Insofar as a State elects to provide medical assistance under title XIX for a drug based on the prices negotiated by a prescription drug plan under this part, the requirements of section 1927 shall not apply to such drugs.

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

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

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

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

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

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

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

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

"(f) COVERED OUTPATIENT DRUGS DEFINED.—

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

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

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

and such term includes any use of a covered outpatient drug for a medically accepted indication (as defined in section 1927(k)(6)).

"(2) EXCLUSIONS.—

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

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

"(3) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this part shall not be so considered under a plan if the plan excludes the drug under a formulary that meets the requirements of section 1860C(f)(2) (including providing an appeal process).

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

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

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

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

"(5) STUDY ON INCLUSION OF DRUGS TREATING MORBID OBESITY.—The Medicare Policy Advisory Board shall provide for a study on removing the exclusion under paragraph (2)(A) for coverage of agents used for weight loss in the case of morbidly obese individuals. The Board shall report to Congress on the results of the study not later than March 1, 2002.

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

"(a) GUARANTEED ISSUE COMMUNITY-RELATED PREMIUMS AND NONDISCRIMINATION.—For provisions requiring guaranteed issue, community-rated premiums, and nondiscrimination, see sections 1860A(c)(1), 1860A(c)(2), and 1860F(b).

"(b) DISSEMINATION OF INFORMATION.—

"(1) GENERAL INFORMATION.—A PDP sponsor shall disclose, in a clear, accurate, and standardized form to each enrollee with a prescription drug plan offered by the sponsor under this part at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such plan. Such information includes the following:

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

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

"(C) Co-payments and deductible requirements.

"(D) Grievance and appeals procedures.

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

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

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

"(c) ACCESS TO COVERED BENEFITS.—

"(1) ASSURING PHARMACY ACCESS.—The PDP sponsor of the prescription drug plan shall secure the participation of sufficient numbers of pharmacies (which may include mail order pharmacies) to ensure convenient access (including adequate emergency access) for enrolled beneficiaries, in accordance with standards established under section 1860D(e) that ensure such convenient access. Nothing in this paragraph shall be construed as requiring the participation of (or permitting the exclusion of) all pharmacies in any area under a plan.

"(2) ACCESS TO NEGOTIATED PRICES FOR PRESCRIPTION DRUGS.—The PDP sponsor of a prescription drug plan shall issue such a card that may be used by an enrolled beneficiary to assure access to negotiated prices under section 1860B(d) for the purchase of prescription drugs for which coverage is not otherwise provided under the prescription drug plan.

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

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

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

"(C) APPEALS AND EXCEPTIONS TO APPLICATION.—The PDP sponsor must have, as part of the appeals process under subsection (f)(2), a process for appeals for denials of coverage based on such application of the formulary.

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

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

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

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

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

"(2) MEDICATION THERAPY MANAGEMENT PROGRAM.—

"(A) IN GENERAL.—A medication therapy management program described in this paragraph is a program of drug therapy management and medication administration that is designed to assure that covered outpatient drugs under the prescription drug plan are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

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

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

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

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

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

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

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

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

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

"(4) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR GENERIC EQUIVALENT DRUGS.—Each PDP sponsor shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered outpatient drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost generic drug that is therapeutically and pharmaceutically equivalent and bioequivalent.

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

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

"(1) IN GENERAL.—A PDP sponsor shall meet the requirements of section 1852(g) with respect to covered benefits under the prescription drug plan it offers under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

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

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

"SEC. 1860D. REQUIREMENTS FOR PRESCRIPTION DRUG PLAN (PDP) SPONSORS; CONTRACTS; ESTABLISHMENT OF STANDARDS.

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

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

"(2) ASSUMPTION OF FULL FINANCIAL RISK.—

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

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

"(3) SOLVENCY FOR UNLICENSED SPONSORS.—In the case of a sponsor that is not described in paragraph (1), the sponsor shall meet solvency standards established by the Medicare Benefits Administrator under subsection (d).

"(b) CONTRACT REQUIREMENTS.—

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

"(2) NEGOTIATION REGARDING TERMS AND CONDITIONS.—The Medicare Benefits Administrator shall have the same authority to negotiate the terms and conditions of prescription drug plans under this part as the Director of the Office of Personnel Management has with respect to health benefits plans under chapter 89 of title 5, United States Code. In negotiating the terms and conditions regarding premiums for which information is submitted under section 1860F(a)(2), the Administrator shall take into account the reinsurance subsidy payments under section 1860H and the adjusted community rate (as defined in section 1854(f)(3)) for the benefits covered.

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

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

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

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

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

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

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

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

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

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

"(4) RULES OF APPLICATION FOR INTERMEDIATE SANCTIONS.—In applying paragraph (3)(E)—

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

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

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

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

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

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

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

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

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

"(B) any reference to solvency standards shall be treated as a reference to solvency standards established under subsection (d).

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

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

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

"(e) OTHER STANDARDS.—The Medicare Benefits Administrator shall establish by regulation other standards (not described in subsection (d)) for PDP sponsors and plans consistent with, and to carry out, this part. The Administrator shall publish such regulations by October 1, 2001. In order to carry out this requirement in a timely manner, the Administrator may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

"(f) RELATION TO STATE LAWS.—

"(1) IN GENERAL.—The standards established under this section shall supersede any State law or regulation (including standards described in paragraph (2)) with respect to prescription drug plans which are offered by PDP sponsors under this part to the extent such law or regulation is inconsistent with such standards.

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

"(A) Benefit requirements.

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

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

"(D) Establishment and regulation of premiums.

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

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

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

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

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

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

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

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

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

"(1) CHOICE OF AT LEAST 2 PLANS IN EACH AREA.—

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

"(B) REQUIREMENT FOR DIFFERENT PLAN SPONSORS.—The requirement in subparagraph (A) is not satisfied with respect to an area if only one PDP sponsor or Medicare+Choice organization offers all the qualifying plans in the area.

"(2) GUARANTEEING ACCESS TO COVERAGE.—In order to assure access under paragraph (1) and consistent with paragraph (3), the Medicare Benefits Administrator may provide financial incentives (including partial underwriting of risk) for a PDP sponsor to expand the service area under an existing prescription drug plan to adjoining or additional areas or to establish such a plan (including offering such a plan on a regional or nationwide basis), but only so long as (and to the extent) necessary to assure the access guaranteed under paragraph (1).

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

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

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

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

"(4) REPORTS.—The Medicare Benefits Administrator shall, in each annual report to Congress under section 1807(f), include information on the exercise of authority under this subsection. The Administrator also shall include such recommendations as may be appropriate to minimize the exercise of such authority, including minimizing the assumption of financial risk.

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

"SEC. 1860F. PREMIUMS.

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

"(1) IN GENERAL.—Each PDP sponsor shall submit to the Medicare Benefits Administrator information of the type described in paragraph (2) in the same manner as information is submitted by a Medicare+Choice organization under section 1854(a)(1).

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

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

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

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

"(i) the actuarial basis for such premium;

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

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

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

"(3) REVIEW.—The Medicare Benefits Administrator shall review the information filed under paragraph (2) for the purpose of conducting negotiations under section 1860D(b)(2).

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

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

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

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

"(2) STANDARD PRESCRIPTION DRUG COVERAGE DEFINED.—For purposes of this subsection, the term 'standard prescription drug coverage' means qualified prescription drug coverage that is standard coverage or that has an actuarial value equivalent to the actuarial value for standard coverage.

"SEC. 1860G. PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS.

"(a) IN GENERAL.—

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

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

"(B) subject to subsection (c), to the substitution for the beneficiary cost-sharing described in paragraphs (1) and (2) of section 1860B(b) (up to the initial coverage limit specified in paragraph (3) of such section) of amounts that are nominal.

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

"(3) DETERMINATION OF ELIGIBILITY.—

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

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

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

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

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

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

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

"(ii) the term 'Federal poverty line' means the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

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

"(b) PREMIUM SUBSIDY AMOUNT.—

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

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

"(A) a prescription drug plan that—

"(i) provides standard coverage (or alternative prescription drug coverage the actuarial value is equivalent to that of standard coverage), the premium imposed for enrollment under the plan under this part (determined without regard to any subsidy under this section or any late enrollment penalty under section 1860A(c)(2)(B)); or

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

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

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

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

"(A) the maximum amount of subsidy that may be provided with respect to an enrollee for a year may not exceed 95 percent of the maximum cost-sharing described in such subsection that may be incurred for standard coverage;

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

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

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

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

"(1) the Administrator provides for a notification of the PDP sponsor or Medicare+Choice organization involved that the individual is eligible for a subsidy and the amount of the subsidy under subsection (a);

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

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

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

"(e) RELATION TO MEDICAID PROGRAM.—

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

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

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

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

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

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

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

This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Administrator to provide for the payment of amounts provided under this section.

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

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

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

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

"(c) REINSURANCE PAYMENT AMOUNT.—

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

"(A) For the portion of the individual's gross covered prescription drug costs (as defined in paragraph (3)) for the year that exceeds $1,250, but does not exceed $1,350, an amount equal to 30 percent of the allowable costs (as defined in paragraph (2)) attributable to such gross covered prescription drug costs.

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

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

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

"(E) For the portion of the individual's gross covered prescription drug costs for the year that exceeds $7,050, an amount equal to 90 percent of the allowable costs attributable to such gross covered prescription drug costs.

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

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

"(4) INDEXING DOLLAR AMOUNTS.—

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

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

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

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

"(d) ADJUSTMENT OF PAYMENTS.—

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

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

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

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

"(e) PAYMENT METHODS.—

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

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

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

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

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

"(B) AUDITS.—The sponsor (and the plan) shall maintain, and afford the Medicare Benefits Administrator access to, such records as the Administrator may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage, the accuracy of payments made, and such other matters as may be appropriate.

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

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

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

"(A) is covered under the plan; and

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

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

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

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

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

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

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

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

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

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

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

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

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

"(a) IN GENERAL.—There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1841 an account to be known as the 'Medicare Prescription Drug Account' (in this section referred to as the 'Account'). The Account shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, such fund as provided in this part. Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund.

"(b) PAYMENTS FROM ACCOUNT.—

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

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

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

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

"(2) TRANSFERS TO MEDICAID ACCOUNT FOR INCREASED ADMINISTRATIVE COSTS.—The Managing Trustee shall transfer from time to time from the Account to the Grants to States for Medicaid account amounts the Secretary certifies are attributable to increases in payment resulting from the application of a higher Federal matching percentage under section 1935(b).

"(3) TREATMENT IN RELATION TO PART B PREMIUM.—Amounts payable from the Account shall not be taken into account in computing actuarial rates or premium amounts under section 1839.

"(c) DEPOSITS INTO ACCOUNT.—

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

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

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

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

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

"(2) INITIAL COVERAGE LIMIT.—The term 'initial coverage limit' means the such limit as established under section 1860B(b)(3), or, in the case of coverage that is not standard coverage, the comparable limit (if any) established under the coverage.

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

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

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

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

"(B) provides qualified prescription drug coverage; and

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) ADDITIONAL CONFORMING CHANGES.—

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

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

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

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

"(j) AVAILABILITY OF PRESCRIPTION DRUG BENEFITS.—

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

"(2) COMPLIANCE WITH ADDITIONAL BENEFICIARY PROTECTIONS.—With respect to the offering of qualified prescription drug coverage by a Medicare+Choice organization under a Medicare+Choice plan, the organization and plan shall meet the requirements of section 1860C, including requirements relating to information dissemination and grievance and appeals, in the same manner as they apply to a PDP sponsor and a prescription drug plan under part D. The Medicare Benefits Administrator shall waive such requirements to the extent the Administrator determines that such requirements duplicate requirements otherwise applicable to the organization or plan under this part.

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

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

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

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

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

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

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

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

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

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

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

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

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

"(7) QUALIFIED PRESCRIPTION DRUG COVERAGE; STANDARD COVERAGE.—For purposes of this part, the terms 'qualified prescription drug coverage' and 'standard coverage' have the meanings given such terms in section 1860B.".

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

(1) in subsection (a)(1)—

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

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

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

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

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

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

SEC. 103. MEDICAID AMENDMENTS.

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

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

(A) in subsection (a)—

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

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

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

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

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

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

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

"SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

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

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

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

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

"(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE COSTS.—

"(1) IN GENERAL.—The amounts expended by a State in carrying out subsection (a) are, subject to paragraph (2), expenditures reimbursable under the appropriate paragraph of section 1903(a); except that, notwithstanding any

other provision of such section, the applicable Federal matching rates with respect to such expenditures under such section shall be increased as follows:

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

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

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

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

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

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

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

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

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

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

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

"(A) MEDICARE SUBSIDIES.—The total amount of payments made in the quarter under section 1860G (relating to premium and cost-sharing prescription drug subsidies for low-income medicare beneficiaries) that are attributable to individuals who are residents of the State and are entitled to benefits with respect to prescribed drugs under the State plan under this title (including such a plan operating under a waiver under section 1115).

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

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

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

"(A) 2003 is 80 percent;

"(B) 2004 is 60 percent;

"(C) 2005 is 40 percent;

"(D) 2006 is 20 percent; or

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

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

"(d) ADDITIONAL PROVISIONS.—

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

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

(d) TREATMENT OF TERRITORIES.—

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

(A) in subsection (a) in the matter preceding paragraph (1), by inserting "subject to subsection (e)" after "section 1903(a)";

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

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

"(e) TREATMENT OF TERRITORIES.—

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

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

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

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

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

"(B) assures that additional amounts received by the State that are attributable to the operation of this subsection are used only for such assistance.

"(3) INCREASED AMOUNT.—

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

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

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

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

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

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

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

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

SEC. 104. MEDIGAP TRANSITION PROVISIONS.

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

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

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

(A) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as "A", "B", "C", "D", "E", "F", or "G" (under the standards established under subsection (p)(2) of section 1882 of the Social Security Act, 42 U.S.C. 1395ss) and that is offered and is available for issuance to new enrollees by such issuer;

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

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

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

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

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

(B) at the time of such enrollment was enrolled and terminates enrollment in a medicare supplemental policy which has a benefit package classified as "H", "I", or "J" under the standards referred to in paragraph (1)(A) or terminates enrollment in a policy to which such standards do not apply but which provides benefits for prescription drugs.

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

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

SEC. 105. DEMONSTRATION PROJECT FOR DISEASE MANAGEMENT FOR SEVERELY CHRONICALLY ILL MEDICARE BENEFICIARIES.

(a) IN GENERAL.—The Administrator of the Medicare Benefits Administration (in this section referred to as the "Administrator") shall conduct a demonstration project under this section (in this section referred to as the "project") to demonstrate the impact on costs and health outcomes of applying disease management to medicare beneficiaries with diagnosed, advanced-stage congestive heart failure, diabetes, or coronary heart disease.

(b) VOLUNTARY PARTICIPATION.—

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

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

(B) their physicians approve of participation in the project; and

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

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

(A) for disease management services related to their chronic health condition; and

(B) if the beneficiary—

(i) is enrolled in a prescription drug plan under part D of title XVIII of the Social Security Act, for payment of any premiums for such plan, any deductible or cost-sharing, and any amounts not covered under the plan because of the application of an initial coverage limit; or

(ii) is not enrolled in such a plan, for payment for all costs for prescription drugs without regard to whether or not they relate to the chronic health condition;

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

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

(c) CONTRACTS WITH DISEASE MANAGEMENT ORGANIZATIONS.—

(1) IN GENERAL.—The Administrator shall carry out the project through contracts with up to 3 disease management organizations. The Administrator shall not enter into such a contract with an organization unless the organization demonstrates that it can produce improved health outcomes and reduce aggregate medicare expenditures consistent with paragraph (2).

(2) CONTRACT PROVISIONS.—Under such contracts—

(A) such an organization shall be required to provide for prescription drug coverage described in subsection (b)(2)(B);

(B) such an organization shall be paid a fee negotiated and established by the Administrator in a manner so that (taking into account savings in expenditures under parts A and B of the medicare program) there will be a net reduction in expenditures under the medicare program as a result of the project; and

(C) such an organization shall guarantee, through an appropriate arrangement with a reinsurance company or otherwise, the net reduction in expenditures described in subparagraph (B).

(3) PAYMENTS.—Payments to such organizations shall be made in appropriate proportion from the Trust Funds established under title XVIII of the Social Security Act.

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

(e) REPORT.—The Administrator shall submit to Congress an interim report on the project not later than 2 years after the date it is first implemented and a final report on the project not later than 6 months after the date of its completion. Such

reports shall include information on the impact of the project on costs and health outcomes and recommendations on the cost-effectiveness of extending or expanding the project.

TITLE II—MODERNIZATION OF ADMINISTRATION OF MEDICARE

Subtitle A—Medicare Benefits Administration

SEC. 201. ESTABLISHMENT OF ADMINISTRATION.

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

"MEDICARE BENEFITS ADMINISTRATION

"SEC. 1807. (a) ESTABLISHMENT.—There is established within the Department of Health and Human Services an agency to be known as the Medicare Benefits Administration.

"(b) ADMINISTRATOR AND DEPUTY ADMINISTRATOR.—

"(1) ADMINISTRATOR.—

"(A) IN GENERAL.—The Medicare Benefits Administration shall be headed by an Administrator (in this section referred to as the 'Administrator') who shall be appointed by the President, by and with the advice and consent of the Senate. The Administrator shall be in direct line of authority to the Secretary.

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

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

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

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

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

"(G) AUTHORITY TO DELEGATE.—The Administrator may assign duties, and delegate, or authorize successive redelegations of, authority to act and to render decisions, to such officers and employees of the Administration as the Administrator may find necessary. Within the limitations of such delegations, redelegations, or assignments, all official acts and decisions of such officers and employees shall have the same force and effect as though performed or rendered by the Administrator.

"(2) DEPUTY ADMINISTRATOR.—

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

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

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

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

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

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

"(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

"(1) DUTIES.—

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

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

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

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

"(C) NONINTERFERENCE.—In carrying out its duties with respect to the provision of qualified prescription drug coverage to beneficiaries under this title, the Administrator may not—

"(i) require a particular formulary or institute a price structure for the reimbursement of covered outpatient drugs;

"(ii) interfere in any way with negotiations between PDP sponsors and Medicare+Choice organizations and drug manufacturers, wholesalers, or other suppliers of covered outpatient drugs; and

"(iii) otherwise interfere with the competitive nature of providing such coverage through such sponsors and organizations.

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

"(2) STAFF.—

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

"(B) FLEXIBILITY WITH RESPECT TO COMPENSATION.—

"(i) IN GENERAL.—The staff of the Medicare Benefits Administration shall, subject to clause (ii), be paid without regard to the provisions of chapter 51 and chapter 53 of such title (relating to classification and schedule pay rates).

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

"(C) LIMITATION ON FULL-TIME EQUIVALENT STAFFING FOR CURRENT HCFA FUNCTIONS BEING TRANSFERRED.—The Administrator may not employ under this paragraph a number of full-time equivalent employees, to carry out functions that were previously conducted by the Health Care Financing Administration and that are conducted by the Administrator by reason of this section, that exceeds the number of such full-time equivalent employees authorized to be employed by the Health Care Financing Administration to conduct such functions as of the date of the enactment of this Act.

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

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

"(B) TRANSFER OF DATA AND INFORMATION.—The Secretary shall ensure that the Administrator of the Health Care Financing Administration transfers to the Administrator of the Medicare Benefits Administration such information and data in the possession of the Administrator of the Health Care Financing Administration as the Administrator of the Medicare Benefits Administration requires to carry out the duties described in paragraph (1).

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

"(d) OFFICE OF BENEFICIARY ASSISTANCE.—

"(1) ESTABLISHMENT.—The Secretary shall establish within the Medicare Benefits Administration an Office of Beneficiary Assistance to carry out functions relating to medicare beneficiaries under this title, including making determinations of eligibility of individuals for benefits under this title, providing for enrollment of medicare beneficiaries under this title, and the functions described in paragraph (2). The Office shall be separate operating division within the Administration.

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

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

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

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

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

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

"(3) MEDICARE OMBUDSMAN.—

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

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

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

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

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

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

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

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

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

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

"(e) MEDICARE POLICY ADVISORY BOARD.—

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

"(2) REPORTS.—

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

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

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

"(ii) EDUCATION AND ENROLLMENT.—Recommendations for the improvement to efforts to provide medicare beneficiaries information and education on the program under this title, and specifically parts C and D, and the program for enrollment under the title.

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

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

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

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

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

"(4) MEMBERSHIP.—

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

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

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

"(iii) 2 members shall be appointed by the President pro tempore of the Senate with the advice of the chairman and the ranking minority member of the Senate Committee on Finance.

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

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

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

"(6) TERMS OF OFFICE.—

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

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

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

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

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

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

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

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

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

"(9) DIRECTOR AND STAFF.—

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

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

"(C) FLEXIBILITY WITH RESPECT TO COMPENSATION.—

"(i) IN GENERAL.—The Director and staff of the Board shall, subject to clause (ii), be paid without regard to the provisions of chapter 51 and chapter 53 of such title (relating to classification and schedule pay rates).

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

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

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

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

(b) EFFECTIVE DATE.—

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

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

(3) DUTIES WITH RESPECT TO ELIGIBILITY DETERMINATIONS AND ENROLLMENT.—The Administrator of the Medicare Benefits Administration shall carry out enrollment under title XVIII of the Social Security Act, make eligibility de-

terminations under such title, and carry out part C of such title for years beginning or after January 1, 2003.

SEC. 202. MISCELLANEOUS ADMINISTRATIVE PROVISIONS.

(a) ADMINISTRATOR AS MEMBER OF THE BOARD OF TRUSTEES OF THE MEDICARE TRUST FUNDS.—Section 1817(b) and section 1841(b) of the Social Security Act (42 U.S.C. 1395i(b), 1395t(b)) are each amended by striking "and the Secretary of Health and Human Services, all ex officio," and inserting "the Secretary of Health and Human Services, and the Administrator of the Medicare Benefits Administration, all ex officio,".

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

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

"Administrator of the Health Care Financing Administration.".

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

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

Subtitle B—Oversight of Financial Sustainability of the Medicare Program

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

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

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

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

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

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

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

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

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

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

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

Subtitle C—Changes in Medicare Coverage and Appeals Process

SEC. 221. REVISIONS TO MEDICARE APPEALS PROCESS.

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

"DETERMINATIONS; APPEALS

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

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

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

"(3) Any other initial determination with respect to a claim for benefits under such parts, including an initial determination by the Secretary that payment may not be made, or may no longer be made, for an item or service under such parts, an initial determination made by a utilization and quality control peer review organization under section 1154(a)(2), and an initial determination made by an entity pursuant to a contract with the Secretary to administer provisions of this title or title XI.

"(b) APPEAL RIGHTS.—

"(1) IN GENERAL.—

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

"(B) REPRESENTATION BY PROVIDER OR SUPPLIER.—

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

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

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

"(iv) REQUIREMENTS FOR REPRESENTATIVES OF A BENEFICIARY.—The provisions of section 205(j) and section 206 (regarding representation of claimants) shall apply to representation of an individual with respect to appeals under this section in the same manner as they apply to representation of an individual under those sections.

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

"(D) TIME LIMITS FOR APPEALS.—

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

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

"(E) AMOUNTS IN CONTROVERSY.—

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

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

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

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

"(F) EXPEDITED PROCEEDINGS.—

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

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

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

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

"(ii) EXPEDITED HEARING.—In a hearing by the Secretary under this section, in which the moving party alleges that no material issues of fact are in dispute, the Secretary shall make an expedited determination as to whether any such facts are in dispute and, if not, shall render a decision expeditiously.

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

"(2) REVIEW OF COVERAGE DETERMINATIONS.—

"(A) NATIONAL COVERAGE DETERMINATIONS.—

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

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

"(II) Such a determination shall not be held unlawful or set aside on the ground that a requirement of section 553 of title 5, United States Code, or section 1871(b) of this title, relating to publication in the Federal Register or opportunity for public comment, was not satisfied.

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

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

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

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

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

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

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

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

"(D) PENDING NATIONAL COVERAGE DETERMINATIONS.—

"(i) IN GENERAL.—In the event the Secretary has not issued a national coverage or noncoverage determination with respect to a particular type or class of items or services, an affected party may submit to the Secretary a request to make such a determination with respect to such items or services. By not later than the end of the 90-day period beginning on the date the Secretary receives such a request, the Secretary shall take one of the following actions:

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

"(II) Issue a national noncoverage determination.

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

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

"(ii) In the case of an action described in clause (i)(IV), if the Secretary fails to take an action referred to in such clause by the deadline specified by the Secretary under such clause, then the Secretary is deemed to have taken an action described in clause (i)(III) as of the deadline.

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

"(E) ANNUAL REPORT ON NATIONAL COVERAGE DETERMINATIONS.—

"(i) IN GENERAL.—Not later than December 1 of each year, beginning in 2001, the Secretary shall submit to Congress a report that sets forth a detailed compilation of the actual time periods that were necessary to complete and fully implement national coverage determinations that were made in the previous fiscal year for items, services, or medical devices not previously covered as a benefit under this title, including, with respect to each new item, service, or medical device, a statement of the time taken by the Secretary to make the necessary coverage, coding, and payment determinations, including the time taken to complete each significant step in the process of making such determinations.

"(ii) PUBLICATION OF REPORTS ON THE INTERNET.—The Secretary shall publish each report submitted under clause (i) on the medicare Internet site of the Department of Health and Human Services.

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

"(4) LIMITATION ON REVIEW OF CERTAIN REGULATIONS.—A regulation or instruction which relates to a method for determining the amount of payment under part B and which was initially issued before January 1, 1981, shall not be subject to judicial review.

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

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

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

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

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

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

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

"(A) IN GENERAL.—The qualified independent contractor shall perform such duties and functions and assume such responsibilities as may be required under regulations of the Secretary promulgated to carry out the provisions of this subsection, and such additional duties, functions, and responsibilities as provided under the contract.

"(B) DETERMINATIONS.—The qualified independent contractor shall determine, on the basis of such criteria, guidelines, and policies established by the Secretary and published under subsection (d)(2)(D), whether payment shall be made for items or services under part A or part B and the amount of such payment. Such determination shall constitute the conclusive determination on those issues for purposes of payment under such parts for fiscal intermediaries, carriers, and other entities whose determinations are subject to review by the contractor; except that payment may be made if—

"(i) such payment is allowed by reason of section 1879;

"(ii) in the case of inpatient hospital services or extended care services, the qualified independent contractor determines that additional time is required in order to arrange for postdischarge care, but payment may be continued under this clause for not more than 2 days, and only in the case in which the provider of such services did not know and could not reasonably have been expected to know (as determined under section 1879) that payment would not otherwise be made for such services under part A or part B prior to notification by the qualified independent contractor under this subsection;

"(iii) such determination is changed as the result of any hearing by the Secretary or judicial review of the decision under this section; or

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

"(C) DEADLINES FOR DECISIONS.—

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

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

"(iii) EXPEDITED RECONSIDERATIONS.—The qualified independent contractor shall perform an expedited reconsideration under subsection (b)(1)(F) of a notice from a provider of services or supplier that payment

may not be made for an item or service furnished by the provider of services or supplier, of a decision by a provider of services to terminate services furnished to an individual, or in accordance with the following:

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

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

"(D) LIMITATION ON INDIVIDUAL REVIEWING DETERMINATIONS.—

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

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

"(II) determinations regarding health care services provided in or by an institution, organization, or agency, if the physician or any member of the physician's family has, directly or indirectly, a significant financial interest in such institution, organization, or agency.

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

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

"(F) NOTICE REQUIREMENTS.—Whenever a qualified independent contractor makes a determination under this subsection, the qualified independent contractor shall promptly notify such individual and the entity responsible for the payment of claims under part A or part B of such determination.

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

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

"(I) DATA COLLECTION.—

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

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

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

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

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

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

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

"(J) HEARINGS BY THE SECRETARY.—The qualified independent contractor shall (i) prepare such information as is required for an appeal of its reconsidered determination to the Secretary for a hearing, including as necessary, explanations of issues involved in the determination and relevant policies, and (ii) participate in such hearings as required by the Secretary.

"(4) NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—The Secretary shall enter into contracts with not fewer than 12 qualified independent contractors under this subsection.

"(5) LIMITATION ON QUALIFIED INDEPENDENT CONTRACTOR LIABILITY.—No qualified independent contractor having a contract with the Secretary under this subsection and no person who is employed by, or who has a fiduciary relationship with, any such qualified independent contractor or who furnishes professional services to such qualified independent contractor, shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this subsection or to a valid contract entered into under this subsection, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) provided due care was exercised in the performance of such duty, function, or activity.

"(d) ADMINISTRATIVE PROVISIONS.—

"(1) OUTREACH.—The Secretary shall perform such outreach activities as are necessary to inform individuals entitled to benefits under this title and providers of services and suppliers with respect to their rights of, and the process for, appeals made under this section. The Secretary shall use the toll-free telephone number maintained by the Secretary (1–800–MEDICAR(E)) (1–800–633–4227) to provide information regarding appeal rights and respond to inquiries regarding the status of appeals.

"(2) GUIDANCE FOR RECONSIDERATIONS AND HEARINGS.—

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

"(B) DEADLINES FOR ADMINISTRATIVE ACTION.—

"(i) HEARING BY ADMINISTRATIVE LAW JUDGE.—

"(II) IN GENERAL.—Except as provided in subclause (II), an administrative law judge shall conduct and conclude a hearing on a decision of a qualified independent contractor under subsection (c) and render a decision on such hearing by not later than the end of the 90-day period beginning on the date a request for hearing has been timely filed.

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

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

"(iii) CONSEQUENCES OF FAILURE TO MEET DEADLINES.—In the case of a failure by an administrative law judge to render a decision by the end of the period described in clause (ii), the party requesting the hearing may request a review by the Departmental Appeals Board of the Department of Health and Human Services, notwithstanding any requirements for a hearing for purposes of the party's right to such a review.

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

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

"(D) PUBLICATION OF MEDICARE COVERAGE POLICIES ON THE INTERNET.—The Secretary shall publish national and local coverage policies under this title on an Internet site maintained by the Secretary.

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

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

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

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

"(A) IN GENERAL.—The Secretary shall provide to each qualified independent contractor, and, in consultation with the Commissioner of Social Security, to administrative law judges that decide appeals of reconsiderations of initial determinations or other decisions or determinations under this section, such continuing education with respect to policies of the Secretary under this title or part B of title XI as is necessary for such qualified independent contractors and administrative law judges to make informed decisions with respect to appeals.

"(B) MONITORING OF DECISIONS BY QUALIFIED INDEPENDENT CONTRACTORS AND ADMINISTRATIVE LAW JUDGES.—The Secretary shall monitor determinations made by all qualified independent contractors and administrative law judges under this section and shall provide continuing education and training to such qualified independent contractors and administrative law judges to ensure consistency of determinations with respect to appeals on similar or related matters. To ensure such consistency, the Secretary shall provide for administration and oversight of qualified independent contractors and, in consultation with the Commissioner of Social Security, administrative law judges through a central office of the Department of Health and Human Services. Such administration and oversight may not be delegated to regional offices of the Department.

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

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

"(6) REPORT TO CONGRESS.—The Secretary shall submit to Congress an annual report describing the number of appeals for the previous year, identifying issues that require administrative or legislative actions, and including any recommendations of the Secretary with respect to such actions. The Secretary shall include in such report an analysis of determinations by qualified independent contractors with respect to inconsistent decisions and an analysis of the causes of any such inconsistencies.".

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subtitle A—Medicare+Choice Reforms

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

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

(1) in clause (iv), by striking "for 2001, 0.5 percentage points" and inserting "for 2001, 0 percentage points"; and

(2) in clause (v), by striking "for 2002, 0.3 percentage points" and inserting "for 2002, 0 percentage points".

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

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

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

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

SEC. 303. INCREASING MINIMUM PAYMENT AMOUNT.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(D) PERMITTING HIGHER RATES THROUGH NEGOTIATION.—

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

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

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

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

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

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

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

"(iii) ADJUSTMENTS FOR OVER OR UNDER PROJECTIONS.—If subparagraph is applied to an organization and payment area for a year, in applying this subparagraph for a subsequent year the provisions of paragraph (6)(C) shall apply in the same manner as such provisions apply under this paragraph.".

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

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

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

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

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

Subtitle B—Preservation of Medicare Coverage of Drugs and Biologicals

SEC. 311. PRESERVATION OF COVERAGE OF DRUGS AND BIOLOGICALS UNDER PART B OF THE MEDICARE PROGRAM.

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

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

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

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

(B) ELEMENTS.—The study shall also assess the consequences of changing the current medicare payment methodology to a payment methodology that is based on the average acquisition cost of the drugs. The study shall, at a minimum, assess the effects of such a reduction on—

(1) the delivery of health care services to Medicare beneficiaries with cancer;

(2) total Medicare expenditures, including an estimate of the number of patients who would, as a result of the payment reduction, receive chemotherapy in a hospital rather than in a physician's office;

(3) the delivery of dialysis services;

(4) the delivery of vaccines;

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

(6) the effect on the delivery of drug therapies by hospital outpatient departments of changing the average wholesale price as the basis for Medicare pass-through payments to such departments, as included in the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

(c) PAYMENT FOR RELATED PROFESSIONAL SERVICES.—The study shall also include a review of the extent to which other payment methodologies under part B of the medicare program, if any, intended to reimburse physician and other suppliers of drugs and biologicals described in subsection (a) for costs incurred in handling, storing and administering such drugs and biologicals are inadequate to cover such costs and whether an additional payment would be required to cover these costs under the average acquisition cost methodology.

(d) CONSIDERATION OF ISSUES IN IMPLEMENTING AN AVERAGE ACQUISITION COST METHODOLOGY.—The study shall assess possible means by which a payment method based on average acquisition cost could be implemented, including at least the following:

(1) Identification of possible bases for determining the average acquisition cost of drugs, such as surveys of wholesaler catalog prices, and determination of the advantages, disadvantages, and costs (to the government and public) of each possible approach.

(2) The impact on individual providers and practitioners if average or median prices are used as the payment basis.

(3) Methods for updating and keeping current the prices used as the payment basis.

(e) COORDINATION WITH BBRA STUDY.—The Comptroller General shall conduct the study under this section in coordination with the study provided for under section 213(a) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A–350), as enacted into law by section 1000(a)(6) of Public Law 106–113.

(f) REPORT.—Not later than 6 months after the date of the enactment of this Act, the Comptroller General shall submit a report on the study conducted under this section, as well as the study referred to in subsection (e). Such report shall include recommendations regarding such changes in the medicare reimbursement policies described in subsections (a) and (c) as the Comptroller General deems appropriate, as well as the recommendations described in section 213(b) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

I. INTRODUCTION

A. PURPOSE AND SUMMARY

Although Medicare currently offers a wide range of health care benefits, it is significantly different from other Federal health care programs and private health insurance plans because it does not generally offer coverage of outpatient prescription drugs to its enrollees. While a patchwork of different coverage sources has assisted most Medicare beneficiaries, a significant number of beneficiaries are without adequate prescription drug coverage. Additionally, while the nation's healthcare system has become increasingly reliant on prescription drugs as effective treatment regimens, the rate of prescription drug spending has exploded and continually surpassed the rate of inflation. The lack of coverage and increased prescription drug spending has resulted in higher out-of-pocket drug spending for beneficiaries and increased beneficiary financial exposure to extraordinarily high drug costs.

H.R. 4680, the "Medicare Rx 2000 Act," amends Title XVIII of the Social Security Act by establishing a voluntary, universally-offered prescription drug benefit for Medicare beneficiaries under a new Part D program. The bill provides prescription drug coverage through private Prescription Drug plans (PDPs) and Medicare+Choice (M+C) plans and makes provisions for a standard, or qualified alternative, benefit which includes a beneficiary out-of-pocket spending limit. The new Part D program, as well as the Medicare+Choice program (Part C), would be administered by a new agency, the Medicare Benefits Administration (MBA), within the U.S. Department of Health and Human Services.

Additionally, provisions in H.R. 4680 make changes to the way some Medicare benefits are administered, reform the coverage and appeals process for Medicare beneficiaries and the health care providers and suppliers that provide services to them, and strengthen and stabilize the Medicare+Choice program.

The Committee strongly believes that the creation of a new agency, given operational flexibility within the U.S. Department of Health and Human Services, will ensure that market competition and private-sector practices are used in the administration of the Part C and Part D programs, since these practices are vital to the

overall long-term health of Medicare+Choice and the new prescription drug benefit.

H.R. 4680 was written after receiving input from public hearings before the Committee on Ways and Means and its Subcommittee on Health. During these hearings, the Committee and Subcommittee received expert testimony from many witnesses, including Members of Congress, representatives of beneficiary organizations, health care providers, and other experts in Medicare and healthcare policy. Additionally, the bill was crafted in deference to the House budget resolution (H. Con. Res. 290) passed in March, which set aside $40 billion over the next five years for legislation "that reforms the Medicare Program and provides coverage for prescription drugs * * *"

B. Background and Need for Legislation

Eighty percent of senior citizens use a prescription drug everyday. On average, seniors currently spend in excess of $600 annually on pharmaceuticals, with future spending anticipated to rise in the next ten years. In the absence of prescription drug coverage under Medicare, more than two-thirds of Medicare beneficiaries have come to rely on other sources to obtain prescription drug benefits, including employer-sponsored retiree health insurance, Medicaid and other State-sponsored health programs, and managed care plans through the Medicare+Choice program. In recent years, Medicare+Choice plans are requiring more cost-sharing, making drug benefits less generous. Also, as the rate of pharmaceutical costs has risen faster than the inflation rate, there have been growing concerns that current coverage sources are becoming inadequate to protect beneficiaries from ever-rising out-of-pocket cost exposure. Specifically, commentators have targeted increased beneficiary cost-sharing and catastrophic costs as major financial concerns for Medicare beneficiaries.

Since the enactment of the Medicare+Choice program in the Balanced Budget Act of 1997 (Public Law 105–33), there have been concerns about its viability. Most problematic has been the number of plans withdrawing from service areas in the past two years, leaving uncertainty in the way enrolled beneficiaries receive their care. In addition to unfavorable competitive markets, plans have tied their withdrawals to low reimbursement rates and administrative burdens associated with Medicare+Choice. In 1999, the Medicare, Medicaid, S–CHIP Balanced Budget Refinement Act, as incorporated in Public Law 106–113, contained several provisions to strengthen the Medicare+Choice program, including changes in the implementation of the proposed risk adjuster, increases in payments to plans entering an area without a Medicare+Choice plan, and the easing of some administrative burdens.

C. Legislative History

Committee bill

H.R. 4680 was introduced on June 15, 2000 by Representative Bill Thomas (R–CA) and was referred to the Committee on Ways and Means and the Committee on Commerce. On June 21, 2000, the Committee on Ways and Means ordered favorably reported the bill, amended by an amendment in the nature of a substitute by

Representative Thomas, to the House of Representatives by a roll call vote of 23 ayes and 14 nays.

The bill contains three main titles. Title I contains provisions establishing the new Medicare prescription drug benefit. Section 101 establishes the Medicare prescription drug benefit and institutes rules and regulations for beneficiary eligibility and requirements for participation in the program. Section 102 consists of provisions ensuring a prescription drug benefit under the Medicare+Choice program, and Sections 103 and 104 amend the Medicaid program and Medigap regulations, respectively.

Title II contains provisions relating to the modernization of the administration of Medicare through a new agency. Subtitle A establishes the Medicare Benefits Administration to oversee the implementation of the Medicare prescription drug benefit and the Medicare+Choice program. Subtitle B requires the Board of Trustees of the Medicare Trust Funds to report on an additional, more relevant measure of solvency using the total Federal resources required to finance Medicare benefits. Subtitle C reforms the Medicare Part A and Part B coverage and appeals process.

Title III contains provisions relating to the Medicare+Choice program and drugs and biologicals covered under Part B. Subtitle A consists of provisions pertaining to Medicare+Choice payment reform and Subtitle B deals with the preservation of certain drugs and biologicals covered under Part B of the Medicare program.

Legislative hearings

The Committee on Ways and Means and its Subcommittee on Health each have held hearings focusing on the addition and implementation of a prescription drug benefit under the Medicare program. On February 15, 2000, the Subcommittee examined seniors' access to a prescription drug benefit. Among topics discussed at the hearing were the effects of prescription drug proposals on publicly and privately financed health care and their long-term effects on the Medicare program.

On May 11, 2000, the Subcommittee held a hearing on the Clinton Administration's prescription drug proposal. The hearing offered the Subcommittee an opportunity to discuss the President's budgetary proposal for a prescription drug benefit. The Subcommittee also examined the analysis provided by the Congressional Budget Office to determine the long-term effects of the Administration's proposal on the financial stability of Medicare.

On June 13, 2000, the Committee held a hearing to discuss legislative proposals to establish a prescription drug benefit under the Medicare program. The primary proposal examined was a House bipartisan plan advocated by Subcommittee Chairman Bill Thomas. The hearing provided an opportunity to receive informative perspectives on the different legislative proposals from Members of Congress, the Administration, health plans, and experts in the pharmaceutical industry.

II. EXPLANATION OF PROVISIONS

Section 1. Short Title; Table of Contents

The Act may be cited as the "Medicare Rx 2000 Act".

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

Section 101. Establishment of a Medicare Prescription Drug Benefit

Current law

Currently Medicare beneficiaries who are inpatients of hospitals or skilled nursing facilities may receive drugs as part of their treatment. Medicare payments made to the facilities cover these costs. In addition, drugs used incident to certain outpatient procedures, whether performed in hospital outpatient departments or ambulatory surgical centers, may be covered and are paid for through a similar bundled payment. Medicare also makes payments to physicians for drugs or biologicals which cannot be self-administered. In addition, Medicare Part B provides some limited coverage for selected self-administered drugs and immunizations in certain circumstances (e.g., immunosuppressive drugs after an organ transplant, pneumococcal pneumonia vaccine if ordered by a physician).

Beyond these limited benefits, Medicare does not generally cover outpatient prescription drugs.

Explanation of provision

The provision would establish a new, universally accessible, voluntary prescription drug program for all Medicare beneficiaries. This program would be created under a new Medicare Part D, consisting of ten new sections (Sections 1860A–J).

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

Section 1860A establishes the new prescription drug benefit and specifies eligibility requirements, enrollment procedures, and allowable coverage restrictions.

Part D benefits would be administered by the Medicare Benefits Administration (MBA), established under Title II of this Act, and be provided through either Medicare+Choice (M+C) plans or new Prescription Drug plans (PDP). All Medicare beneficiaries who are enrolled in Part B would be eligible to obtain qualified prescription drug coverage through Part D. A special rule is included allowing for a one-time enrollment opportunity at the initiation of the program for those who are currently eligible for Medicare Part A but not now enrolled in Medicare Part B to elect Part D benefits. All beneficiaries electing Part D coverage would be guaranteed a choice of at least two drug plan options, at least one of which is a prescription drug plan.

Beneficiaries who elect to participate in Medicare Part D would select and enroll in a plan available in their area through a process similar to that now provided for Part B enrollment. All eligible beneficiaries would be entitled to enroll in a plan without any late enrollment penalty during a six-month period at the initiation of the new prescription drug program, and could change plans during annual and specified special enrollment periods thereafter. Annual enrollment periods would be conducted in conjunction with Medicare+Choice enrollment. Special enrollment periods could be established by the MBA Administrator and, at minimum, would be provided for those who involuntarily lose alternative prescription

drug coverage, miss an enrollment deadline due to an error in the processing of a request for enrollment, or met exceptional conditions determined by the Administrator. As with Part B, individuals who become eligible for Medicare in the future would have seven months to decide whether or not to participate in Part D. Current beneficiaries who elect Part D benefits upon the program's initiation, and future beneficiaries who join the program in their initial eligibility period, would be guaranteed the protection of community rating and the non-application of pre-existing condition limitations, so long as they maintain continuous coverage while in the program. As in Part B, those electing not to participate in Part D during their initial eligibility period could (unless continuously covered under alternative prescription drug coverage) be assessed late enrollment penalties if they decided to join the program at a later date.

The section specifies what forms of alternative prescription drug coverage qualify for purposes of administering the continuous coverage rules and includes conforming amendments to allow for the administration of such rules. It also specifies when plan elections and terminations would take effect, and provides that the initial period of coverage under the program would begin January 1, 2003.

Sec. 1860B Requirements for qualified prescription drug coverage

Section 1860B establishes the benefit requirements that plans participating in Part D would have to meet. First, a plan would be required to make available to its enrollees the benefit of all price discounts that it negotiates on behalf of its enrollees, even when the plan is under no obligation to pay benefits itself. Second, a plan would be required to provide, at a minimum, coverage for covered outpatient drugs that was either standard coverage (defined in law) or qualified alternative coverage. For plans offering in 2003, standard coverage would be defined as having: (1) A $250 deductible; (2) required cost-sharing of on average 50% on the next $2,100 of incurred costs (above the deductible); and (3) a limitation on overall beneficiary out-of-pocket spending of $6,000. The standard coverage deductible, initial coverage limit and limitation on out-of-pocket spending would be indexed to the average annual increase in per capita aggregate expenditures for covered outpatient drugs for Medicare beneficiaries, and rounded to the nearest appropriate multiple. In any given year, qualified alternative coverage would be defined as coverage that: (1) Is at least actuarially equivalent to the standard coverage required for such year; (2) provides coverage the unsubsidized value of which is at least equal to the unsubsidized value of the standardized coverage; (3) is designed to provide, using an actuarially representative pattern of utilization, for the payment of the initial benefit that is at least equal to the standard benefit; and (4) limits overall out-of-pocket spending that was the same as that required under standard coverage for such year.

Participating plans could offer coverage that is more munificent than standard coverage, if approved by the MBA Administrator. The Administrator would be required to review and approve all plans before they were made available to beneficiaries, and could terminate the contract of any plan sponsor if the sponsor purpose-

fully engaged in any activities intended to result in favorable selection.

Covered outpatient drugs would be defined to include: (1) A drug that may only be dispensed subject to a prescription and which is described in subparagraph (A)(i) or (A)(ii) of Section 1927(k)(2) of the Social Security Act (relating to drugs for which federal matching payments may be made under the Medicaid program); (2) a biological product described in subparagraph (B) of such section; (3) insulin described in subparagraph (C) of such section; and (4) prescription smoking cessation agents otherwise excluded from coverage under Medicaid. The definition includes any use of a covered outpatient drug for a medically accepted indication. Drugs for which benefits could be paid under Part B would not be covered under Part D. If a plan met the associated patient protection requirements included in Section 1860C, it could elect to utilize a formulary to limit benefits for certain covered outpatient drugs.

Sec. 1860C Beneficiary protections for qualified prescription drug coverage

Section 1860C specifies beneficiary protections to protect the interests of beneficiaries who might elect to enroll in Medicare Part D. A participating plan would be required to provide each enrolling beneficiary information about the plan's benefit structure, its affiliated networks of pharmacy providers, any applicable formulary requirements, and their right to file grievances and/or seek benefit appeals. In addition, as is the case in Medicare+Choice, beneficiaries would have a right to obtain more detailed plan information, including comparable quality information, at any time upon request. Plans would be required to have a mechanism for responding to beneficiary inquiries and make available information regarding any changes in the plan's formulary. Plans would be required to furnish enrollees with a detailed explanation of benefits when prescription drug benefits were provided under the program. Plans would also be required to secure agreements with sufficient numbers of pharmacies to make access to covered benefits convenient for enrolled beneficiaries. In addition, plans would be required to guarantee that enrolled beneficiaries were able to continue benefitting from any price discounts the plan negotiates from affiliated pharmacies or manufacturers for covered prescription drugs, even when the plan was under no obligation to pay benefits.

Plans that elect to establish drug formularies would be required to establish a pharmaceutical and therapeutic committee (that includes representatives from both medicine and pharmacy) to develop and maintain the formulary. Plans would be required to cover drugs from each therapeutic class. Beneficiaries could appeal any denial of a request for benefits based on the application of a formulary whenever their attending physician indicates that the use of a drug listed on the formulary is not sufficient to meet the patient's medical needs.

In addition, plans participating in Part D would be required to establish and maintain quality assurance, utilization management, and medication therapy management programs so that the health and safety of program enrollees would be protected. Utilization management programs would be required to include incentives to use generic drugs when appropriate. Medication therapy manage-

ment programs would have to be developed in cooperation with licensed pharmacists and physicians. Such programs would be used to reduce adverse drug interactions and increase beneficiary adherence with prescription medication regimens through refill reminders, special packaging and other appropriate means. Prescription drug plans would also ensure that enrolled beneficiaries were informed, at the time of purchase, of any price differential between their prescribed drug and the lowest cost generic drug therapeutically and pharmaceutically equivalent and bioequivalent.

Finally, all participating plans would be required to maintain meaningful procedures for the hearing and resolving of any enrollee grievances, protect the confidentiality and accuracy of all enrollee records, and provide enrollee access to both expedited coverage determinations and a procedure for the reconsideration of any benefit denials, in the same way as such rights are currently provided to enrollees of Medicare+Choice plans. As is the case in Medicare Part C, the Administrator would be required to contract with an independent review organization to review and resolve in a timely manner any plan reconsiderations that affirm a denial of coverage.

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

Section 1860D specifies organizational requirements for prescription drug plan sponsors who seek to participate in Part D. In general, provisions in this section would require participating plans to be licensed under state law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each state in which the plan operated. Additionally, the provisions would require plans who contract with the Administrator to provide covered drugs to beneficiaries who are entitled to receive benefits under the program to accept full financial risk for the provision of such benefits to each such beneficiary whom they enroll.

The Administrator would be required to enter into contracts binding plan sponsors to fulfill the requirements specified. Such contracts could apply to one or more prescription drug plans. By reference, the section would incorporate and impose on prescription drug plans many of the contract requirements now required of Medicare+Choice plans in Section 1857, including requirements pertaining to allowable audits to guard against fraud and abuse, minimum enrollments, contract periods, intermediate sanctions and contract terminations. A special rule is included allowing for the imposition of limited, pro rata user fees on prescription drug plans. Such fees would be used to help finance related beneficiary educational activities, as is the case with Medicare+Choice.

In order to maximize choice and access, the Administrator would be empowered to waive plan licensure requirements in circumstances similar to those allowable under Part C for provider-sponsored organizations. In such cases, plans would be required to meet financial solvency and capital adequacy standards established by the Administrator. The Administrator would be given the authority to establish by regulation such additional plan and plan sponsor standards as deemed appropriate to implement Part D, and would be required to publish such regulations by October 1, 2001.

As is the case under Part C, the standards that would be established for plans and plan sponsors under Part D would supercede any state law or regulation affecting such entities to the extent that they were inconsistent with such standards. Specifically, state laws relating to benefit requirements, laws relating to the inclusion or treatment of affiliated providers, laws related to coverage determinations, and the establishment and regulation of premiums would be preempted. In addition, States would be prohibited from imposing premium taxes, similar taxes with respect to premiums or other funds paid to PDP sponsors in exchange for the provision of benefits described in Part D.

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

Section 1860E specifies the procedures by which eligible beneficiaries would be able to select a prescription drug or Medicare+Choice plan that provided qualified prescription drug coverage under Part D. The Administrator, acting through the Office of Beneficiary Assistance (established under Title II), would be required to establish and maintain plan election procedures consistent with those now provided for the election of M+C plans under Part C. Such procedures would include the conducting of open annual enrollment periods in which beneficiaries already enrolled in a plan under Part D could elect to change plans, the active dissemination of comparative plan information (including price, quality and comparative benefit information) in a manner consistent with and in coordination with the dissemination of information regarding M+C plans, and the coordination of elections through filing with an M+C organization or a PDP sponsor in a manner consistent with that provided for the election of benefits under Part C.

The Administrator would be instructed to administer the program in a manner such that all eligible individuals would be assured of the availability of at least two qualifying plan options in their area of residence. If necessary to ensure such access, the Administrator is authorized to provide financial incentives, including the partial underwriting of risk, for a PDP sponsor to expand its service area under an existing prescription drug plan to adjoining or additional areas, or to establish such a plan (including offering such a plan on a regional or nationwide basis). Limitations on this authority would be included so as to maximize, to the extent possible, the assumption of financial risk by PDP sponsors and M+C organizations. The Administrator would be required to report to Congress annually on the exercise of this authority.

Sec. 1860F Premiums

New Section 1860F requires each PDP sponsor to submit to the MBA Administrator specified information in the same manner as information is submitted by an M+C organization. The information to be submitted is information on the qualified drug coverage to be provided, the actuarial value of the coverage, and the monthly premium to be charged for the coverage. The PDP sponsor must include an actuarial certification of the actuarial basis for the premium, the portion of the premium attributable to benefits in excess of the standard coverage, and the reduction in the premium result-

ing from reinsurance subsidies. The MBA Administrator would review the submitted information and approve or disapprove the rates, values, and amounts submitted. The Administrator would take into account the adjusted community rate (ACR) for the covered benefits and would have the same authority to negotiate the terms and conditions of the plans as the Director of the Office of Personnel Management has with respect to Federal Employees Health Benefits Program (FEHBP) plans.

The premium for a prescription drug plan could not vary among individuals enrolled in the plan in the same service area, provided the individuals are not subject to late enrollment penalties. The M+C provisions relating to the terms and conditions for imposing premiums would apply to the new Part D.

The PDP sponsor of any prescribed drug plan offered in the area would be required to accept the reference premium as the full premium for qualified prescription drug coverage if there was no standard coverage available in an area. M+C plans would be required to accept the reference premium under the same conditions.

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

New Section 1860G would provide subsidies for low-income individuals. Individuals who met the resource requirements of the Qualified Medicare Beneficiary (QMB) program, and who had incomes under 135% of poverty, would be entitled to a full premium subsidy for the standard plan (or actuarially equivalent alternative) coverage. Such individuals would also be entitled to cost-sharing subsidies, of an amount equal to 95% of the potential cost-sharing obligations a non-subsidized beneficiary would face on spending up to the initial coverage limit if enrolled in a standard plan. Individuals who obtained coverage via these subsidies would still be charged nominal copays for each prescription. Individuals who met the QMB program resource test and had incomes between 135% and 150% of poverty would be entitled to phased-out premium subsidies, ranging from 100% for persons at 135% of poverty to 0% for those at 150% of poverty. State Medicaid plans would determine whether an individual is eligible for a subsidy and the amount of the subsidy. The determination would be made by the MBA Administrator if a state does not operate such a plan (or a state waiver program under Section 1115 of the Social Security Act).

The premium subsidy amount would be defined as the reference premium for the qualified prescription drug coverage that the entitled beneficiary selects, whether it is offered by a prescription drug plan or an M+C plan in the area. The reference premium means the premium imposed (without regard to any subsidies or late enrollment penalties) for enrollment in a plan providing standard coverage (or alternative coverage if the actuarial value is equivalent). If a plan provides alternative coverage with a higher actuarial value than that for standard coverage, the reference premium is the same ratio to the total premium as the actuarial value of standard coverage is to the actuarial value of the alternative coverage.

The MBA Administrator would provide a process whereby the Administrator would notify the PDP sponsor or M+C organization

that an individual is eligible for a subsidy and the amount of the subsidy. The sponsor or organization would reduce the premiums or cost-sharing otherwise imposed by the amount of the subsidy. The Administrator would periodically and on a timely basis reimburse the sponsor or organization for the amount of the reductions.

Part D coverage would be primary to any drug benefits under Medicaid.

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

In order to reduce premiums for all beneficiaries, mitigate adverse selection, and encourage participation, the MBA Administrator would provide for reinsurance payments for qualifying entities. Such payments would be made for specified costs incurred in providing prescription drug coverage for individuals enrolled in a PDP plan under Part D, for individuals enrolled in an M+C plan that provides qualified drug coverage, and for persons enrolled in a qualified retiree drug plan. The section would constitute budget authority in advance of appropriations and represent the obligation of the Administrator to provide payments of the amounts provided under Section 1860H.

Entities qualified to receive subsidies would be a PDP sponsor, an M+C organization offering qualified prescription drug coverage, and the sponsor of a qualified retiree drug plan.

In 2003, the reinsurance payment amount for a qualifying covered individual would be equal to the sum of the following: (a) for the portion of an individual's gross covered drug costs that exceeds $1,250 but does not exceed $1,350, 30% of the allowable costs for such coverage; (b) for the portion of an individual's gross covered drug costs that exceeds $1,350 but does not exceed $1,450, 50% of the allowable costs for such coverage; (c) for the portion of an individual's gross covered drug costs that exceeds $1,450 but does not exceed $1,550, 70% of the allowable costs for such coverage; (d) for the portion of an individual's gross covered drug costs that exceeds $1,550 but does not exceed $2,350, 90% of the allowable costs for such coverage; and (e) for the portion of an individual's gross covered drug costs that exceeds $7,050, 90% of the allowable costs for such coverage. In subsequent years, these dollar amounts are increased by the percentage increase in average per capita aggregate expenditures for covered drugs for beneficiaries for the 12–month period ending the previous July. The amounts so determined would be rounded to the nearest multiple of $5.

Allowable costs would be defined as the portion of gross covered prescription drug costs that are actually paid by the plan, but in no case be more than the part of such costs that would have been paid by the plan if the drug coverage under the plan were standard coverage. Gross covered drug costs would be defined as costs incurred under the plan for covered prescription drugs, including costs related to the deductible, whether paid by the enrollee or the plan, regardless of whether coverage under the plan exceeded standard coverage and regardless of when the payment for drugs is made.

The MBA Administrator would be required to estimate the total reinsurance payments that would be made throughout the program during the year under the reinsurance schedule described above,

and the total benefit payments that would be expected to be made by qualifying entities for standard coverage during the year. The Administrator would proportionately adjust payments such that total reinsurance payments made during the year are equal to 35% of total payments made by qualifying plans for standard coverage during the year. The payment method would be determined by the MBA Administrator, who could use an interim payment system based on estimates. Payments would be made from the Medicare Prescription Drug Account.

A "qualified retiree prescription drug plan" would be defined as employment-based retiree health coverage that met the following requirements: (1) the sponsor of the plan would be required to annually attest to the MBA Administrator (and to provide such assurances as required by the Administrator) that the coverage meets the requirements for qualified coverage; (2) the sponsor and the plan would have to maintain and provide access to records needed to ensure the adequacy of coverage and the accuracy of payments made; (3) payment could not be made for an individual unless the individual is covered under the plan and is entitled to obtain coverage through a PDP or M+C plan but elected not to; and (4) payments could only be made for Medicare primary individuals.

Sec. 1860I Medicare prescription drug account in Federal Supplementary Medical Insurance Trust Fund

New Section 1860I would create a Medicare Prescription Drug Account within the Part B Trust Fund. Funds provided under Part D to the Account would be kept separate from all other funds within Part B. The MBA Administrator would pay from the account, from time to time, low-income subsidies, reinsurance payments, and administrative costs. The Managing Trustee would transfer, from time to time, to the Medicaid account amounts attributable to allowable increases in administrative costs associated with identifying and qualifying beneficiaries eligible for low-income subsidies. Amounts deposited to the Account would include Federal amounts which would otherwise be payable by Medicaid, except for the fact that Medicaid becomes the secondary payer of drug benefits for dual-eligibles.

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

New Section 1860J includes definitions of terms and specifies how cross references to Part C are to be applied. It further provides conforming changes to the Federal Supplementary Medical Insurance Trust Fund. It also requires the Secretary to submit a legislative proposal for technical changes within six months of enactment.

Effective date

Date of enactment of the act.

Reason for change

The Committee recognizes that modern medicine is increasingly reliant upon the use of outpatient prescription drug therapies in the fight against disease. This is particularly true in the Medicare population. It has been estimated recently that the average Medicare beneficiary spends more than $600 a year on prescription

medications. For some indications, drug therapies can cost tens of thousands of dollars a year. However, currently the Medicare program generally excludes coverage for these drugs. While most beneficiaries have obtained alternative forms of insurance to help them finance needed prescription medications, more than 10 million current beneficiaries lack affordable access to such protection. This provision adds a new Medicare prescription drug benefit to the Medicare program in recognition of this need. By including both an initial standard benefit covering costs of up to $2,350 a year in 2003 and an out-of-pocket spending limit of $6,000, the provision would provide all beneficiaries access to coverage for both routine and catastrophic drug expenses. The low-income and reinsurance subsidies ensure that the benefit will be affordable for those in need. In addition, by providing the benefit through a voluntary, competitive, private-sector delivery model, the Committee notes that beneficiaries will be provided the benefits of greater price discounts and the ability to either maintain their current coverage, if they have it, or in the alternative, to choose a plan that best meets their needs.

The Committee recommends that all medication therapy management programs include services routinely provided or coordinated by pharmacists, including services related to case management, disease management, drug therapy management, patient training and education, face-to-face counseling, medication refill reminders, drug therapy problem identification and resolution, the provision of special packaging, or other services that enhance the use of prescription medications.

Section 102. Offering of Qualified Prescription Drug Coverage Under the Medicare+Choice Program

Current law

Under current law Medicare+Choice plans may elect to offer prescription drug coverage under Part C. The extent of these benefits vary and are not subject to any explicit standardization requirements. However, as with all Medicare+Choice benefit specifics, the financing and design of such benefits must meet the approval of the Secretary under the adjusted community rate (ACR) approval process. Generally, plans offering drugs must either finance such benefits from differences between the applicable county payment rate and their costs in providing Medicare's basic benefits, or by assessing beneficiaries who enroll in the plan supplemental premiums.

Explanation of provision

A Medicare+Choice plan could not offer drug coverage (other than that already required under Medicare) unless the coverage was qualified prescription drug coverage. The organization would be required to meet beneficiary protections outlined in the new Section 1860C, including requirements relating to information dissemination and grievance and appeals. The Administrator could waive such requirements to the extent the Administrator determined they were duplicative of requirements otherwise applicable to the plan or organization.

Medicare+Choice organizations would be required to compute and publish: (a) a premium for drug benefits that is separate from other coverage; (b) the ratio of the actuarial value of standard coverage to the actuarial value of prescription drug coverage offered under the plan; and (c) a standard premium. Medicare+Choice organizations would be permitted to reduce the amount of premiums charged for qualified coverage through the application of overages identified through the ACR process provided for in Part C. For purposes of low-income subsidy payments, the organization would be required to accept the reference premium as the full premium if there is no standard or equivalent coverage in the area (as provided under Section 1860F(d)).

Effective date

Changes apply to Medicare+Choice plan coverage that is provided on or after January 1, 2003.

Reason for change

This provision makes the conforming changes needed to integrate the new drug benefit into the Medicare+Choice program. It ensures that Medicare+Choice plans can continue offering enrollees prescription drug benefits; however, it requires that they meet the requisite standards specified in the new Part D if they do. Standardization of the minimum benefit requirements ensures that the new drug program will not be harmed by the potential for adverse selection that could result if Medicare+Choice plans were allowed to offer prescription drug benefits that did not meet the minimum requirements included in Part D. The Committee expects that through these changes, and the additional resources provided under Section 101 and Title III of this Act, the Medicare+Choice program will be greatly strengthened and that Medicare+Choice plans will become instrumental in expanding beneficiary access to multiple prescription drug coverage options.

Section 103. Medicaid Amendments

Current law

State Medicaid programs have the option to include prescription drugs in their Medicaid benefits package. All states and the five territories (American Samoa, Guam, Northern Mariana Islands, Puerto Rico and Virgin Islands) currently do so. In general, a Medicare beneficiary who is fully entitled to Medicaid benefits is eligible to receive prescription drug coverage under his or her state's Medicaid program.

Medicaid also provides a very limited benefit to certain elderly and disabled Medicare beneficiaries. They include "qualified Medicare beneficiaries" (QMBs), "specified low-income Medicare beneficiaries" (SLMBs), and other "qualified individuals." QMBs are aged and disabled persons who are receiving Medicare, whose income is below 100 percent of the Federal poverty level, and whose resources do not exceed twice the allowable amount under SSI. They receive Medicaid coverage for the cost of Medicare Part B premiums (and if applicable, Part A premiums) and Medicare coinsurance and deductible amounts. (Those QMBs who are otherwise eligible for full Medicaid receive QMB benefits in addition to Med-

icaid benefits.) SLMBs are like QMBs except that their income is between 100% and 120% of the Federal poverty level and they receive coverage for only Medicare Part B premiums.

Qualified individuals (QI1s) with income between 120% and 135% of the Federal poverty level and qualified individuals (QI2s) with income between 135% and 175% of the Federal poverty level are unique in that neither group is entitled to their benefit. States are allotted amounts to cover QI1s and QI2s on a first-come, first-serve basis, and states do not contribute to the cost of their benefits. In addition, QI1s and QI2s cannot otherwise be eligible for Medicaid. QI1s are eligible for Medicaid payment of their Medicare Part B premium. QI2s are eligible for Medicaid payment of the small portion of the Medicare Part B premium attributable to the transfer of certain home health visits (estimated to be just over $1 per month in 2000) from Part A. Coverage of these special groups of Medicare beneficiaries is optional in the five territories. Currently, none of these territories have elected such coverage. However, territories may pay Medicare premiums (i.e., buy-in) for some dual-enrolled persons.

All Medicaid costs are financed by the states and federal government through a system of "matching payments." Most of the costs of administering the Medicaid program are shared evenly by the states and the federal government, with each paying 50%. State shares of Medicaid benefits are determined by a formula in Medicaid statute that is based on average per capita income in each state compared to the national average. The federal share (the "federal matching percentage" or FMAP) is equal to 100% minus each calculated state share. States with higher average incomes receive lower federal matching shares. The FMAP for benefits is subject to a floor of 50% and a ceiling of 83%.

In the 50 States and the District of Columbia, Medicaid is an individual entitlement. There are no upper limits on the Federal payments for Medicaid as long as states contribute their share of matching funds. In contrast, Medicaid in the territories is subject to Federal spending caps. Every year, those caps are increased by the percentage change in the medical care component of the Consumer Price Index for all urban consumers (as published by the Bureau of Labor Statistics). The Federal matching rate is statutorily set at 50 percent for the territories.

Explanation of provision

Section 103 adds a new Section 1935 to the Social Security Act entitled "Special Provisions Relating to Medicare Prescription Drug Benefit." The provision requires States, as a condition of receiving Federal assistance, to make eligibility determinations for premium and cost-sharing assistance for Part D, inform the MBA Administrator of cases where eligibility has been established, and otherwise provide information to the MBA Administrator as may be required to carry out Part D.

The provision provides for a phased-in Federal assumption of the costs associated with providing dual-eligible Medicaid beneficiaries qualified drug coverage under Medicare Part D. These costs would be assumed by the Federal government over a period of five years, in increments of 20% each year, and be assumed through appropriate revisions in the Medicaid matching payments for each State.

The provision includes clarification that in the case of individuals dually entitled to prescription drug coverage under Part D and drug coverage under Medicaid, that those individuals' coverage under Medicare would be primary. The provision allows States to require, as a condition for receipt of Medicaid drug benefits, that a dually-entitled individual elect qualified prescription drug coverage under Medicare.

Residents of Territories are not eligible for regular low-income subsidies. However, Territories would be able to get additional Medicaid funds, beginning at $20 million a year and escalating by the annual percentage increase in prescription drug costs for Medicare beneficiaries. In order to obtain these funds, Territories would be required to formulate a plan on how they would dedicate the funds to assist low-income Medicare beneficiaries in obtaining covered outpatient prescription drugs.

Effective date

Date of enactment of the act.

Reason for change

The Medicaid amendments included in Section 103 are necessary to implement and provide for the ongoing administration of the new Medicare drug program specified in Section 101. The administrative payments authorized in this provision are necessary to ensure that low-income beneficiaries who are eligible for the new subsidies provided for in Section 101 are appropriately identified and enrolled in the program. The provisions in subsection (b) provide for a federal assumption of the costs associated with making the new Medicare drug benefit primary for individuals who are dually entitled to Medicare and Medicaid. The Committee notes that the assumption of these costs will reduce projected state Medicaid obligations by billions of dollars over the next several years, freeing up resources that could be used to expand or improve existing state medical assistance or other pharmacy assistance programs.

Section 104. Medigap Transition Provisions

Current law

Under current law private insurance companies may sell one of ten standardized supplemental Medicare insurance (a.k.a "Medigap") products, three of which contain limited coverage for prescription drugs. In addition, insurers can renew policies that provide some coverage for prescription drugs if those policies were initially sold before the Medigap program was standardized.

Explanation of provision

Beneficiaries who have current Medigap prescription drug insurance could maintain such coverage. However, no new (not including renewals of existing policies) Medigap prescription drug policies could be sold to an individual after January 1, 2003. Individuals who currently have a Medigap policy with prescription drug coverage and who elect to terminate such coverage and enroll in Part D would be able to enroll in a Medigap policy without prescription drug coverage without penalty within 63 days of the termination of prior coverage.

Effective date

Date of enactment of the act.

Reason for change

The provisions in Section 104 provide conforming changes necessary to integrate the new prescription drug program with the Medigap insurance market. The provisions ensure that individuals who currently maintain prescription drug coverage through a Medigap policy may continue such coverage; however, they also ensure that the stability of the drug program will not be threatened by the issuance of additional policies which do not meet the minimum benefit requirements specified in Part D. After consultation with the Congressional Budget Office and independent actuaries, the Committee concluded that these provisions were necessary to protect against undue adverse selection in the new Medicare drug program.

Section 105. Demonstration Project for Disease Management for Severely Chronically Ill Medicare Beneficiaries

Current law

Medicare does not currently provide direct reimbursement for disease management services under the fee-for service program. The Secretary does have standing authority to initiate demonstration projects. However, currently there is no operative disease management program of that kind in place.

Explanation of provision

The MBA Administrator would conduct a three-year demonstration project applying disease management to Medicare beneficiaries diagnosed with advanced-stage congestive heart failure, diabetes, or coronary disease. A beneficiary would be eligible for the demonstration project if: (1) the beneficiary met the appropriate diagnosis; (2) the beneficiary's physician approved of the participation; and (3) the beneficiary was not a Medicare+Choice enrollee. Enrolled beneficiaries would be eligible for disease management services, as well as decreased premiums, deductible, cost-sharing, and out-of-pocket costs if they were also enrolled in a prescription drug plan, or payment for all costs of prescription drugs if they were not enrolled in a prescription drug plan.

The MBA Administrator would contract with up to 3 disease management organizations to conduct the demonstration, and provide the disease management services and prescription drug benefits. The organizations would be paid in a manner so that there would be a net reduction in expenditures under the Medicare program as a result of the demonstration project.

The MBA Administrator would be required to submit an interim report not later than 2 years after the demonstration project was first implemented and a final report not later than 6 months after the project's completion. The reports would focus on the costs, health outcomes, and recommendations associated to the project and its possible extension or expansion.

Effective date

Date of enactment.

Reason for change

The provision is included to examine whether active use of disease management services may improve the overall health of Medicare beneficiaries with advanced illnesses, while effectively reducing overall program costs.

The Committee recommends that all disease management demonstration projects include pharmacist participation in case management, drug therapy management, patient training and education, drug therapy problem identification and resolution, the provision of special packaging, or other services that enhance the use of prescription medications.

TITLE II—MODERNIZATION OF ADMINISTRATION OF MEDICARE

SUBTITLE A—MEDICARE BENEFITS ADMINISTRATION

Section 201(a). Establishment of Administration

Current law

At present, the Health Care Financing Administration (HCFA) located within the Department of Health and Human Services (DHHS) administers the Medicare program along with several other programs.

Explanation of provision

The provision would establish a new agency, the Medicare Benefits Administration (MBA), within the Department of Health and Human Services.

Effective date

Date of enactment of the act.

Reason for change

This provision creates a new agency, the Medicare Benefits Administration (MBA), to strengthen and modernize the Medicare program. The Committee notes that the range and complexity of activities involved in managing Medicare are considerable and continue to grow. The Health Care Financing Administration (HCFA), which currently administers Medicare, also oversees more than 50 Medicaid programs, the State Children's Health Insurance Programs and has many other duties.

Historically, adding a new mission to a government agency, such as the Medicare+Choice program in 1997 and now the new prescription drug benefit provided in this bill, may mean that the new functions do not get the management attention they deserve and need in order to flourish. The Committee believes these two aspects of the Medicare program are sufficiently different from operating the fee-for-service portion of Medicare to warrant the creation of a new agency to manage them, particularly in light of the movement toward negotiated pricing. The Committee believes that a new agency will enable these two programs to develop and mature to their maximum potential, and provide an opportunity to create a culture attuned to fostering innovation, flexibility, and competitive pricing in health care delivery. A new agency will relieve some of the considerable pressures on HCFA and enable it to focus on the

increasingly complex tasks associated with administering the fee-for-service portion of the Medicare program.

The MBA provides an appropriate structure for administering portions of the Medicare program, including a new prescription drug benefit, through a partnership with the private sector, and ensuring health plan choices for beneficiaries in the Medicare+Choice. Additionally, the new agency, through its Office of Beneficiary Assistance, will streamline and simplify beneficiaries' access to consumer information about their benefits, rights, and health care plan options and, through the Ombudsman program, will provide assistance to seniors in resolving problems with Medicare. The Committee notes that as the Medicare program has become increasingly complex, it is critical to provide seamless, easy access to information about the program provided in a consumer-oriented manner that reflects the best communication practices of the private sector. The Committee intends that the MBA organize and manage the Office of Beneficiary Assistance and the Ombudsman program with these goals in mind.

This provision calls for a structure that is flexible, yet accountable to the President and Congress, but to some degree, is independent of Executive Branch involvement in carrying out the duties of the MBA. For example, the new Medicare Policy Advisory Board, a separate entity created to advise the MBA on policy, will include both Presidential and Congressional appointees, and will make recommendations directly to the Congress without review or comment by any Federal office or official. The Committee will look to the Board to provide objective assessments of the administration of the MBA, the operation of the new Medicare programs as well as the functioning of Medicare as a whole.

The fixed five-year terms of the Administrator and Deputy Administrator provide some necessary stability to the management of this agency as well as a measure of independence from the President. Flexibility with respect to hiring and compensation, within limits, is provided to attract personnel who will bring private sector, best business practices experience to the new agency. However, for example, the Committee expects that the MBA Administrator would hire personnel at reasonable compensation levels, even though he/she has considerable freedom to set salary structure. The Committee notes that the President can remove the MBA Administrator at any time if the individual's behavior is egregious in any respect. The Committee hopes that in allowing the MBA Administrator this flexibility in terms of staffing, the organizational culture will be oriented toward the identification, expeditious hiring and retention of highly qualified personnel to enable the quality management and operation of a competition-based program.

The new agency is established within the Department of Health and Human Services to provide accountability to the executive and legislative branches and to the public. The Secretary is directed to ensure appropriate coordination between the two agencies, the MBA and the HCFA, in carrying out the Medicare program, including the transfer and/or sharing of data and information. The Committee anticipates that coordinated, focused management activities will be necessary to ensure that effective administration of Medicare as a whole. With that need in mind, we encourage the Secretary to develop the necessary mechanisms to foster interagency

cooperation not only at the MBA's inception but also on an ongoing basis. However, the Committee is concerned about the duplication of functions and increases in overall personnel in creating a second government agency to administer Medicare. With respect to this concern, the provision limits staffing in the MBA, only for those functions being transferred to it from HCFA, to the number of full-time equivalent HCFA employees currently performing those duties.

The Committee does not wish to minimize the number of tasks involved in establishing a new agency. It is expected that the Secretary would begin to craft an implementation plan upon enactment, including the oversight of transition tasks, consideration of potential candidates for the Administrator and Deputy Administrator positions, and the development of interagency memoranda of understanding. The Committee encourages the Secretary to share the implementation plan with the Committee as soon as feasible so that appropriate oversight can be exercised.

Section 201(b). Administrator and Deputy Administrator

Current law

Currently, HCFA is headed by an Administrator, appointed by the President with the advice and consent of the Senate. The Administrator is at Executive Level IV and is appointed to an indefinite term of office. At present, HCFA has a Deputy Administrator who is in the Senior Executive Service and is appointed by the Secretary of Health and Human Services.

The heads of departments and agencies generally have authority over the various programs carried out by various units under them, and are responsible for the appropriate coordination of those programs.

Explanation of provision

The Medicare Benefits Administration (MBA) would be headed by an Administrator who would report directly to the Secretary. The Administrator would be appointed by the President to a fixed five-year term of office, subject to the advice and consent of the Senate, at Executive Level III. When the term expires, the Administrator could continue in office until a successor was appointed. Anyone appointed to complete an unexpired term could be appointed only for the remainder of the term.

The Administrator would be responsible for the exercise of all powers and the discharge of all duties of the MBA, could establish and reorganize units with the administration, could prescribe rules and regulations under the Administrative Procedures Act, and could delegate authority to his or her subordinates.

There would be a Deputy Administrator appointed by the President at Executive Level IV to a fixed five-year term of office, subject to the advice and consent of the Senate. When the term expires, the Deputy Administrator could continue in office until a successor was appointed. Anyone appointed to complete an unexpired term could be appointed only for the remainder of the term. The Deputy Administrator is to perform the duties and exercise the powers delegated to him or her by the Administrator.

The Secretary of HHS would ensure appropriate coordination between the Administrator of the MBA and the Administrator of HCFA in carrying out the Medicare program.

Effective date

Date of enactment of the act, except that the Administrator and the Deputy Administrator cannot be appointed before March 1, 2001.

Reason for change

See Section 201(a).

Section 201(c). Duties; Administrative Provisions

Current law

Currently, the HCFA Administrator is responsible for the effective administration and oversight of the Medicare program (both Parts A and B or traditional fee-for-service, as well as Part C or the Medicare managed care), the Federal portion of the Medicaid program, the Children's Health Insurance Program, and related quality assurance programs including oversight of clinical laboratories, oversight of Medicare supplemental insurance, certification and survey activities for nursing homes, and oversight of certain aspects of private health insurance markets.

Many units within executive departments are required to submit annual reports regarding their activities to Congress and the President.

At present, HCFA staff, with the approval of the Secretary, is appointed and paid in accordance with Title V Civil Service provisions.

When a new entity is established, information and data that is needed by the new entity, but that is in the possession of an existing entity, normally is transferred to the new entity.

Explanation of provision

The Administrator would carry out Parts C and D of Title XVIII of the Social Security Act (hereby referred to as "Title XVIII"), including negotiating, entering into, and enforcing contracts with plans under Medicare+Choice and contracts with PDP sponsors offering prescription drug plans under Part D. The Administrator also would carry out other duties under Parts C and D, including demonstration projects and the Programs of All-Inclusive Care for the Elderly (PACE), Social Health Maintenance Organizations (SHMOs), and EverCare. Additionally, in administering the prescription drug benefit, the Administrator would not: (1) Require a particular formulary or price structure for drug reimbursement; (2) interfere with negotiations between Medicare+Choice plans and PDP sponsors and drug manufacturers, wholesalers, or other suppliers; or (3) interfere with the competitive nature of providing drug coverage through PDP sponsors and Medicare+Choice plans.

The MBA Administrator would be required, not later than March 31 of each year, to submit a report covering the administration of Parts C and D during the previous fiscal year to Congress and the President.

The MBA Administrator, with the approval of the Secretary, would be authorized to employ staff in a flexible manner without regard to the Title V Civil Service provisions governing appointment (5 U.S.C. 31) and pay (5 U.S.C. 51 and 53), except that the rate of compensation may not exceed the rate of basic pay for Executive Level IV ($122,400).

The Secretary is to establish an appropriate transition of responsibility to redelegate the administration of Part C from the HCFA Administrator to the Administrator of the MBA. The Secretary also would ensure that information and data in the possession of the HCFA Administrator that is needed by the MBA Administrator to carry out his or her duties will be transferred to the latter.

Effective date

Date of enactment of the act. However, the Administrator cannot be appointed until March 1, 2001. The MBA Administrator's duties in carrying out Parts C and D would begin in 2003.

Reason for change

See Section 201(a).

Section 201(d). Office of Beneficiary Assistance

Current law

At present, the Center for Beneficiary Services in HCFA serves as the central location for interactions with beneficiaries, including beneficiary-centered information, education and service initiatives.

Explanation of provision

The Secretary of HHS would establish the Office of Beneficiary Assistance (OBA) within the MBA to carry out functions relating to beneficiaries' access to the entire Medicare program. Some of these functions would include responsibility for eligibility and enrollment, and for dissemination of information on benefits and appeals rights for Medicare Parts A, B ,C, and D. In addition, the OBA would disseminate information on benefits and limitations on payment, including cost-sharing, stop-loss and formulary restrictions under Parts C and D. The OBA would make available other information so that beneficiaries could compare benefits throughout the entire program, including comparisons of M+C benefits under Part C with Medicare supplemental policies. The OBA also would disseminate information on beneficiaries' grievance and appeals procedural rights for the entire Medicare program. Dissemination of benefits information would occur through the mail, Internet, and toll-free telephone number.

Effective date

Date of enactment. The Administrator of the MBA would carry out enrollment and make eligibility determinations beginning on or after January 1, 2003.

Reason for change

See Section 201(a).

Section 201(d)(3). Medicare Ombudsman

Current law

At present, there is a National Ombudsman in the Elder Rights Protection Office in the Administration on Aging in the Department of Health and Human Services. (The office, originally named Office of Long-Term Care Ombudsman Programs, was established under 42 U.S.C. 3011(d)). The Director of the office is appointed by the Assistant Secretary of the Administration on Aging from among individuals who have expertise and background in the fields of long-term care advocacy and management. The National Ombudsman and the Director serve as advocates on behalf of older individuals who reside in long-term care facilities regarding all Federal policies affecting such individuals. Among other activities, they advocate, monitor, and coordinate Federal and State activities of Long-term Care Ombudsmen. The Director makes recommendations to the Secretary and Assistant Secretary regarding long-term care programs, and submits to the Speaker of the House of Representatives and President pro tempore of the Senate an annual report on the effectiveness of services provided under the State Long-Term Care Ombudsman programs.

Explanation of provision

A Medicare Ombudsman (MO) would be established within the Office of Beneficiary Assistance (OBA). The MO would be appointed by the Secretary from among individuals with expertise and experience in the fields of health care and advocacy, to assist Medicare beneficiaries regarding their complaints, grievances, and requests for information with respect to any aspect of the Medicare program.

The duties of the MO would include assisting Medicare beneficiaries: (1) In collecting relevant information to seek an appeal of a decision or determination made by a Fiscal Intermediary, Medicare Carrier, Medicare+Choice organization, a PDP sponsor under Part D, or the Secretary; and (2) with any problems arising from disenrollment from an M+C plan under Part C of Title XVIII or a prescription drug plan under Part D of Title XVIII. The MO would also be required to submit annual reports to Congress, the Secretary, and the Medicare Policy Advisory Board describing the activities of the Office, including recommendations for improvement in the administration of this title.

The MO also would help guide and coordinate the efforts of State medical ombudsman programs and State-based and community-based consumer organizations to provide information about the Medicare program and educate Medicare beneficiaries regarding how problems under the Medicare program may be resolved or avoided.

Effective date

Date of enactment of the act.

Reason for change

See Section 201(a).

Section 201(e). Medicare Policy Advisory Board

Current law

Established in statute, the Social Security Advisory Board advises the Commissioner of Social Security on numerous Social Security issues, including policies related to old-age, survivors, and disability insurance. The Board submits reports to Congress and the President regarding the various issues affecting Social Security. While there are numerous advisory boards operating throughout the Federal government, the Social Security Advisory Board closely approximates the structure and function of the proposed Medicare Policy Advisory Board.

Explanation of provision

The Medicare Policy Advisory Board (MPAB) would be established within the Medicare Benefits Administration (MBA). The Board would advise, consult with, and make recommendations to the Administrator of the MBA regarding the administration of Parts C and D of Title XVIII, including the review of payment policies.

The Board is to submit to Congress and the MBA Administrator, and publish in the Federal Register, such reports as it determines appropriate, including legislative or administrative recommendations to improve Parts C and D. The reports may include recommendations on such topics as fostering competition under Parts C and D, improving education and enrollment processes for Medicare beneficiaries, implementation of risk-adjustment methodology under Medicare+Choice, the inclusion of disease management programs, and improving competition and access to Part C and Part D plans in rural areas. The reports would be submitted directly to Congress, and no officer or agency of the United States may require that they be submitted to any officer or agency for approval, comments, or review, before being submitted to Congress.

The MBA Administrator, within 90 days after a report by MPAB is submitted, is to submit to Congress and the President an analysis of any recommendations in the report, and is to publish the analysis in the Federal Register.

Effective date

Date of enactment of the act.

Reason for change

See Section 201(a).

Section 201(e). (4) Membership, (5) Compensation, (6) Terms of Office, (7) Chair, (8) Meetings, (9) Director and Staff

Current law

The Social Security Advisory Board consists of seven members, no more than four of whom may be from the same political party. Three members are appointed by the President, with the advice and consent of the Senate; two by the President pro tempore of the Senate, with the advice of the chair and ranking minority member of the Committee on Finance; and two by the Speaker of the House,

with the advice of the chair and ranking minority member of the Committee on Ways and Means.

Members are entitled to travel and per diem expenses while serving on Board business. Members serve six-year staggered terms; they must leave office when their terms expire. A member appointed to an unexpired term serves only for the remainder of the term. The Chair is designated by the President for a four-year term; the Board meets at the call of the Chair, but not less than four times a year.

The Board appoints a staff director without regard to Civil Service provisions, who is paid at a rate equivalent to the rate for the Senior Executive Service ($106,200 to $122,400). The Board also appoints additional personnel and may compensate such personnel without regard to Title V regarding the competitive service.

Explanation of provisions

The Medicare Policy Advisory Board is to consist of seven members, of which three are to be appointed by the President; two by the Speaker of the House, with the advice of the chairmen and ranking minority members of the Committee on Ways and Means and the Committee on Commerce; and two by the President pro tempore of the Senate, with the advice of the chairman and ranking minority member of the Committee on Finance. The members are to be chosen based on their integrity, impartiality, and good judgment, and are to be exceptionally qualified by reason of their education and experience in health care benefits management.

While engaged on Board business, members are to be compensated at rates not to exceed the daily equivalent to the annual rate in effect for Executive Level IV.

Terms of office are to be for three years, and, as designated by the President at the time of appointment, one is to be appointed for one year; three for two years, and three for three years. No member may serve for more than eight years. A member appointed to fill an unexpired term may be appointed only to complete the term. A member whose term expires may continue to serve until a successor is appointed.

The Chair of the Board would be elected by the members to a three-year term. The Board is to meet at the call of the Chair, but not less than three times during the fiscal year.

The Board would have a director who would be appointed by the Chair. With the Board's approval, the director appoints and fixes the pay of the staff. Both the director and staff are to be appointed and paid without regard to Civil Service provisions governing appointment (5 U.S.C. 31) and pay (5 U.S.C. 51 and 53), except that the rate of pay may not exceed the rate of basic pay for Executive Level IV ($122,400).

The MBA Administrator is to make available to the Board such information and other assistance as it may require to carry out its functions. The MPAB may contract with and compensate government and private agencies to carry out its duties.

Effective date

Date of enactment of the act.

Reason for change

See Section 201(a).

Section 201(f). Funding

Current law

HCFA currently is authorized to be appropriated in part from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund such sums as are necessary to carry out its Medicare programs. Funds are appropriated under the normal appropriations process.

Explanation of provision

The provision would authorize funds for the MBA and the MPAB, like HCFA, to be appropriated in part from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund in such sums as are necessary to carry out this section of the act. The funds would be appropriated under the normal appropriations process.

Effective date

Date of enactment of the act.

Reason for change

See Section 201(a).

Section 202. Miscellaneous Administrative Provisions

Current law

At present, the HCFA Administrator is the Secretary of the Board of Trustees of the Medicare Trust Funds, while the Secretary of the Treasury is the managing trustee and an ex officio member. Other ex officio members of the Board include the Commissioner of Social Security, the Secretary of Labor, and the Secretary of Health and Human Services.

The Administrator of HCFA is at Executive Level IV position.

Explanation of provision

The provision would make the MBA Administrator an ex officio member of the Board. The provision also would raise the HCFA Administrator to Executive Level III.

Effective date

The provision would become effective on March 1, 2001.

Reason for change

This provision recognizes that the Administrator of the Health Care Financing Administration and the Administrator of the new Medicare Benefits Administration should have equal professional status in the Department of Health and Human Services. A review of the other Cabinet level departments' executive structures demonstrates that the Administrators of large, complex governmental programs, such as Medicare, warrant recognition commensurate with their management responsibilities.

SUBTITLE B—OVERSIGHT OF FINANCIAL SUSTAINABILITY OF THE MEDICARE PROGRAM

Section 211. Additional Requirements for Annual Financial Report and Oversight on Medicare Program

Current law

The Board of Trustees of the Medicare Trust Funds are required to submit reports to Congress concerning the operation and status of each Trust Fund during the preceding fiscal year and the next two fiscal years no later than the first day of April of each year. The reports also include an actuarial opinion by the Chief Actuarial Officer of the Health Care Financing Administration certifying that the techniques and methods are generally accepted and reasonable.

Explanation of provision

The Board of Trustees would be required to submit an additional report to Congress on the operation and status of the Hospital Insurance (Part A) Trust Fund and Federal Supplemental Medical Insurance (Part B) Trust Fund that would include information on the obligations from the general revenues of the Treasury for Medicare benefits (in total, in relation to all other general revenue amounts, and as a percent of gross domestic product); a historical overview of that spending; and 10-year and 50-year projections. The report would be published by the Committee on Ways and Means and published on the Internet.

Effective date

This provision would be effective the fiscal years following the date of enactment.

Reason for change

This provision requires the Medicare Board of Trustees to adopt a test of financial solvency for the Medicare program in addition to the tests that currently exists. The Committee believes that this test, which measures overall spending from the general revenues of the Treasury for Medicare benefits, provides a more relevant and realistic picture of the financial viability of the Medicare program. The current concept of Medicare's solvency is based on the fiscal outlook for the Federal Hospital Insurance (HI) Trust Fund (Part A), which is funded by a payroll tax paid by employers and employees, and the Federal Supplementary Medical Insurance Trust Fund (Part B), which is funded by premiums paid by beneficiaries and general revenue. The Committee notes that the current measurement of solvency is open to manipulation by moving funds between the two accounts, as was done in 1997 when spending for home health services was transferred gradually from the HI Trust Fund to Part B, thus artificially improving the financial outlook of the HI Trust Fund. The Committee notes that rosy projections of HI Trust Fund spending belie the true state of Medicare's solvency, encouraging the delay of important reform and financing decisions for years and making them dramatic and painful when they must be implemented. The Committee believes that the critical question for Medicare's financial health is not how much revenue from payroll taxes is needed to fund a portion of Medicare, but rather how

much total tax revenue is needed to fund the entire program. The Committee includes this provision to focus the public debate about Medicare's financial viability in a more realistic and meaningful way.

SUBTITLE C—CHANGES IN MEDICARE COVERAGE AND APPEALS PROCESS

Section 221. Revisions to Medicare Appeals Process

Current law

Medicare beneficiaries and, in certain circumstances, providers and suppliers of health care services may appeal adverse determinations regarding claims for benefits under Part A and Part B. Section 1869 of the Social Security Act allows these parties who have been denied coverage of an item or service the right to appeal that decision through a series of administrative appeals and then into federal district court if the amounts of disputed claims in question meet certain thresholds at each step of the appeals process.

The procedures differ for Medicare Part A and Medicare Part B services. Generally, each part has its own initial appeals process which the beneficiary must exhaust before moving on to a hearing before an administrative law judge (ALJ), then to review by the Health and Human Services Department Appeals Board (DAB) and then possibly to federal court. Under Part A, an ALJ hearing is available for disputed amounts greater than $100 and judicial review is available for disputed amounts greater than $1,000. Under Part B, an ALJ hearing is available for disputed amounts greater than $500 and judicial review is available for amounts greater than $1,000. Generally, claims involving the delivery of similar or related services to the same individual or involving common issues of law and fact arising from services furnished to two or more individuals can be aggregated to reach the jurisdictional amount.

Generally, current law provides that a beneficiary may be represented in an appeal by a person who supplied the service or item. However, the supplier or provider must first waive their rights to payment from the beneficiary for the services or items that are being appealed. The person may not impose any financial liability on the beneficiary in connection with such representation.

Current law includes provisions for an expedited appeal process where a party may request court review in place of an ALJ hearing or DAB review when all parties to the reconsidered decision (including the Secretary) concur that the only issue precluding a favorable determination is a statutory provision which the individual requesting review alleges to be unconstitutional or a regulation, national coverage decision under Section 1862(a)(1) of the Social Security Act, or a HCFA ruling is alleged to be invalid. HCFA policy currently provides that an expedited review would not apply to a challenge to a manual instruction, local medical policy, or a policy statement; only agency determinations, such as regulations, HCFA rulings, and national coverage determinations, that are binding on the ALJ can be appealed in such a fashion.

Significant statutory limitations have been imposed on the review of national coverage determinations (called national coverage decisions by HCFA). Specifically, an ALJ may not review a national coverage determination, except to decide whether the determina-

tion has been applied correctly to the claim at issue. A court would not set aside or invalidate a national coverage determination because public rulemaking provisions contained in the Administrative Procedure Act (5 U.S.C. 553) or Section 1871(b) of the Social Security Act have not been followed. Further, any case in which a court determines that the record is incomplete or otherwise lacks adequate information to support the validity of a national coverage determination is remanded back to the Secretary for additional proceedings to supplement the record. The court may not determine that an item or service is covered in the particular case except upon review of the supplemented record. Finally, the statute limits judiciary review of certain Part B payment methodologies.

Explanation of provision

These provisions would revise Section 1869, change certain statutory requirements and codify, clarify and, in some instances, redefine certain actions currently established through regulation. In general, the provisions would combine the Part A and Part B beneficiary appeal processes; would permit providers and suppliers adversely affected by claims processing and coverage decisions to appeal; would give qualified independent review contractors the responsibility for reconsiderations of initial determinations; would provide for expedited reconsideration of certain initial determinations that could cause the termination of ongoing care; would establish a review process, including judicial review, for both national and local coverage determinations; would extend the limitations on liability provided to qualified independent contractors to Medicare +Choice independent appeals contractors; and would make all decisions made by the Provider Reimbursement Review Board subject to appeal under 1869.

Initial determinations would be defined to include determinations regarding: (1) whether a beneficiary is entitled to Medicare benefits; (2) the amount of Medicare benefits available to a beneficiary; (3) a claim for benefits under Parts A or B, including an initial determination by the Secretary that payment may not be made, or may no longer be made, for an item or service under such Parts; (4) the appropriateness of a discharge of a beneficiary from a provider, made by a utilization and quality control peer review organization; and (5) other initial determinations with respect to benefits made by contractors administering Medicare or Title XI (peer review).

At the request of an affected beneficiary, the Secretary would be required to provide for a reconsideration of initial determinations, including a hearing thereon. The Secretary would enter into contracts with qualified independent contractors to conduct reconsiderations of initial determinations. Under this subsection, the Secretary would enter into contracts with not fewer than 12 qualified independent contractors. The qualified independent contractor would be an entity that is independent of any organization under contract with the Secretary that makes initial determinations and that meets requirements established by the Secretary. Contracts would be for an initial term of three years and renewable every three years thereafter. The Secretary would provide specific criteria and guidance, including all applicable national and local coverage policies necessary to assist the contractors to make informed deci-

sions. These policies would be published on the Internet. Contractors would only be bound by local or national coverage policies that were published on the Internet. Contractors would not be bound by any other policies (not local or national coverage policies) if not provided in a published format.

The qualified independent contractor would determine whether payment would be made for items or services under Part A or Part B and the amount of such payment. The qualified independent contractor would conduct and conclude a determination or reconsideration and then would mail the notice of the decision by not later than the end of the 45-day period from the date that a reconsideration request had been filed. If the deadline for mailing the decision is missed, the appealing party would be able to request an ALJ hearing. The Secretary would be able to reopen or revise any initial or reconsidered determination under guidelines that would be established in regulation.

Beneficiaries would be able to request, in writing or orally, an expedited determination or expedited reconsideration of an initial determination. The qualified independent contractor would provide notice (by telephone and in writing) of the reconsideration results to the Medicare beneficiary, provider of services, and attending physician no later than 1 day after the medical or other records needed for reconsideration are received. The contractor would solicit the views of the individual involved and conduct the reconsideration regardless of whether the beneficiary would be charged for continuing services or be liable for payment.

Each qualified independent contractor would monitor its own determinations to ensure consistency by collecting and maintaining an electronic database that identifies: (1) specific claims that give rise to appeals; (2) situations where further provider education may be necessary; and (3) situations where changes in national coverage, local coverage or local medical review policies may be necessary. The database would be used for the contractors own purposes. Additionally, the contractor would submit its database annually to the Secretary for the Secretary's own purposes.

After a determination has been made, contractors would promptly notify the individual and the Medicare claims payer. Contractor determinations would be in writing and include a detailed explanation of the determination. The Secretary would establish a methodology under which qualified independent contractors would make available all determinations to fiscal intermediaries, carriers, peer review organizations, Medicare+Choice organizations and other entities under contract to make initial determinations under Medicare or peer review statutes. Qualified independent contractors and their employees would not be held liable under any federal or state criminal or civil law if due care was exercised in the performance of its duties, functions or activities.

The Secretary would also establish in regulation the time limits for requesting a hearing. Hearings would be available for disputed amounts greater than $100. Judicial review would be available for disputed amounts greater than $1,000. Aggregation of claims to meet these thresholds, with certain restrictions, would be permitted. An ALJ would conduct a hearing on a contractor's determination and issue a decision no later than 90 days after the hearing request date. However, the party requesting the hearing can re-

quest the 90 day period be waived. The DAB would conduct a review on an ALJ's decision and issue a decision or remand no later than 90 days after the review request date. In the event that an ALJ does not issue a hearing decision by the appropriate time period, the party requesting the hearing would be able to request the DAB to review the case de novo. All hearing decisions would be made public and published on the website of Health and Human Services absent information that would identify the beneficiary, provider or supplier.

National coverage determinations would be determinations by the Secretary regarding whether a particular item or service is covered under this title. Like current law, national coverage determinations would not be reviewed by an ALJ and would not be held to be unlawful because of rulemaking violations. These determinations would be reviewed by the Department Appeals Board (DAB) of the Department of Health and Human Services, who would be able to review the record, as well as permit discovery and the taking of evidence. The DAB would defer only to reasonable findings of fact, interpretations of law and reasonable applications of fact to law by the Secretary. A decision by the DAB would constitute a final agency action and would be subject to judicial review. Local coverage determinations would be determinations made by a fiscal intermediary or a carrier under Part A or Part B regarding whether a particular type or class of items or services is covered under such Parts. Local coverage determinations made by Medicare claims processing contractors would be subject to review by an ALJ of the Social Security Administration, who would be able to review the record, as well as permit discovery and the taking of evidence to evaluate the reasonableness of the determination. The ALJ would defer only to reasonable findings of fact, interpretations of law, and reasonable applications of fact to law by the Secretary. An ALJ decision would constitute a final agency action and would be subject to review by the DAB, constituting a final agency action which is subject to judicial review. When there are no material issues of facts in dispute and the issues concern either the constitutionality of the provision or the validity of a regulation, ruling or determination, the aggrieved party would be able to seek review in a court of competent jurisdiction.

When the Secretary has not issued a national coverage or noncoverage determination, with respect to a particular type or class of item or service, an affected party would be able to submit a request to make such a determination. The Secretary would have 90 days to either: (1) issue a national coverage determination, with or without limitations; (2) issue a national noncoverage determination; (3) issue a determination that no determination is appropriate; or (4) issue a notice that the Secretary has not completed a review of the national coverage determination and identify the remaining steps in the Secretary's review process and a deadline by which the Secretary would complete the review. All of these actions would be accompanied by an explanation of the basis for the determination. Failure to complete a review pursuant to the above (4) would be deemed to be an action under (3). Any action under (1), (2) or (3) is deemed to be national coverage determinations and subject to review. Also, all decisions of hearings by the Secretary would be made public and published on the Internet.

The Secretary would submit a report to Congress annually, and subsequently publish the report on the Internet, on the actual time periods necessary to fully implement national coverage determinations made in the previous fiscal year.

Aggrieved persons with standing to initiate action under this section would include: (1) individuals entitled to Part A or enrolled in Part B or both who are in need of the items or services involved in the coverage determination and (2) persons or classes of persons who make, manufacture, offer, supply, make available, or provide such items and services. Included are many of the existing provisions and protections with respect to people providing items and services representing beneficiaries.

The Secretary would perform outreach activities to inform beneficiaries, providers, and suppliers of their appeal rights and procedures, including the use of the toll-free telephone number to respond to inquiries about the status of appeals. No later than one year after enactment of these provisions, the Secretary would promulgate regulations governing reconsideration and hearing procedures which would include such specific criteria and guidance to ensure adequately functional and consistent reconsiderations and hearings. The Secretary would provide each qualified independent contractor and ALJ (in consultation with the Social Security Administration) continuing education regarding Medicare or PRO policies so that informed appeal decisions would be made.

The Secretary would monitor determinations made by all qualified independent contractors and ALJs to ensure consistency of their determinations by providing for the continuing education, administration and oversight of qualified independent contractors and ALJs through a central office in HHS.

The Secretary would submit a report to Congress not less frequently than every five years on beneficiary, provider, and supplier satisfaction with the appeals process of determinations, as well as the respective education and training involved in the process. The report would include any legislative and administrative recommendations the Secretary determines appropriate.

In addition, the Secretary would submit an annual report to Congress on the number of appeals for the previous year, identifying issues that require administrative or legislative action, and any recommendations of the Secretary on these actions. The report would also include an analysis and causes of inconsistent decisions of determinations by qualified independent contractors.

Effective date

The Secretary would promulgate regulations governing reconsideration and hearing procedures no later than one year after enactment of these provisions.

Reason for change

The Committee held several hearings in the last two years dealing with both private-sector patient protections and the Medicare coverage and appeals procedures. These hearings revealed that when compared to enrollees in private sector health plans, Medicare beneficiaries have far fewer legal protections when denied coverage for a requested benefit. Not only do Medicare beneficiaries have to wait much longer periods of time to have claims disputes

resolved (e.g. Part B claims take on average over 400 days to resolve), often times they lack detailed information about Medicare's coverage policies, and due to administrative delay and obfuscation, can be effectively precluded from challenging disputed policies in court.

The provisions in this section are intended to correct these deficiencies, and ensure that all beneficiaries maintain a legitimate right to challenge in a timely manner, before an independent decisionmaker, any adverse coverage or claims decisions that may impact their ability to obtain quality health care. In addition, by combining the Part A and Part B appeals processes, the Committee intends, along with the changes in subtitle A, to streamline and improve the administration of Medicare appeals.

Section 222. Provisions with Respect to Limitations of the Liability of Beneficiaries

Current law

Under certain circumstances, Medicare will pay for services that are not normally covered. In general, Medicare will pay for these services if neither the beneficiary, nor the provider, practitioner, or supplier knew, or could have reasonably been expected to know, that the services were excluded from coverage. A beneficiary will be liable if given advance notice, in writing, the service may not be covered. The written notice, called a notice of noncoverage for Part A services and an advance beneficiary notice (ABN) for Part B services, must have been given to the beneficiary (or someone acting on the beneficiary's behalf) by a provider, practitioner, or supplier furnishing the service and then signed by the beneficiary or by the beneficiary's representative.

Explanation of provision

These provisions would amend Section 1879 of the Social Security Act to clarify situations and establish procedures where beneficiaries who are furnished items or services that are subsequently found not to be covered under Medicare will and will not be liable for repayment.

Specifically, a Medicare beneficiary furnished a service or item would not be liable for repayment if a claim for an item or service is incorrectly paid by the Secretary except when Medicare payments are made to the beneficiary and then only up to the amount of the payment.

A Medicare beneficiary furnished a service or item would not be liable for payment if: (1) the initial determination on payment of a benefit had not been made by the Secretary to establish whether Medicare payment can be made; or (2) the claim for an item or service is improperly submitted by a provider or supplier or is rejected by an entity under contract to review or pay Medicare claims or by an M+C organization. These limitations of beneficiary liability would not apply if the beneficiary signs a waiver form, developed by the Secretary, that clearly informs beneficiaries of their limitations on liability, their rights to obtain an initial determination of Medicare payment of the benefit, and their rights to appeals The waiver form would also include the toll-free number maintained by the Secretary to obtain any further information

These waiver forms are the only manner in which beneficiaries may waive their liability. This waiver is not applicable in cases where a claim is denied for noncompliance with Medicare or peer review regulations.

A Medicare beneficiary who is furnished services by a provider would not be liable for payment prior to noon of the first working day after the date the beneficiary receives notice of determination of discharge and a notice of appeal rights unless: (1) the provider furnishes the notice of discharge and appeal rights to each Medicare beneficiary served upon admission and furnishes a notice of the beneficiary's limitation of liability and appeal rights upon notice of determination of discharge; and (2) the beneficiary, prior to discharge, appeals the determination to discharge no later than noon of the first working day and the provider by close of that business day provides the records necessary to review the determination.

A Medicare beneficiary would not be liable for payment of cost-sharing amounts of more than $50 for a furnished item or service unless the beneficiary has been informed in advance of the estimated cost-sharing amount of the item or service using a standard form established by the Secretary.

Information regarding the beneficiary's payment liability for furnished benefits and the toll-free number to access information on beneficiary liability and appeal rights would be required to be included on the explanation of Medicare benefits.

Effective date

Date of enactment of the act.

Reason for change

This provision clarifies the circumstances in which Medicare beneficiaries may and may not be held liable for the costs of care not reimbursable under the Medicare program. The use of a standardized waiver form is intended to better protect the interests of Medicare beneficiaries, and help educate them about their rights under the improved appeals process.

Section 223. Waivers of Liability for Cost Sharing Amounts

Current law

Providers, suppliers and practitioners who routinely waive beneficiary coinsurance and deductible amounts may be held liable under the Medicare and Medicaid anti-kickback statute. A routine waiver of beneficiary cost-sharing amounts may result in false claims as well as excessive utilization of items and services paid for by Medicare. Providers, suppliers and practitioners may forgive the copayment in consideration of a particular patient's financial hardship; this exception is not to be used routinely, but should be used occasionally to address the financial needs of a given patient.

Explanation of provision

This provision would revise the circumstances in which the beneficiary's cost-sharing amounts can be waived if: (1) the waiver is offered as part of a supplemental insurance policy or retiree health plan; (2) the waiver is not part of any advertisement or solicitation;

(3) the person waives the coinsurance and deductible after the beneficiary informs the person that payment would pose a financial hardship; (4) the person determines that the coinsurance and deductible would not justify the costs of collection.

Effective date

Date of enactment of the act.

Reason for change

This provision clarifies and rationalizes the circumstances in which providers of health services may lawfully elect to forgo the collection or imposition of Medicare's scheduled cost-sharing requirements. The changes included in this provision will ensure that providers have greater discretion to waive cost-sharing requirements if they would pose a financial hardship to patients, and allow for the more efficient operation of provider collection practices.

Section 224. Elimination of Motions by the Secretary on Decisions of the Provider Reimbursement Review Board

Current law

Providers who submit required cost reports and are dissatisfied with the resolution of issues that affect their Medicare reimbursement may apply for hearing in front of the Provider Reimbursement Review Board (PRRB). The amount in controversy must be at least $10,000. At the hearing, providers have the right to be represented by counsel, introduce evidence, and examine witnesses. The PRRB has the power to affirm, modify or reverse a final determination of a fiscal intermediary with respect to a cost report. A PRRB decision would be final unless the Secretary, within 60 days after the date the provider is informed of this decision, acts to reverse, affirm, or modify the decision.

Explanation of provision

The provision would eliminate the Secretary's authority to reverse, affirm or modify PRRB decisions within 60 days after the provider is notified of the decision.

Effective date

Date of enactment of the act.

Reason for change

This provision streamlines the appeals process for providers seeking reimbursement under Part A of the Medicare program. The change is consistent with the concepts of binding external review and specified timeframes for appeals that are also incorporated in the beneficiary appeals provisions in Section 221 and comparable requirement imposed on private sector health plans by other law.

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

SUBTITLE A—MEDICARE+CHOICE REFORMS

Section 301. Increase in National Per Capita Medicare+Choice Growth Percentage in 2001 and 2002

Current law

For each beneficiary enrolled, the Medicare+Choice (M+C) plan receives the M+C payment rate applicable to the payment area (typically a county) in which the enrollee resides, adjusted for risk. This rate is based on a formula which gives the county the highest of three different rates: (1) a floor, or minimum payment rate; (2) a minimum update rate; and (3) a blended rate. After each county's payment rate is determined, the total projected spending for Medicare+Choice is compared to a budget-neutral amount. If the projected spending is greater than the budget-neutral amount, payment rates are reduced until budget neutrality is met. This is accomplished by lowering payments in counties with blended rates. However, no county will receive less than the floor rate or the minimum update rate, whichever is larger.

The floor payment rate was set at $401.61 per month for aged beneficiaries in 2000. Each year the floor is increased by an annual update factor, equal to adjusted growth in Medicare fee-for-service expenditures per capita, minus 0.5 percentage points in 2000 and 2001, and minus 0.3 percentage points in 2002.

The minimum update rate was set at the county rate in 1997, increased by 2%. This rate increases 2% each year.

The blended rate represents an average of local and national rates. The local rate is an area-specific capitation rate, which is adjusted to remove the share of payments that represent payments for graduate medical education (GME), with a phase-out over 5 years. Beginning in 1998, local rates for blending purposes had 20% of GME spending removed. The reduction in GME payments is increased by 20% annually, until all GME funds are removed from 2002 forward. The local rate is the 1997 county rate, updated annually by the national per capita M+C growth percentage. The national rate is the average of local area-specific payment rates, weighted by the number of Medicare beneficiaries in each county. For blending purposes, the national rate is input-price adjusted to reflect differences in the costs of providing medical care across counties. The blended rate is computed as follows: 90% local/10% national in 1998; 82% local/18% national in 1999; 74% local/26% national in 2000; 66% local/34% national in 2001; 58% local/42% national in 2002; 50% local/50% national from 2003 onward.

Explanation of provision

The provision would remove the decrease in the annual update factor, equal to adjusted growth in Medicare fee-for-service expenditures per capita. The decrease would be changed from minus 0.5 percentage points to minus 0.0 percentage points in 2001, and from minus 0.3 percentage points to minus 0.0 percentage point in 2002.

Effective date

The provision would be effective beginning in January 2001.

Reason for change

This provision will remove the reductions from the national per capita growth rate in 2001 and 2002, which are scheduled to be minus 0.5 percentage point and 0.3 percentage point respectively. The Committee notes that the reductions are inappropriate at this time, given the current state of the Medicare+Choice program.

Section 302. Permanently Removing Application of Budget Neutrality Beginning in 2002

Current law

After each county's payment rate is determined under the formula, the total projected spending for Medicare+Choice is compared to a budget-neutral amount. If the projected spending is greater than the budget-neutral amount, payment rates are reduced until budget neutrality is met. This is accomplished by lowering payments in counties with blended rates. However, no county receives less than the floor rate or the minimum update rate, whichever is larger.

Explanation of provision

The provision would remove budget neutrality beginning in 2002.

Effective date

The provision would become effective beginning with payment rates for 2002.

Reason for change

This provision permanently removes the application of budget neutrality in the calculation of the Medicare+Choice starting in 2002. The Committee agrees that "funding the blended rates" will increase the rates for many payment areas.

Section 303. Increasing Minimum Payment Amount

Current law

For each beneficiary enrolled, the M+C plan receives the M+C payment rate applicable to the payment area (typically a county) in which the enrollee resides, adjusted for risk. This rate is based on a formula which gives the county the highest of three different rates: (1) a floor, or minimum payment rate; (2) a minimum update rate; and (3) a blended rate.

Explanation of provision

The floor, or minimum payment rate, would be raised in 2002 to $450 for aged beneficiaries, with proportional increases for disabled beneficiaries and those with end-stage renal disease. After 2002, the minimum payment rate would be allowed to increase at the rate of Medicare fee-for-service per capita growth.

Effective date

The provision would be effective in 2002.

Reason for change

This provision increases the minimum payment amount to $450 in 2002, and provides for an update at the rate of fee-for-service per capita growth thereafter. The Committee recognizes that changes in payment policy need to occur to attract Medicare+Choice plans to rural areas. Raising the minimum payment amount is one change that can accomplish this objective.

Section 304. Allowing Movement to 50:50 Percent Blend in 2002

Current law

The blended rate represents an average of local and national rates. The local rate is an area-specific capitation rate, which is adjusted to remove the share of payments that represent payments for graduate medical education (GME), with a phase-out over 5 years, ending in 2002. The national rate is the average of local area-specific payment rates, weighted by the number of Medicare beneficiaries in each county. For blending purposes, the national rate is input-price adjusted to reflect differences in the costs of providing medical care across counties. The blended rate is computed as follows: 90% local/10% national in 1998; 82% local/18% national in 1999; 74% local/26% national in 2000; 66% local/34% national in 2001; 58% local/42% national in 2002; and 50% local/50% national from 2003 onward.

Explanation of provision

The provision would allow plans to choose to be paid a blend of 50 percent local costs and 50 percent national costs in 2002 instead of the 58 percent local/42 percent national blend scheduled to be in effect in that year. For 2003, the blend would be 50 percent local/50 percent national.

Effective date

The provision would be effective in 2002.

Reason for change

This provision would allow health plans to move more quickly to a blended rate of 50 percent local area costs and 50 percent national costs in 2002, instead of in 2003 as currently scheduled. Current law provides for a blend of 58 percent local costs and 42 percent national costs in 2002. The Committee believes that health plans, particularly those serving local areas with relatively low costs, should have the opportunity to benefit one year sooner from a rate based on a higher percentage of national costs.

Section 305. Increased Update for Payment Areas with Only One or No Medicare+Choice Contracts

Current law

For each beneficiary enrolled, the M+C plan receives the M+C payment rate applicable to the payment area (typically a county) in which the enrollee resides, adjusted for risk. This rate is based on a formula which gives the county the highest of three different rates: (1) a floor, or minimum payment rate; (2) a minimum update rate; and (3) a blended rate. The minimum update rate was set at

the county rate in 1997 increased by 2%. This rate increases 2% each year.

The Balanced Budget Refinement Act of 1999 (BBRA) encouraged new M+C plans to enter counties that would otherwise not have a private plan participating. The first plan to enter a previously unserved county receives a 5% added payment during its first year and a 3% added payment during its second year, applied during the 2-year period beginning January 1, 2000.

Explanation of provision

The provision would allow plans to apply for a higher update to their rates if there are one or no contracts in the county. Instead of the 2% minimum update, plans would receive a 2.5% update in 2002 through 2005.

Effective date

This provision would become effective beginning in 2002.

Reason for change

This provision allows Medicare+Choice plans to receive a 2.5 percent update in payment areas where there is only one or no contract, compared to the 2 percent minimum update they normally would receive. The Committee believes strongly in offering many choices to seniors and views this change as one way to encourage health plans to participate in the program.

Section 306. Permitting Higher Negotiated Rates in Certain Payment Areas Below National Average

Current law

Plans are paid an administered monthly price, called the Medicare+Choice payment rate, for each enrollee. It is calculated according to a formula established in statute and updated by law.

Explanation of provision

The provision would introduce an element of negotiated pricing into the rates paid to plans by allowing them to negotiate their annual update with the Medicare Benefits Administration (MBA), the new agency that administers the M+C program. Only those plans with rates below the national average, the USPCC (United States Per Capita Cost), would be allowed to negotiate their updates.

Plans would negotiate with the MBA by presenting data on costs, benefits and utilization to the agency. A plan would be required to submit its current audited adjusted community rates (ACRs) to the new agency. Starting in 2004, plans could negotiate updates up to a ceiling of the growth rate of the private insurance market, net of the increases in prescription drug costs and adjusted for the characteristics of the Medicare population, as calculated by the Medicare Benefits Administration. However, no plan would be permitted to negotiate a rate that exceeds the USPCC.

Effective date

The provision would become effective in 2004.

Reason for change

This provision permits health plans to negotiate inflation updates to their rates with the Medicare Benefits Administration beginning in 2004. Health plans will present current, audited data to the Administrator to prove that their costs warrant an increase higher than the mandated update. The Committee believes that this is a first step toward introducing negotiated pricing and increasing competition in the Medicare program.

Section 307. Ten-Year Phase-In of Risk Adjustment Based on Data from All Settings

Current law

M+C payments to plans are currently adjusted using a blend of demographically-based and health status-based adjusters. Prior to 2000, payments were adjusted solely based on demographic characteristics of plan enrollees. These demographic factors included age, gender, coverage by Medicaid, institutionalized status, and working status.

As required under the Balanced Budget Act of 1997, the Secretary began using a health status-based risk adjustment system in 2000. The Secretary chose the principal inpatient diagnostic cost groups (PIP–DCG) method, which supplements demographic factors with health status factors. This prospective model uses diagnoses in a base year to adjust payment for a future payment year. Payment is determined by each Medicare+Choice enrollee's risk factor, which is based on inpatient data using the PIP–DCG adjusters. These adjusters predict incremental costs, above the average for the demographic group, which are expected to be incurred in the year after hospitalization.

The BBRA required a phase-in of the new risk adjustment methodology such that M+C payments would reflect a blend of payments under the older demographic adjustment procedure and the new PIP–DCG procedure. The BBRA held the risk adjuster at 90% demographic/10% PIP–DCG blend for 2000 and 2001. In 2002, not more than 20% of the risk adjuster may be based on the health status method.

The BBRA requires the Medicare Payment Advisory Commission (MedPAC) to conduct a study that evaluates the risk adjustment method and report findings by December 2000. The Secretary is required to study and report on how to reduce the costs and burdens of M+C plans' reporting of encounter data, due January 1, 2001. The Secretary has proposed moving to comprehensive risk adjustment, which would take into account a wider range of measures for health status, not just hospitalization, by 2004.

Explanation of provision

The provision would phase in a new risk adjustment method based on data from all settings gradually over ten years, in one-tenth increments, starting in 2004.

Effective date

The transition would begin in 2004.

Reason for change

This provision provides for a gradual phase-in of risk adjustment over a ten-year period, once the methodology is based on data from all settings. The Committee recognizes that risk-adjusted payments will likely have dramatic effects on some health plans, and notes that sweeping payment policy changes in the Medicare program, such as the hospital inpatient prospective payment system for capital-related costs, have been implemented with very long transition periods so that entities can adjust gradually.

SUBTITLE B—PRESERVATION OF MEDICARE COVERAGE OF DRUGS AND BIOLOGICALS

Section 311. Preservation of Coverage of Drugs and Biologicals Under Part B of the Medicare Program

Current law

Section 1862(s) of the Social Security Act defines covered "medical and other health services" for purposes of coverage under Medicare Part B. The definition includes:

> (2)(A) services and supplies (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) furnished as incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills * * *

The phrase "cannot be self-administered" is defined in the Medicare Carrier's Manual as follows:

> Whether a drug or biological is of a type which cannot be self-administered is based on the usual method of administration of the form of that drug or biological as furnished by the physician. Thus, where a physician gives a patient pills or other oral medication, these are excluded from coverage since the form of the drug given to the patient is usually self-administered. Similarly, if a physician gives a patient an injection which is usually self-injected (e.g., insulin or calcitonin), this drug is excluded from coverage, unless administered to the patient in an emergency situation (e.g., diabetic coma). Where, however, a physician injects a drug which is not usually self-injected, this drug is not subject to the self-administrable drug exclusion (regardless of whether the drug may also be available in oral form) since it is not self-administrable in the form in which it was furnished to the patient.

Individual Medicare carriers have reportedly applied different policies when considering whether a drug or biological can or cannot be self-administered. Some carriers have based the determination on the typical means of administration while others have assessed the individual patient's ability to administer the drug.

On August 13, 1997, HCFA issued a memorandum to Medicare carriers which was intended to clarify program policy. The memorandum stated that the inability to self-administer is to be based on the typical means of administration of the drug, not on the indi-

vidual patient's ability to administer the drug. The memorandum stated that: "The individual patient's mental or physical ability to administer any drug is not a consideration for this purpose." The memorandum went on to note that certain drugs that are generally self-administered may not be self-administered under certain limited circumstances such as when the patient first learns how to administer the drug. Coverage in these limited situations is at the discretion of the Medicare carrier; i.e. the carrier determines in these instances whether it is medically necessary for the physician or staff to administer the drug. The carrier could not consider the patient's condition such as a mental or physical disability.

As a result of this memorandum, certain patients (for example, patients with multiple sclerosis) no longer had Medicare coverage for certain drugs. However, implementation of this policy directive was halted for FY2000 by a provision in the Consolidated Appropriations Act. The provision prohibits the use of any funds to carry out the August 13, 1997 transmittal or to promulgate any regulation or other transmittal or policy directive that has the effect of imposing (or clarifying the imposition of) a restriction on the coverage of injectable drugs beyond those applied on the day before issuance of the transmittal. HCFA issued a Program Memorandum in April 2000 which suspended application of the August 13, 1997 memorandum. It noted that each carrier or intermediary must establish its own policies individually and could not establish model policies as a group.

Explanation of provision

Section 311 would replace the current phrase in Section 1862(a)(2) relating to self-administered drugs and biologicals. The new language would permit coverage of "injectable and infusable drugs and biologicals which are not usually administered by the patient."

Effective date

This provision applies to drugs and biologicals administered on or after October 1, 2000.

Reason for change

This provision ensures that Medicare beneficiaries will continue to be able to obtain the full range of medications covered by Part B prior to HCFA's issuance of its revised carrier memorandum of August 17, 1998.

Section 312. GAO Report on Part B Payment for Drugs and Biologicals and Related Services

Current law

Under current law, Medicare Part B pays for some medications in certain circumstances. Currently, those who supply these drugs are reimbursed the average wholesale price of the drug minus 5%, as specified under Section 1842(o).

Explanation of provision

The provision would require the General Accounting Office to conduct a study on the extent to which Medicare payment method-

ology overpays for the cost of drugs and biologicals currently covered under Medicare Part B compared to the average acquisition cost paid by other suppliers. The study would also address: (1) the consequences of changing current methodology to one based on average acquisition of costs on the delivery of oncology, chemotherapy, dialysis, and vaccine services, on the administration of drugs in physician offices, and on the effect of drug therapy delivery in the hospital outpatient setting; (2) other Part B payment methodologies intended to reimburse physician and supplier costs in handling, storing, and administering these drugs and biologicals; and (3) issues on the implementation of an average acquisition cost methodology.

Effective date

The report would be submitted 6 months after the date of enactment.

Reason for change

In the past, the General Accounting Office (GAO) and the Office of Inspector General in the Department of Health and Human Services have criticized the current methodology for the Part B drug and biological reimbursement and reported that Medicare has overpaid for drugs and biologicals covered under Part B. The Committee finds these reports troubling and is intent on devising improvements in this area so as to prevent the overpayment of covered drugs and biologicals in the future. The intent of this section is to gather more information on the average actual acquisition costs incurred by those who routinely supply covered drugs and biologicals to Medicare beneficiaries, and to examine the related quality and access to care issues that may arise, especially with respect to oncology care, if the current payment methodology for Part B drugs and biologicals were changed. The report would be done along with a pending GAO report, authorized under Public Law 106–113, to study the adequacy of practice expense payments for providers of drug and biological services.

III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statements are made concerning the votes of the Committee on Ways and Means in its consideration of the bill, H.R. 4680.

MOTION TO REPORT THE BILL

The bill, H.R. 4680, as amended, was ordered favorably reported by a rollcall vote of 23 yeas to 14 nays (with a quorum being present). The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer	X			Mr. Rangel			
Mr. Crane	X			Mr. Stark		X	
Mr. Thomas	X			Mr. Matsui		X	
Mr. Shaw	X			Mr. Coyne		X	
Mrs. Johnson	X			Mr. Levin		X	
Mr. Houghton	X			Mr. Cardin		X	
Mr. Herger	X			Mr. McDermott		X	
Mr. McCrery	X			Mr. Kleczka		X	

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Camp	X			Mr. Lewis (GA)		X	
Mr. Ramstad	X			Mr. Neal			
Mr. Nussle	X			Mr. McNulty		X	
Mr. Johnson	X			Mr. Jefferson		X	
Ms. Dunn	X			Mr. Tanner		X	
Mr. Collins	X			Mr. Becerra		X	
Mr. Portman	X			Mrs. Thurman		X	
Mr. English	X			Mr. Doggett		X	
Mr. Watkins	X						
Mr. Hayworth	X						
Mr. Weller	X						
Mr. Hulshof	X						
Mr. McInnis	X						
Mr. Lewis (KY)	X						
Mr. Foley	X						

VOTES ON AMENDMENTS

Rollcall votes were conducted on the following amendments to the Thomas amendment in the nature of a substitute.

An amendment by Mr. Cardin, to allow the Health Care Financing Administration to be a Prescription Drug plan (PDP) sponsor for a nationwide prescription drug plan, was defeated by a rollcall vote of 12 yeas to 22 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Rangel			
Mr. Crane		X		Mr. Stark	X		
Mr. Thomas		X		Mr. Matsui	X		
Mr. Shaw		X		Mr. Coyne	X		
Mrs. Johnson		X		Mr. Levin	X		
Mr. Houghton		X		Mr. Cardin	X		
Mr. Herger		X		Mr. McDermott	X		
Mr. McCrery		X		Mr. Kleczka	X		
Mr. Camp		X		Mr. Lewis (GA)			
Mr. Ramstad		X		Mr. Neal	X		
Mr. Nussle		X		Mr. McNulty	X		
Mr. Johnson		X		Mr. Jefferson			
Ms. Dunn		X		Mr. Tanner	X		
Mr. Collins		X		Mr. Becerra	X		
Mr. Portman		X		Mrs. Thurman	X		
Mr. English		X		Mr. Doggett	X		
Mr. Watkins		X					
Mr. Hayworth		X					
Mr. Weller		X					
Mr. Hulshof		X					
Mr. McInnis		X					
Mr. Lewis (KY)		X					
Mr. Foley		X					

An amendment by Mrs. Thurman and Mr. Doggett, to give legal authority and require Medicare prescription drug plans to obtain prescription drugs for their enrollees and make them available at the lower of two federally-negotiated prices, was defeated by a rollcall vote of 13 yeas to 21 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Rangel			
Mr. Crane		X		Mr. Stark	X		
Mr. Thomas		X		Mr. Matsui			
Mr. Shaw		X		Mr. Coyne			
Mrs. Johnson		X		Mr. Levin	X		
Mr. Houghton		X		Mr. Cardin	X		

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Herger		X		Mr. McDermott	X		
Mr. McCrery		X		Mr. Kleczka	X		
Mr. Camp		X		Mr. Lewis (GA)	X		
Mr. Ramstad		X		Mr. Neal	X		
Mr. Nussle		X		Mr. McNulty	X		
Mr. Johnson				Mr. Jefferson	X		
Ms. Dunn		X		Mr. Tanner	X		
Mr. Collins		X		Mr. Becerra	X		
Mr. Portman		X		Mrs. Thurman	X		
Mr. English		X		Mr. Doggett	X		
Mr. Watkins		X					
Mr. Hayworth		X					
Mr. Weller		X					
Mr. Hulshof		X					
Mr. McInnis		X					
Mr. Lewis (KY)		X					
Mr. Foley		X					

An amendment by Mr. McDermott and Mr. Lewis of Georgia, to require the Administrator of the Medicare Benefits Administration to determine whether an individual is eligible for the low-income subsidy, was defeated by a rollcall vote of 14 yeas to 23 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Rangel			
Mr. Crane		X		Mr. Stark	X		
Mr. Thomas		X		Mr. Matsui	X		
Mr. Shaw		X		Mr. Coyne	X		
Mrs. Johnson		X		Mr. Levin	X		
Mr. Houghton		X		Mr. Cardin	X		
Mr. Herger		X		Mr. McDermott	X		
Mr. McCrery		X		Mr. Kleczka	X		
Mr. Camp		X		Mr. Lewis (GA)	X		
Mr. Ramstad		X		Mr. Neal			
Mr. Nussle		X		Mr. McNulty	X		
Mr. Johnson		X		Mr. Jefferson	X		
Ms. Dunn		X		Mr. Tanner	X		
Mr. Collins		X		Mr. Becerra	X		
Mr. Portman		X		Mrs. Thurman	X		
Mr. English		X		Mr. Doggett	X		
Mr. Watkins		X					
Mr. Hayworth		X					
Mr. Weller		X					
Mr. Hulshof		X					
Mr. McInnis		X					
Mr. Lewis (KY)		X					
Mr. Foley		X					

An amendment by Mr. Tanner, to modify how PDP sponsors permit pharmacy participation in their plan, was defeated by a rollcall vote of 15 yeas to 22 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Rangel			
Mr. Crane		X		Mr. Stark	X		
Mr. Thomas		X		Mr. Matsui	X		
Mr. Shaw		X		Mr. Coyne	X		
Mrs. Johnson		X		Mr. Levin	X		
Mr. Houghton		X		Mr. Cardin	X		
Mr. Herger		X		Mr. McDermott	X		
Mr. McCrery		X		Mr. Kleczka	X		
Mr. Camp		X		Mr. Lewis (GA)	X		
Mr. Ramstad		X		Mr. Neal			

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Nussle		X		Mr. McNulty	X		
Mr. Johnson		X		Mr. Jefferson	X		
Ms. Dunn		X		Mr. Tanner	X		
Mr. Collins	X			Mr. Becerra	X		
Mr. Portman		X		Mrs. Thurman	X		
Mr. English		X		Mr. Doggett	X		
Mr. Watkins		X					
Mr. Hayworth		X					
Mr. Weller		X					
Mr. Hulshof		X					
Mr. McInnis		X					
Mr. Lewis (KY)		X					
Mr. Foley		X					

A substitute amendment by Mr. Stark was defeated by a rollcall vote of 14 yeas to 23 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Rangel			
Mr. Crane		X		Mr. Stark	X		
Mr. Thomas		X		Mr. Matsui	X		
Mr. Shaw		X		Mr. Coyne	X		
Mrs. Johnson		X		Mr. Levin	X		
Mr. Houghton		X		Mr. Cardin	X		
Mr. Herger		X		Mr. McDermott	X		
Mr. McCrery		X		Mr. Kleczka	X		
Mr. Camp		X		Mr. Lewis (GA)	X		
Mr. Ramstad		X		Mr. Neal			
Mr. Nussle		X		Mr. McNulty	X		
Mr. Johnson		X		Mr. Jefferson	X		
Ms. Dunn		X		Mr. Tanner	X		
Mr. Collins		X		Mr. Becerra	X		
Mr. Portman		X		Mrs. Thurman	X		
Mr. English		X		Mr. Doggett	X		
Mr. Watkins		X					
Mr. Hayworth		X					
Mr. Weller		X					
Mr. Hulshof		X					
Mr. McInnis		X					
Mr. Lewis (KY)		X					
Mr. Foley		X					

IV. BUDGET EFFECTS OF THE BILL

A. Committee Estimate of Budgetary Effects

In compliance with clause 3(d)(2) of rule XIII of the Rules of the House of Representatives, the following statement is made:

The Committee agrees with the estimate prepared by the Congressional Budget Office (CBO) which is included below. The Committee notes that the CBO has provided a revised estimate which takes into account modifications that will be made to the bill by an en bloc amendment to be offered by the Chairman of the Committee to be incorporated upon adoption of the rule providing for floor consideration. The Committee notes that a technical change to the disease management demonstration project contained in Section 105 was made to limit the cost of the provision and keep the bill within the amount provided for in the budget resolution.

B. Statement Regarding New Budget Authority and Tax Expenditures

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee states that the Committee bill would result in increased federal direct spending over the five-year period and a negligible indirect effect on revenues over the five-year period.

C. Cost Estimate Prepared by the Congressional Budget Office

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives requiring a cost estimate prepared by the Congressional Budget Office (CBO), the following report prepared by CBO is provided.

U.S. Congress,
Congressional Budget Office,
Washington, DC, June 27, 2000.

Hon. Bill Archer,
Chairman, Committee on Ways and Means,
House of Representatives, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the attached table of the estimated effects on spending and revenues of H.R. 4680, the Medicare Rx 2000 Act, as ordered reported by the committee on Ways and Means on June 21, 2000.

CBO estimates H.R. 4680, as ordered reported, would increase direct spending by $0.4 billion in 2001, by $40.7 billion over the 2001–2005 period, and by $159.9 billion over the 2001–2010 period. The increase in budget authority for direct spending would be equal to the increase in outlays.

We also estimate that the bill would reduce revenues from income and payroll taxes by $0.2 billion during the 2001–2010 period. Social Security payroll taxes, which are off-budget, account for $0.1 billion of that amount. Subject to Appropriation of the necessary amounts, CBO estimates the bill would increase discretionary spending by $0.2 billion in 2001 and by $6.6 billion over the 2001–2010 period.

The bill contains a number of preemptions of state law that would be intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMBRA). CBO cannot estimate the costs of a preemption of state taxing authority because of uncertainties about market changes. The other preemptions in the bill would impose no costs on state, local, or tribal governments.

The bill contains a private-sector mandate on medigap insurers that would bar them from providing coverage of prescription drug expenses for certain individuals, but CBO estimates that its cost would not exceed the threshold specified in UMRA ($109 million in 2000, adjusted annually for inflation).

I hope this information is helpful to you. The CBO staff contact is Tom Bradley.

Sincerely,

Barry B. Anderson,
(For Dan L. Crippen, Director).

Attachments.

ESTIMATED BUDGETARY EFFECT OF THE MEDICARE Rx 2000 ACT—AS ORDERED REPORTED ON JUNE 21, 2000

	By fiscal year, in billions of dollars—									
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
CHANGES IN DIRECT SPENDING										
Medicare outlays:										
Payments to qualifying drug plans	0	0	6.2	7.7	8.6	9.5	10.5	11.5	12.7	14.1
Disease management project	0	0	0.1	0.3	0.6	0.1	−0.1	0	0	0
Coverage and appeals	0.1	0.1	0.1	0.2	0.2	0.3	0.4	0.5	0.6	0.7
Medicare+Choice payments	0.2	1.2	0.2	0.9	1.1	1.1	1.5	1.8	2.2	2.6
SMI coverage of drugs and biologicals	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2
Low-income subsidy for premium and cost-sharing assistance	0	0	5.0	7.9	9.6	10.9	12.1	13.4	14.9	16.5
SMI transfer to Medicaid for subsidy administration	0	0	[1]	0.1	0.1	0.2	0.2	0.3	0.3	0.3
Subtotal	0.4	1.5	11.9	17.1	20.3	22.2	24.7	27.6	30.8	34.3
Medicaid outlays:										
Change to current-law drug spending	0	0	−2.6	−3.7	−4.1	−4.6	−5.1	−5.7	−6.3	−7.0
Part A/B benefits and other Medicaid costs	0	0	0.3	0.7	1.2	1.4	1.5	1.6	1.7	1.9
Reductions in payments to states	0	0	−0.6	−1.3	−1.2	−0.8	−0.3	0	0	0
Administration (net of SMI transfer)	0	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Subtotal	0	0.1	−2.7	−4.1	−3.9	−3.8	−3.7	−3.9	−4.4	−4.9
Effect of higher drug prices on outlays by federal programs:										
Medicaid	0	0	[1]	[1]	[1]	[1]	[1]	[1]	0.1	0.1
FEHB (for annuitants, on-budget)	0	0	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]
Subtotal, on-budget	0	0	[1]	[1]	[1]	[1]	[1]	0.1	0.1	0.1
Total, on-budget outlays	0.4	1.7	9.2	13.0	16.4	18.5	21.0	23.8	26.4	29.4
Off-budget outlays (FEHB for postal workers and annuitants)	0	0	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]
CHANGES IN REVENUES										
Income and Medicare payroll taxes (on-budget)	0	0	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]
Social Security payroll taxes (off-budget)	0	0	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]
Total	0	0	[1]	[1]	[1]	[1]	[1]	[1]	[1]	−0.1
CHANGES IN SPENDING SUBJECT TO APPROPRIATION										
Administration of drug benefit and related activities	0.2	0.4	0.5	0.5	0.6	0.6	0.6	0.6	0.7	0.7
Administration of coverage/appeals provision	[1]	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2
Effect of higher drug prices on outlays for FEHB (for active workers) and other federal programs	0	0	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]
Total	0.2	0.4	0.6	0.6	0.7	0.7	0.7	0.8	0.9	0.9

[1] Costs or savings of less than $50 million.

Notes:—SMI = Supplementary Medical Insurance (Part B of Medicare); FEHB = Federal Employees Health Benefits.

Source: Congressional Budget office.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 27, 2000.

Hon. BILL ARCHER,
Chairman, Committee on Ways and Means,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached table of the estimated effects on spending and

revenues of H.R. 4680, the Medicare Rx 2000 Act, as ordered reported by the Committee on Ways and Means on June 21, 2000, and modified by a Manager's Amendment provided on June 26, 2000.

The Manager's Amendment permits the Medicare Benefits Administrator to add coverage of drugs otherwise excluded, and it caps participation in the Disease Management Project at 30,000. The amendment also contains several technical corrections.

CBO estimates H.R. 4680, as amended, would increase direct spending by $0.4 billion in 2001, by $40.0 billion over the 2001–2005 period, and by $159 billion over the 2001–2010 period. The increase in budget authority for direct spending would be equal to the increase in outlays.

We also estimate that the bill would reduce revenues from income and payroll taxes by $0.2 billion during the 2001–2010 period. Social Security payroll taxes, which are off-budget, account for $0.1 billion of that amount. Subject to appropriation of the necessary amounts, CBO estimates the bill would increase discretionary spending by $0.2 billion in 2001 and by $6.6 billion over the 2001–2010 period.

CBO is preparing a detailed cost estimate of the bill, which we expect to deliver later today.

I hope this information is helpful to you. The CBO staff contact is Tom Bradley.

Sincerely,

BARRY B. ANDERSON
(For Dan L. Crippen, Director).

ESTIMATED BUDGETARY EFFECT OF THE MEDICARE Rx 2000 ACT

	By fiscal year, in billions of dollars—									
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
CHANGES IN DIRECT SPENDING										
Medicare outlays:										
Payments to qualifying drug plans	0	0	6.2	7.7	8.6	9.5	10.5	11.5	12.7	14.1
Disease management project	0	0	0.1	0.1	0.1	(1)	(1)	0	0	0
Coverage and appeals	0.1	0.1	0.1	0.2	0.2	0.3	0.4	0.5	0.6	0.7
Medicare+Choice payments	0.2	1.2	0.2	0.9	1.1	1.1	1.5	1.8	2.2	2.6
SMI coverage of drugs and biologicals	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2
Low-income subsidy for premium and cost-sharing assistance	0	0	5.0	7.9	9.6	10.9	12.1	13.4	14.9	16.5
SMI transfer to Medicaid for subsidy administration	0	0	a	0.1	0.1	0.2	0.2	0.3	0.3	0.3
Subtotal	0.4	1.5	11.9	16.9	19.9	22.1	24.7	27.6	30.8	34.3
Medicaid outlays:										
Change to current-law drug spending	0	0	−2.6	−3.7	−4.1	−4.6	−5.1	−5.7	−6.3	−7.0
Part A/B benefits and other Medicaid costs	0	0	0.3	0.7	1.2	1.4	1.5	1.6	1.7	1.9
Reductions in payments to states	0	0	−0.6	−1.3	−1.2	−0.8	−0.3	0	0	0
Administration (net of SMI transfer)	0	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Subtotal	0	0.1	−2.7	−4.1	−3.9	−3.8	−3.7	−3.9	−4.4	−4.9
Effect of higher drug prices on outlays by federal programs:										
Medicaid	0	0	(1)	(1)	(1)	(1)	(1)	(1)	0.1	0.1
FEHB (for annuitants, on-budget)	0	0	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Subtotal, on-budget	0	0	(1)	(1)	(1)	(1)	(1)	0.1	0.1	0.1
Total, on-budget outlays	0.4	1.7	9.2	12.8	16.0	18.4	21.1	23.8	26.4	29.4

ESTIMATED BUDGETARY EFFECT OF THE MEDICARE Rx 2000 ACT—Continued

	By fiscal year, in billions of dollars—									
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Off-budget outlays (FEHB for postal workers and annuitants)	0	0	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
CHANGES IN REVENUES										
Income and Medicare payroll taxes (on-budget)	0	0	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Social Security payroll taxes (off-budget)	0	0	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Total	0	0	(1)	(1)	(1)	(1)	(1)	(1)	(1)	−0.1
CHANGES IN SPENDING SUBJECT TO APPROPRIATION										
Administration of drug benefit and related activities	0.2	0.4	0.5	0.5	0.6	0.6	0.6	0.6	0.7	0.7
Administration of coverage/appeals provision	(1)	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2
Effect of higher drug prices on outlays for FEHB (for active workers) & other federal programs	0	0	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Total	0.2	0.4	0.6	0.6	0.7	0.7	0.7	0.8	0.9	0.9

[1] Costs or savings of less than $50 million.

Notes.—SMI=Supplementary Medical Insurance (Part B of Medicare); FEHB=Federal Employees Health Benefits.

Source: Congressional Budget Office.

V. OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

A. Committee Oversight Findings and Recommendations

In compliance with clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee reports that the need for this legislation was confirmed by the oversight hearings of the Committee and its Subcommittee on Health. The hearings were as follows:

The Subcommittee on Health held a hearing on February 15, 2000 examining the implications of different proposals aimed at helping seniors gain more affordable access to prescription drugs. Testimony at the hearing was presented by the General Accounting Office and health care experts and advocates.

On May 11, 2000, the Subcommittee held a hearing to examine the Clinton Administration's prescription drug proposal and its effect on beneficiary care. Testimony at the hearing was provided by the Health Care Financing Administration, the Congressional Budget Office, and the General Accounting Office.

Finally, on June 13, 2000, the Committee held a hearing on legislation to cover prescription drugs under Medicare and the related effects on the financial outlook of the Medicare program. Testimony at the hearing was received from Members of Congress and other parties pertinent to the development of legislation.

B. Summary of Findings and Recommendations of the Government Reform Committee

In compliance with clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee states that no oversight findings or recommendations have been submitted to the Committee on Government Reform regarding the subject of the bill.

C. CONSTITUTIONAL AUTHORITY STATEMENT

In compliance with clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, relating to Constitutional Authority, the Committee states that the Committee's action in reporting the bill is derived from Article I of the Constitution, Section 8 ("The Congress shall have power to lay and collect taxes, duties, imposts and excises, to pay the debts and to provide for * * * the general welfare of the United States * * *").

VI. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION

* * * * * * *

SEC. 1108. ADDITIONAL GRANTS TO PUERTO RICO, THE VIRGIN ISLANDS, GUAM, AND AMERICAN SAMOA; LIMITATION ON TOTAL PAYMENTS.

(a) * * *

* * * * * * *

(f) Subject to subsection (g) *and section 1935(e)(1)(B)*, the total amount certified by the Secretary under title XIX with respect to a fiscal year for payment to—

(1) * * *

* * * * * * *

CIVIL MONETARY PENALTIES

SEC. 1128A. (a) * * *

* * * * * * *

(i) For the purposes of this section:

(1) The term "State agency" means the agency established or designated to administer or supervise the administration of the State plan under title XIX of this Act or designated to administer the State's program under title V or title XX of this Act.

(6) The term "remuneration" includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. The term "remuneration" does not include—

(A) the waiver of coinsurance and deductible amounts by a person, if—

[(i) the waiver is not offered as part of any advertisement or solicitation;

[(ii) the person does not routinely waive coinsurance or deductible amounts; and

[(iii) the person—

[(I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need; or

[(II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts;]

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

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

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

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

* * * * * * *

CRIMINAL PENALTIES FOR ACTS INVOLVING FEDERAL HEALTH CARE PROGRAMS

SEC. 1128B. (a) * * *

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) * * *

* * * * * * *

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

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

EXPLANATION OF MEDICARE BENEFITS

SEC. 1806. (a) IN GENERAL.—The Secretary shall furnish to each individual for whom payment has been made under this title (or would be made without regard to any deductible) a statement which—

(1) lists the item or service for which payment has been made and the amount of such payment for each item or service; [and]

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

[(2)] *(3)* includes a notice of the individual's right to request an itemized statement (as provided in subsection (b))[.]*; and*

(4) includes the toll-free telephone number (1–800–MEDICAR(E)) (1–800–633–4227) for information and questions

concerning the statement, liability of the individual for payment, and appeal rights.

* * * * * * *

MEDICARE BENEFITS ADMINISTRATION

SEC. 1807. (a) ESTABLISHMENT.—There is established within the Department of Health and Human Services an agency to be known as the Medicare Benefits Administration.

(b) ADMINISTRATOR AND DEPUTY ADMINISTRATOR.—

(1) ADMINISTRATOR.—

(A) IN GENERAL.—The Medicare Benefits Administration shall be headed by an Administrator (in this section referred to as the "Administrator") who shall be appointed by the President, by and with the advice and consent of the Senate. The Administrator shall be in direct line of authority to the Secretary.

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

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

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

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

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

(G) AUTHORITY TO DELEGATE.—The Administrator may assign duties, and delegate, or authorize successive redelegations of, authority to act and to render decisions, to such officers and employees of the Administration as the Administrator may find necessary. Within the limitations of such delegations, redelegations, or assignments, all official acts and decisions of such officers and employees shall have the same force and effect as though performed or rendered by the Administrator.

(2) DEPUTY ADMINISTRATOR.—

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

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

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

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

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

(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

(1) DUTIES.—

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

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

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

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

(C) NONINTERFERENCE.—In carrying out its duties with respect to the provision of qualified prescription drug coverage to beneficiaries under this title, the Administrator may not—

(i) require a particular formulary or institute a price structure for the reimbursement of covered outpatient drugs;

(ii) interfere in any way with negotiations between PDP sponsors and Medicare+Choice organizations and drug manufacturers, wholesalers, or other suppliers of covered outpatient drugs; and

(iii) otherwise interfere with the competitive nature of providing such coverage through such sponsors and organizations.

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

(2) STAFF.—

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

(B) FLEXIBILITY WITH RESPECT TO COMPENSATION.—

(i) IN GENERAL.—The staff of the Medicare Benefits Administration shall, subject to clause (ii), be paid without regard to the provisions of chapter 51 and chapter 53 of such title (relating to classification and schedule pay rates).

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

(C) LIMITATION ON FULL-TIME EQUIVALENT STAFFING FOR CURRENT HCFA FUNCTIONS BEING TRANSFERRED.—The Administrator may not employ under this paragraph a number of full-time equivalent employees, to carry out functions that were previously conducted by the Health Care Financing Administration and that are conducted by the Administrator by reason of this section, that exceeds the number of such full-time equivalent employees authorized to be employed by the Health Care Financing Administration to conduct such functions as of the date of the enactment of this Act.

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

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

(B) TRANSFER OF DATA AND INFORMATION.—The Secretary shall ensure that the Administrator of the Health Care Financing Administration transfers to the Administrator of the Medicare Benefits Administration such information and data in the possession of the Administrator of the Health Care Financing Administration as the Administrator of the Medicare Benefits Administration requires to carry out the duties described in paragraph (1).

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

(d) OFFICE OF BENEFICIARY ASSISTANCE.—

(1) ESTABLISHMENT.—The Secretary shall establish within the Medicare Benefits Administration an Office of Beneficiary Assistance to carry out functions relating to medicare beneficiaries under this title, including making determinations of eligibility of individuals for benefits under this title, providing for enrollment of medicare beneficiaries under this title, and the functions described in paragraph (2). The Office shall be separate operating division within the Administration.

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

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

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

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

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

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

(3) MEDICARE OMBUDSMAN.—

(A) IN GENERAL.—Within the Office of Beneficiary Assistance, there shall be a Medicare Ombudsman, appointed by the Secretary from among individuals with expertise and

experience in the fields of health care and advocacy, to carry out the duties described in subparagraph (B).

(B) DUTIES.—The Medicare Ombudsman shall—

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

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

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

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

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

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

(i) provide information about the medicare program; and

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

(e) MEDICARE POLICY ADVISORY BOARD.—

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

(2) REPORTS.—

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

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

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

(ii) EDUCATION AND ENROLLMENT.—Recommendations for the improvement to efforts to provide medicare beneficiaries information and education on the program under this title, and specifically parts C and D, and the program for enrollment under the title.

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

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

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

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

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

(4) MEMBERSHIP.—

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

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

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

(iii) 2 members shall be appointed by the President pro tempore of the Senate with the advice of the chairman and the ranking minority member of the Senate Committee on Finance.

(B) QUALIFICATIONS.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education and experience in health care benefits manage-

ment, exceptionally qualified to perform the duties of members of the Board.

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

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

(6) TERMS OF OFFICE.—

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

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

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

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

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

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

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

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

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

(9) DIRECTOR AND STAFF.—

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

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

(C) FLEXIBILITY WITH RESPECT TO COMPENSATION.—

(i) IN GENERAL.—The Director and staff of the Board shall, subject to clause (ii), be paid without regard to the provisions of chapter 51 and chapter 53 of such title (relating to classification and schedule pay rates).

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

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

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

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

* * * * * * *

PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * * * *

FEDERAL HOSPITAL INSURANCE TRUST FUND

SEC. 1817. (a) * * *

(b) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the "Board of Trustees") composed of the Commissioner of Social Security, the Secretary of the Treasury, the Secretary of Labor, [and the Secretary of Health and Human Services, all ex officio,] *the Secretary of Health and Human Services, and the Administrator of the Medicare Benefits Administration, all ex officio,* and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to confirmation by the Senate. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the "Managing Trustee"). The Administrator of the Health Care Financing Administration shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

(1) * * *

* * * * * * *

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

(1) IN GENERAL.—In addition to the duty of the Board of Trustees to report to Congress under subsection (b), on the date the Board submits the report required under subsection (b)(2), the Board shall submit to Congress a report on the operation and status of the Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under section 1841

(in this subsection referred to as the "Trust Funds"). Such report shall included the following information:

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

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

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

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

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

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PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

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FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

SEC. 1841. (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Supplementary Medical Insurance Trust Fund" (hereinafter in this section referred to as the "Trust Fund"). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), [and] such amounts as may be deposited in, or appropriated to, such fund as provided in this part *and such amounts as may be deposited in, or appropriated to, the Medicare Prescription Drug Account established by section 1860I.*

(b) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the "Board of Trustees") composed of the Commissioner of Social Security, Secretary of the Treasury, the Secretary of Labor, [and the Secretary of Health and Human Services, all ex officio,] *the Secretary of Health and Human Services, and the Administrator of the Medicare Benefits Administration, all ex officio,* and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to con-

firmation by the Senate. A member of the Board of Trustees serving as a member of the public and nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member's term until the earlier of the time at which the member's successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member's term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the "Managing Trustee"). The Administrator of the Health Care Financing Administration shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

(1) * * *

* * * * * * *

(g) The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health and Human Services certifies are necessary to make the payments provided for by this part, *the payments provided for under part D (in which case the payments shall come from the Medicare Prescription Drug Account in the Trust Fund),* and the payments with respect to administrative expenses in accordance with section 201(g)(1).

* * * * * * *

PART C—MEDICARE+CHOICE PROGRAM

ELIGIBILITY, ELECTION, AND ENROLLMENT

SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS THROUGH MEDICARE+CHOICE PLANS.—

(1) IN GENERAL.—Subject to the provisions of this section, each Medicare+Choice eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits *(other than qualified prescription drug benefits)* under this title—

(A) through the original medicare fee-for-service program under parts A and B, or

(B) through enrollment in a Medicare+Choice plan under this part**[**.**]**,

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

* * * * * * *

(g) GUARANTEED ISSUE AND RENEWAL.—

(1) IN GENERAL.—Except as provided in this subsection *and section 1860A(c)(2)(B)*, a Medicare+Choice organization shall provide that at any time during which elections are accepted under this section with respect to a Medicare+Choice plan offered by the organization, the organization will accept without restrictions individuals who are eligible to make such election.

* * * * * * *

(j) AVAILABILITY OF PRESCRIPTION DRUG BENEFITS.—

(1) IN GENERAL.—A Medicare+Choice organization may not offer prescription drug coverage (other than that required under

parts A and B) to an enrollee under a Medicare+Choice plan unless such drug coverage is at least qualified prescription drug coverage and unless the requirements of this subsection with respect to such coverage are met.

(2) COMPLIANCE WITH ADDITIONAL BENEFICIARY PROTECTIONS.—With respect to the offering of qualified prescription drug coverage by a Medicare+Choice organization under a Medicare+Choice plan, the organization and plan shall meet the requirements of section 1860C, including requirements relating to information dissemination and grievance and appeals, in the same manner as they apply to a PDP sponsor and a prescription drug plan under part D. The Medicare Benefits Administrator shall waive such requirements to the extent the Administrator determines that such requirements duplicate requirements otherwise applicable to the organization or plan under this part.

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

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

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

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

(5) SPECIFICATION OF SEPARATE AND STANDARD PREMIUM.—

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

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

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

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

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

(B) REDUCTION OF PREMIUMS ALLOWED.—Nothing in this subsection shall be construed as preventing a Medicare+Choice organization from reducing the amount of

a premium charged for prescription drug coverage because of the application of section 1854(f)(1)(A) to other coverage.

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

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

(7) QUALIFIED PRESCRIPTION DRUG COVERAGE; STANDARD COVERAGE.—For purposes of this part, the terms "qualified prescription drug coverage" and "standard coverage" have the meanings given such terms in section 1860B.

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BENEFITS AND BENEFICIARY PROTECTIONS

SEC. 1852. (a) * * *

* * * * * * *

(g) COVERAGE DETERMINATIONS, RECONSIDERATIONS, AND APPEALS.—

(1) * * *

* * * * * * *

(4) INDEPENDENT REVIEW OF CERTAIN COVERAGE DENIALS.—The Secretary shall contract with an independent, outside entity to review and resolve in a timely manner reconsiderations that affirm denial of coverage, in whole or in part. *The provisions of section 1869(c)(5) shall apply to independent outside entities under contract with the Secretary under this paragraph.*

* * * * * * *

PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS

SEC. 1853. (a) PAYMENTS TO ORGANIZATIONS.—

(1) * * *

* * * * * * *

(3) ESTABLISHMENT OF RISK ADJUSTMENT FACTORS.—

(A) * * *

* * * * * * *

(C) INITIAL IMPLEMENTATION.—

(i) * * *

(ii) PHASE-IN.—Such risk adjustment methodology shall be implemented in a phased-in manner so that the methodology insofar as it makes adjustments to capitation rates for health status applies to—

(I) * * *

(II) not more than 20 percent of such capitation rate in 2002**[**.**]***;*

and, beginning in 2004, insofar as such risk adjustment is based on data from all settings, the method-

ology shall be phased in equal increments over a 10 year period, beginning with 2004 or (if later) the first year in which such data is used.

* * * * * * *

(c) CALCULATION OF ANNUAL MEDICARE+CHOICE CAPITATION RATES.—

(1) IN GENERAL.—For purposes of this part, subject to paragraphs (6)(C) and (7), each annual Medicare+Choice capitation rate, for a Medicare+Choice payment area for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraph (A), (B), [or (C)] *(C), or (D)*:

(A) BLENDED CAPITATION RATE.—The sum of—

(i) * * *

(ii) the national percentage (as specified under paragraph (2) for the year) of the input-price-adjusted annual national Medicare+Choice capitation rate, as determined under paragraph (4) for the year,

multiplied *(for years before 2002)* by the budget neutrality adjustment factor determined under paragraph (5).

(B) MINIMUM AMOUNT.—12 multiplied by the following amount:

(i) * * *

[(ii) For a succeeding year] *(ii)(I) Subject to subclause (II), for a succeeding year*, the minimum amount specified in this clause (or clause (i)) for the preceding year increased by the national per capita Medicare+Choice growth percentage, described in paragraph (6)(A) for that succeeding year.

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

(C) MINIMUM PERCENTAGE INCREASE.—

(i) * * *

[(ii) For a subsequent year] *(ii)(I) Subject to subclause (II), for a subsequent year*, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

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

(D) PERMITTING HIGHER RATES THROUGH NEGOTIATION.—

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

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

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

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

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

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

(II) to eliminate the costs of prescription drugs.

(iii) ADJUSTMENTS FOR OVER OR UNDER PROJECTIONS.—If subparagraph is applied to an organization and payment area for a year, in applying this subparagraph for a subsequent year the provisions of paragraph (6)(C) shall apply in the same manner as such provisions apply under this paragraph.

(2) AREA-SPECIFIC AND NATIONAL PERCENTAGES.—For purposes of paragraph (1)(A)—

(A) * * *

* * * * * * *

(F) for a year after 2002, the "area-specific percentage" is 50 percent and the "national percentage" is 50 percent[.]*;*

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

* * * * * * *

(5) PAYMENT ADJUSTMENT BUDGET NEUTRALITY FACTOR.—For purposes of paragraph (1)(A), for each year *(before 2002)*, the Secretary shall determine a budget neutrality adjustment factor so that the aggregate of the payments under this part (other than those attributable to subsection (i)) shall equal the aggregate payments that would have been made under this part if payment were based entirely on area-specific capitation rates.

(6) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE DEFINED.—

(A) * * *

(B) ADJUSTMENT.—The number of percentage points specified in this subparagraph is—

(i) * * *

* * * * * * *

(iv) [for 2001, 0.5 percentage points] *for 2001, 0 percentage points*,

(v) [for 2002, 0.3 percentage points] *for 2002, 0 percentage points*, and

* * * * * * *

PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

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

(a) PROVISION OF QUALIFIED PRESCRIPTION DRUG COVERAGE THROUGH ENROLLMENT IN PLANS.—Subject to the succeeding provisions of this part, each individual who is enrolled under part B is entitled to obtain qualified prescription drug coverage (described in section 1860B(a)) as follows:

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

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

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

(b) GENERAL ELECTION PROCEDURES.—

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

(2) ELECTION PERIODS.—

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

(i) annual coordinated election periods; and

(ii) special election periods.

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

(B) INITIAL ELECTION PERIODS.—

(i) INDIVIDUALS CURRENTLY COVERED.—In the case of an individual who is enrolled under part B as of November 1, 2002, there shall be an initial election period of 6 months beginning on that date.

(ii) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who is first enrolled under part B after November 1, 2002, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

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

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

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

(iii) in the case of an individual who meets such exceptional conditions (including conditions recognized under section 1851(d)(4)(D)) as the Administrator may provide.

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

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

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

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

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

(1) GUARANTEED ISSUE.—

(A) IN GENERAL.—An eligible individual who is eligible to elect qualified prescription drug coverage under a prescription drug plan or Medicare+Choice plan at a time during which elections are accepted under this part with respect to the plan shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

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

(2) COMMUNITY-RATED PREMIUM.—

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

the premium under the plan based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act or any other factor.

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

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

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

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

(iii) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any outpatient prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan as defined in section 1860H(f)(1).

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

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

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

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

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

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

(d) EFFECTIVE DATE OF ELECTIONS.—

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

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

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

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

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

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

(a) REQUIREMENTS.—

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

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

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

(2) PERMITTING ADDITIONAL OUTPATIENT PRESCRIPTION DRUG COVERAGE.—

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

(B) DISAPPROVAL AUTHORITY.—The Medicare Benefits Administrator shall review the offering of qualified prescription drug coverage under this part or part C. If the Administrator finds that, in the case of a qualified prescription drug coverage under a prescription drug plan or a Medicare+Choice plan, that the organization or sponsor offering the coverage is purposefully engaged in activities intended to result in favorable selection of those eligible medicare beneficiaries obtaining coverage through the plan, the Administrator may terminate the contract with the sponsor or organization under this part or part C.

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

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

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

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

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

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

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

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

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

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

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

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

(A) IN GENERAL.—Notwithstanding paragraph (3), the coverage provides benefits without any cost-sharing after the individual has incurred costs (as described in subpara-

graph (C)) for covered outpatient drugs in a year equal to the annual out-of-pocket limit specified in subparagraph (B).

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

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

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

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

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

(i) incurred costs shall only include costs incurred for the annual deductible (described in paragraph (1)), cost-sharing (described in paragraph (2)), and amounts for which benefits are not provided because of the application of the initial coverage limit described in paragraph (3); and

(ii) such costs shall be treated as incurred without regard to whether the individual or another person, including a State program or other third-party coverage, has paid for such costs.

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

(c) ALTERNATIVE COVERAGE REQUIREMENTS.—A prescription drug plan or Medicare+Choice plan may provide a different prescription drug benefit design from the standard coverage described in subsection (b) so long as the following requirements are met:

(1) ASSURING AT LEAST ACTUARIALLY EQUIVALENT COVERAGE.—

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

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

(C) ASSURING STANDARD PAYMENT FOR COSTS AT INITIAL COVERAGE LIMIT.—The coverage is designed, based upon an actuarially representative pattern of utilization (as determined under subsection (e)), to provide for the payment, with respect to costs incurred that are equal to the sum of

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

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

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

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

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

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

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

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

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

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

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

(f) COVERED OUTPATIENT DRUGS DEFINED.—

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

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

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

and such term includes any use of a covered outpatient drug for a medically accepted indication (as defined in section 1927(k)(6)).

(2) EXCLUSIONS.—

(A) IN GENERAL.—Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section

1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents).

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

(3) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this part shall not be so considered under a plan if the plan excludes the drug under a formulary that meets the requirements of section 1860C(f)(2) (including providing an appeal process).

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

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

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

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

(5) STUDY ON INCLUSION OF DRUGS TREATING MORBID OBESITY.—The Medicare Policy Advisory Board shall provide for a study on removing the exclusion under paragraph (2)(A) for coverage of agents used for weight loss in the case of morbidly obese individuals. The Board shall report to Congress on the results of the study not later than March 1, 2002.

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

(a) GUARANTEED ISSUE COMMUNITY-RELATED PREMIUMS AND NONDISCRIMINATION.—For provisions requiring guaranteed issue, community-rated premiums, and nondiscrimination, see sections 1860A(c)(1), 1860A(c)(2), and 1860F(b).

(b) DISSEMINATION OF INFORMATION.—

(1) GENERAL INFORMATION.—A PDP sponsor shall disclose, in a clear, accurate, and standardized form to each enrollee with a prescription drug plan offered by the sponsor under this part at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such plan. Such information includes the following:

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

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

(C) Co-payments and deductible requirements.

(D) Grievance and appeals procedures.

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

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

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

(c) ACCESS TO COVERED BENEFITS.—

(1) ASSURING PHARMACY ACCESS.—The PDP sponsor of the prescription drug plan shall secure the participation of sufficient numbers of pharmacies (which may include mail order pharmacies) to ensure convenient access (including adequate emergency access) for enrolled beneficiaries, in accordance with standards established under section 1860D(e) that ensure such convenient access. Nothing in this paragraph shall be construed as requiring the participation of (or permitting the exclusion of) all pharmacies in any area under a plan.

(2) ACCESS TO NEGOTIATED PRICES FOR PRESCRIPTION DRUGS.—The PDP sponsor of a prescription drug plan shall issue such a card that may be used by an enrolled beneficiary to assure access to negotiated prices under section 1860B(d) for the purchase of prescription drugs for which coverage is not otherwise provided under the prescription drug plan.

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

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

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

(C) APPEALS AND EXCEPTIONS TO APPLICATION.—The PDP sponsor must have, as part of the appeals process under subsection (f)(2), a process for appeals for denials of coverage based on such application of the formulary.

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

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

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

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

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

(2) MEDICATION THERAPY MANAGEMENT PROGRAM.—

(A) IN GENERAL.—A medication therapy management program described in this paragraph is a program of drug therapy management and medication administration that is designed to assure that covered outpatient drugs under the prescription drug plan are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

(B) ELEMENTS.—Such program may include—

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

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

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

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

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

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

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

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

(4) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR GENERIC EQUIVALENT DRUGS.—Each PDP sponsor shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered outpatient drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost generic drug that is therapeutically and pharmaceutically equivalent and bioequivalent.

(e) GRIEVANCE MECHANISM.—Each PDP sponsor shall provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the sponsor provides covered benefits) and enrollees with prescrip-

tion drug plans of the sponsor under this part in accordance with section 1852(f).

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

(1) IN GENERAL.—A PDP sponsor shall meet the requirements of section 1852(g) with respect to covered benefits under the prescription drug plan it offers under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

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

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

SEC. 1860D. REQUIREMENTS FOR PRESCRIPTION DRUG PLAN (PDP) SPONSORS; CONTRACTS; ESTABLISHMENT OF STANDARDS.

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

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

(2) ASSUMPTION OF FULL FINANCIAL RISK.—

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

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

(3) SOLVENCY FOR UNLICENSED SPONSORS.—In the case of a sponsor that is not described in paragraph (1), the sponsor shall meet solvency standards established by the Medicare Benefits Administrator under subsection (d).

(b) CONTRACT REQUIREMENTS.—

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

that the sponsor agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

(2) NEGOTIATION REGARDING TERMS AND CONDITIONS.—The Medicare Benefits Administrator shall have the same authority to negotiate the terms and conditions of prescription drug plans under this part as the Director of the Office of Personnel Management has with respect to health benefits plans under chapter 89 of title 5, United States Code. In negotiating the terms and conditions regarding premiums for which information is submitted under section 1860F(a)(2), the Administrator shall take into account the reinsurance subsidy payments under section 1860H and the adjusted community rate (as defined in section 1854(f)(3)) for the benefits covered.

(3) INCORPORATION OF CERTAIN MEDICARE+CHOICE CONTRACT REQUIREMENTS.—The following provisions of section 1857 shall apply, subject to subsection (c)(5), to contracts under this section in the same manner as they apply to contracts under section 1857(a):

(A) MINIMUM ENROLLMENT.—Paragraphs (1) and (3) of section 1857(b).

(B) CONTRACT PERIOD AND EFFECTIVENESS.—Paragraphs (1) through (3) and (5) of section 1857(c).

(C) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—Section 1857(d).

(D) ADDITIONAL CONTRACT TERMS.—Section 1857(e); except that in applying section 1857(e)(2) under this part—

(i) such section shall be applied separately to costs relating to this part (from costs under part C);

(ii) in no case shall the amount of the fee established under this subparagraph for a plan exceed 20 percent of the maximum amount of the fee that may be established under subparagraph (B) of such section; and

(iii) no fees shall be applied under this subparagraph with respect to Medicare+Choice plans.

(E) INTERMEDIATE SANCTIONS.—Section 1857(g).

(F) PROCEDURES FOR TERMINATION.—Section 1857(h).

(4) RULES OF APPLICATION FOR INTERMEDIATE SANCTIONS.—In applying paragraph (3)(E)—

(A) the reference in section 1857(g)(1)(B) to section 1854 is deemed a reference to this part; and

(B) the reference in section 1857(g)(1)(F) to section 1852(k)(2)(A)(ii) shall not be applied.

(c) WAIVER OF CERTAIN REQUIREMENTS TO EXPAND CHOICE.—

(1) IN GENERAL.—In the case of an entity that seeks to offer a prescription drug plan in a State, the Medicare Benefits Administrator shall waive the requirement of subsection (a)(1) that the entity be licensed in that State if the Administrator determines, based on the application and other evidence presented to the Administrator, that any of the grounds for approval of the application described in paragraph (2) has been met.

(2) GROUNDS FOR APPROVAL.—The grounds for approval under this paragraph are the grounds for approval described in subparagraph (B), (C), and (D) of section 1855(a)(2), and also

include the application by a State of any grounds other than those required under Federal law.

(3) APPLICATION OF WAIVER PROCEDURES.—With respect to an application for a waiver (or a waiver granted) under this subsection, the provisions of subparagraphs (E), (F), and (G) of section 1855(a)(2) shall apply.

(4) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that an entity is licensed in accordance with subsection (a)(1) does not deem the entity to meet other requirements imposed under this part for a PDP sponsor.

(5) REFERENCES TO CERTAIN PROVISIONS.—For purposes of this subsection, in applying provisions of section 1855(a)(2) under this subsection to prescription drug plans and PDP sponsors—

(A) any reference to a waiver application under section 1855 shall be treated as a reference to a waiver application under paragraph (1); and

(B) any reference to solvency standards shall be treated as a reference to solvency standards established under subsection (d).

(d) SOLVENCY STANDARDS FOR NON-LICENSED SPONSORS.—

(1) ESTABLISHMENT.—The Medicare Benefits Administrator shall establish, by not later than October 1, 2001, financial solvency and capital adequacy standards that an entity that does not meet the requirements of subsection (a)(1) must meet to qualify as a PDP sponsor under this part.

(2) COMPLIANCE WITH STANDARDS.—Each PDP sponsor that is not licensed by a State under subsection (a)(1) and for which a waiver application has been approved under subsection (c) shall meet solvency and capital adequacy standards established under paragraph (1). The Medicare Benefits Administrator shall establish certification procedures for such PDP sponsors with respect to such solvency standards in the manner described in section 1855(c)(2).

(e) OTHER STANDARDS.—The Medicare Benefits Administrator shall establish by regulation other standards (not described in subsection (d)) for PDP sponsors and plans consistent with, and to carry out, this part. The Administrator shall publish such regulations by October 1, 2001. In order to carry out this requirement in a timely manner, the Administrator may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

(f) RELATION TO STATE LAWS.—

(1) IN GENERAL.—The standards established under this section shall supersede any State law or regulation (including standards described in paragraph (2)) with respect to prescription drug plans which are offered by PDP sponsors under this part to the extent such law or regulation is inconsistent with such standards.

(2) STANDARDS SPECIFICALLY SUPERSEDED.—State standards relating to the following are superseded under this subsection:

(A) Benefit requirements.

(B) Requirements relating to inclusion or treatment of providers.

(C) Coverage determinations (including related appeals and grievance processes).

(D) Establishment and regulation of premiums.

(3) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to premiums paid to PDP sponsors for prescription drug plans under this part, or with respect to any payments made to such a sponsor by the Medicare Benefits Administrator under this part.

SEC. 1860E. PROCESS FOR BENEFICIARIES TO SELECT QUALIFIED PRESCRIPTION DRUG COVERAGE.

(a) IN GENERAL.—The Medicare Benefits Administrator, through the Office of Beneficiary Assistance, shall establish, based upon and consistent with the procedures used under part C (including section 1851), a process for the selection of the prescription drug plan or Medicare+Choice plan which offer qualified prescription drug coverage through which eligible individuals elect qualified prescription drug coverage under this part.

(b) ELEMENTS.—Such process shall include the following:

(1) Annual, coordinated election periods, in which such individuals can change the qualifying plans through which they obtain coverage, in accordance with section 1860A(b)(2).

(2) Active dissemination of information to promote an informed selection among qualifying plans based upon price, quality, and other features, in the manner described in (and in coordination with) section 1851(d), including the provision of annual comparative information, maintenance of a toll-free hotline, and the use of non-federal entities.

(3) Coordination of elections through filing with a Medicare+Choice organization or a PDP sponsor, in the manner described in (and in coordination with) section 1851(c)(2).

(c) MEDICARE+CHOICE ENROLLEE IN PLAN OFFERING PRESCRIPTION DRUG COVERAGE MAY ONLY OBTAIN BENEFITS THROUGH THE PLAN.—An individual who is enrolled under a Medicare+Choice plan that offers qualified prescription drug coverage may only elect to receive qualified prescription drug coverage under this part through such plan.

(d) ASSURING ACCESS TO A CHOICE OF QUALIFIED PRESCRIPTION DRUG COVERAGE.—

(1) CHOICE OF AT LEAST 2 PLANS IN EACH AREA.—

(A) IN GENERAL.—The Medicare Benefits Administrator shall assure that each individual who is enrolled under part B and who is residing in an area has available, consistent with subparagraph (B), a choice of enrollment in at least 2 qualifying plans (as defined in paragraph (5)) in the area in which the individual resides, at least one of which is a prescription drug plan.

(B) REQUIREMENT FOR DIFFERENT PLAN SPONSORS.—The requirement in subparagraph (A) is not satisfied with respect to an area if only one PDP sponsor or Medicare+Choice organization offers all the qualifying plans in the area.

(2) GUARANTEEING ACCESS TO COVERAGE.—In order to assure access under paragraph (1) and consistent with paragraph (3), the Medicare Benefits Administrator may provide financial in-

centives (including partial underwriting of risk) for a PDP sponsor to expand the service area under an existing prescription drug plan to adjoining or additional areas or to establish such a plan (including offering such a plan on a regional or nationwide basis), but only so long as (and to the extent) necessary to assure the access guaranteed under paragraph (1).

(3) LIMITATION ON AUTHORITY.—In exercising authority under this subsection, the Medicare Benefits Administrator—

(A) shall not provide for the full underwriting of financial risk for any PDP sponsor;

(B) shall not provide for any underwriting of financial risk for a public PDP sponsor with respect to the offering of a nationwide prescription drug plan; and

(C) shall seek to maximize the assumption of financial risk by PDP sponsors or Medicare+Choice organizations.

(4) REPORTS.—The Medicare Benefits Administrator shall, in each annual report to Congress under section 1807(f), include information on the exercise of authority under this subsection. The Administrator also shall include such recommendations as may be appropriate to minimize the exercise of such authority, including minimizing the assumption of financial risk.

(5) QUALIFYING PLAN DEFINED.—For purposes of this subsection, the term "qualifying plan" means a prescription drug plan or a Medicare+Choice plan that includes qualified prescription drug coverage.

SEC. 1860F. PREMIUMS.

(a) SUBMISSION OF PREMIUMS AND RELATED INFORMATION.—

(1) IN GENERAL.—Each PDP sponsor shall submit to the Medicare Benefits Administrator information of the type described in paragraph (2) in the same manner as information is submitted by a Medicare+Choice organization under section 1854(a)(1).

(2) TYPE OF INFORMATION.—The information described in this paragraph is the following:

(A) Information on the qualified prescription drug coverage to be provided.

(B) Information on the actuarial value of the coverage.

(C) Information on the monthly premium to be charged for the coverage, including an actuarial certification of—

(i) the actuarial basis for such premium;

(ii) the portion of such premium attributable to benefits in excess of standard coverage; and

(iii) the reduction in such premium resulting from the reinsurance subsidy payments provided under section 1860H.

(D) Such other information as the Medicare Benefits Administrator may require to carry out this part.

(3) REVIEW.—The Medicare Benefits Administrator shall review the information filed under paragraph (2) for the purpose of conducting negotiations under section 1860D(b)(2).

(b) UNIFORM PREMIUM.—The premium for a prescription drug plan charged under this section may not vary among individuals enrolled in the plan in the same service area, except as is permitted under section 1860A(c)(2)(B) (relating to late enrollment penalties).

(c) TERMS AND CONDITIONS FOR IMPOSING PREMIUMS.—The provisions of section 1854(d) shall apply under this part in the same manner as they apply under part C, and, for this purpose, the reference in such section to section 1851(g)(3)(B)(i) is deemed a reference to section 1860A(d)(3)(B) (relating to failure to pay premiums required under this part).

(d) ACCEPTANCE OF REFERENCE PREMIUM AS FULL PREMIUM IF NO STANDARD (OR EQUIVALENT) COVERAGE IN AN AREA.—

(1) IN GENERAL.—If there is no standard prescription drug coverage (as defined in paragraph (2)) offered in an area, in the case of an individual who is eligible for a premium subsidy under section 1860G and resides in the area, the PDP sponsor of any prescription drug plan offered in the area (and any Medicare+Choice organization that offers qualified prescription drug coverage in the area) shall accept the reference premium under section 1860G(b)(2) as payment in full for the premium charge for qualified prescription drug coverage.

(2) STANDARD PRESCRIPTION DRUG COVERAGE DEFINED.—For purposes of this subsection, the term "standard prescription drug coverage" means qualified prescription drug coverage that is standard coverage or that has an actuarial value equivalent to the actuarial value for standard coverage.

SEC. 1860G. PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS.

(a) IN GENERAL.—

(1) FULL PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR INDIVIDUALS WITH INCOME BELOW 135 PERCENT OF FEDERAL POVERTY LEVEL.—In the case of a subsidy eligible individual (as defined in paragraph (3)) who is determined to have income that does not exceed 135 percent of the Federal poverty level, the individual is entitled under this section—

(A) to a premium subsidy equal to 100 percent of the amount described in subsection (b)(1); and

(B) subject to subsection (c), to the substitution for the beneficiary cost-sharing described in paragraphs (1) and (2) of section 1860B(b) (up to the initial coverage limit specified in paragraph (3) of such section) of amounts that are nominal.

(2) SLIDING SCALE PREMIUM SUBSIDY FOR INDIVIDUALS WITH INCOME ABOVE 135, BUT BELOW 150 PERCENT, OF FEDERAL POVERTY LEVEL.—In the case of a subsidy eligible individual who is determined to have income that exceeds 135 percent, but does not exceed 150 percent, of the Federal poverty level, the individual is entitled under this section to a premium subsidy determined on a linear sliding scale ranging from 100 percent of the amount described in subsection (b)(1) for individuals with incomes at 135 percent of such level to 0 percent of such amount for individuals with incomes at 150 percent of such level.

(3) DETERMINATION OF ELIGIBILITY.—

(A) SUBSIDY ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, subject to subparagraph (D), the term "subsidy eligible individual" means an individual who—

(i) is eligible to elect, and has elected, to obtain qualified prescription drug coverage under this part;

(ii) has income below 150 percent of the Federal poverty line; and

(iii) meets the resources requirement described in section 1905(p)(1)(C).

(B) DETERMINATIONS.—The determination of whether an individual residing in a State is a subsidy eligible individual and the amount of such individual's income shall be determined under the State medicaid plan for the State under section 1935(a). In the case of a State that does not operate such a medicaid plan (either under title XIX or under a statewide waiver granted under section 1115), such determination shall be made under arrangements made by the Medicare Benefits Administrator.

(C) INCOME DETERMINATIONS.—For purposes of applying this section—

(i) income shall be determined in the manner described in section 1905(p)(1)(B); and

(ii) the term "Federal poverty line" means the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(D) TREATMENT OF TERRITORIAL RESIDENTS.—In the case of an individual who is not a resident of the 50 States or the District of Columbia, the individual is not eligible to be a subsidy eligible individual but may be eligible for financial assistance with prescription drug expenses under section 1935(e).

(b) PREMIUM SUBSIDY AMOUNT.—

(1) IN GENERAL.—The premium subsidy amount described in this subsection for an individual residing in an area is the reference premium (as defined in paragraph (2)) for qualified prescription drug coverage offered by the prescription drug plan or the Medicare+Choice plan in which the individual is enrolled.

(2) REFERENCE PREMIUM DEFINED.—For purposes of this subsection, the term "reference premium" means, with respect to qualified prescription drug coverage offered under—

(A) a prescription drug plan that—

(i) provides standard coverage (or alternative prescription drug coverage the actuarial value is equivalent to that of standard coverage), the premium imposed for enrollment under the plan under this part (determined without regard to any subsidy under this section or any late enrollment penalty under section 1860A(c)(2)(B)); or

(ii) provides alternative prescription drug coverage the actuarial value of which is greater than that of standard coverage, the premium described in clause (i) multiplied by the ratio of (I) the actuarial value of standard coverage, to (II) the actuarial value of the alternative coverage; or

(B) a Medicare+Choice plan, the standard premium computed under section 1851(j)(4)(A)(iii), determined without regard to any reduction effected under section 1851(j)(4)(B).

(c) RULES IN APPLYING COST-SHARING SUBSIDIES.—

(1) IN GENERAL.—In applying subsection (a)(1)(B)—

(A) the maximum amount of subsidy that may be provided with respect to an enrollee for a year may not exceed 95 percent of the maximum cost-sharing described in such subsection that may be incurred for standard coverage;

(B) the Medicare Benefits Administrator shall determine what is "nominal" taking into account the rules applied under section 1916(a)(3); and

(C) nothing in this part shall be construed as preventing a plan or provider from waiving or reducing the amount of cost-sharing otherwise applicable.

(2) LIMITATION ON CHARGES.—In the case of an individual receiving cost-sharing subsidies under subsection (a)(1)(B), the PDP sponsor may not charge more than a nominal amount in cases in which the cost-sharing subsidy is provided under such subsection.

(d) ADMINISTRATION OF SUBSIDY PROGRAM.—The Medicare Benefits Administrator shall provide a process whereby, in the case of an individual who is determined to be a subsidy eligible individual and who is enrolled in prescription drug plan or is enrolled in a Medicare+Choice plan under which qualified prescription drug coverage is provided—

(1) the Administrator provides for a notification of the PDP sponsor or Medicare+Choice organization involved that the individual is eligible for a subsidy and the amount of the subsidy under subsection (a);

(2) the sponsor or organization involved reduces the premiums or cost-sharing otherwise imposed by the amount of the applicable subsidy and submits to the Administrator information on the amount of such reduction; and

(3) the Administrator periodically and on a timely basis reimburses the sponsor or organization for the amount of such reductions.

The reimbursement under paragraph (3) with respect to cost-sharing subsidies may be computed on a capitated basis, taking into account the actuarial value of the subsidies and with appropriate adjustments to reflect differences in the risks actually involved.

(e) RELATION TO MEDICAID PROGRAM.—

(1) IN GENERAL.—For provisions providing for eligibility determinations, and additional financing, under the medicaid program, see section 1935.

(2) MEDICAID PROVIDING WRAP AROUND BENEFITS.—The coverage provided under this part is primary payor to benefits for prescribed drugs provided under the medicaid program under title XIX.

SEC. 1860H. SUBSIDIES FOR ALL MEDICARE BENEFICIARIES THROUGH REINSURANCE FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

(a) REINSURANCE SUBSIDY PAYMENT.—In order to reduce premium levels applicable to qualified prescription drug coverage for all medicare beneficiaries, to reduce adverse selection among prescription drug plans and Medicare+Choice plans that provide qualified prescription drug coverage, and to promote the participation of PDP sponsors under this part, the Medicare Benefits Administrator shall provide in accordance with this section for payment to a quali-

fying entity (as defined in subsection (b)) of the reinsurance payment amount (as defined in subsection (c)) for excess costs incurred in providing qualified prescription drug coverage—

(1) for individuals enrolled with a prescription drug plan under this part;

(2) for individuals enrolled with a Medicare+Choice plan that provides qualified prescription drug coverage under part C; and

(3) for medicare primary individuals (described in subsection (f)(3)(D)) who are enrolled in a qualified retiree prescription drug plan.

This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Administrator to provide for the payment of amounts provided under this section.

(b) QUALIFYING ENTITY DEFINED.—For purposes of this section, the term "qualifying entity" means any of the following that has entered into an agreement with the Administrator to provide the Administrator with such information as may be required to carry out this section:

(1) A PDP sponsor offering a prescription drug plan under this part.

(2) A Medicare+Choice organization that provides qualified prescription drug coverage under a Medicare+Choice plan under part C.

(3) The sponsor of a qualified retiree prescription drug plan (as defined in subsection (f)).

(c) REINSURANCE PAYMENT AMOUNT.—

(1) IN GENERAL.—Subject to subsection (d)(2) and paragraph (4), the reinsurance payment amount under this subsection for a qualifying covered individual (as defined in subsection (g)(1)) for a coverage year (as defined in subsection (g)(2)) is equal to the sum of the following:

(A) For the portion of the individual's gross covered prescription drug costs (as defined in paragraph (3)) for the year that exceeds $1,250, but does not exceed $1,350, an amount equal to 30 percent of the allowable costs (as defined in paragraph (2)) attributable to such gross covered prescription drug costs.

(B) For the portion of the individual's gross covered prescription drug costs for the year that exceeds $1,350, but does not exceed $1,450, an amount equal to 50 percent of the allowable costs attributable to such gross covered prescription drug costs.

(C) For the portion of the individual's gross covered prescription drug costs for the year that exceeds $1,450, but does not exceed $1,550, an amount equal to 70 percent of the allowable costs attributable to such gross covered prescription drug costs.

(D) For the portion of the individual's gross covered prescription drug costs for the year that exceeds $1,550, but does not exceed $2,350, an amount equal to 90 percent of the allowable costs attributable to such gross covered prescription drug costs.

(E) For the portion of the individual's gross covered prescription drug costs for the year that exceeds $7,050, an

amount equal to 90 percent of the allowable costs attributable to such gross covered prescription drug costs.

(2) ALLOWABLE COSTS.—For purposes of this section, the term "allowable costs" means, with respect to gross covered prescription drug costs under a plan described in subsection (b) offered by a qualifying entity, the part of such costs that are actually paid under the plan, but in no case more than the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were standard coverage.

(3) GROSS COVERED PRESCRIPTION DRUG COSTS.—For purposes of this section, the term "gross covered prescription drug costs" means, with respect to an enrollee with a qualifying entity under a plan described in subsection (b) during a coverage year, the costs incurred under the plan for covered prescription drugs dispensed during the year, including costs relating to the deductible, whether paid by the enrollee or under the plan, regardless of whether the coverage under the plan exceeds standard coverage and regardless of when the payment for such drugs is made.

(4) INDEXING DOLLAR AMOUNTS.—

(A) AMOUNTS FOR 2003.—The dollar amounts applied under paragraph (1) for 2003 shall be the dollar amounts specified in such paragraph.

(B) FOR 2004.—The dollar amounts applied under paragraph (1) for 2004 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase described in section 1860B(b)(5) for 2004.

(C) FOR SUBSEQUENT YEARS.—The dollar amounts applied under paragraph (1) for a year after 2004 shall be the amounts (under this paragraph) applied under paragraph (1) for the preceding year increased by the annual percentage increase described in section 1860B(b)(5) for the year involved.

(D) ROUNDING.—Any amount, determined under the preceding provisions of this paragraph for a year, which is not a multiple of $5 shall be rounded to the nearest multiple of $5.

(d) ADJUSTMENT OF PAYMENTS.—

(1) IN GENERAL.—The Medicare Benefits Administrator shall estimate—

(A) the total payments to be made (without regard to this subsection) during a year under this section; and

(B) the total payments to be made by qualifying entities for standard coverage under plans described in subsection (b) during the year.

(2) ADJUSTMENT OF PAYMENTS.—The Administrator shall proportionally adjust the payments made under this section for a coverage year in such manner so that the total of the payments made for the year under this section is equal to 35 percent of the total payments described in paragraph (1)(B) during the year.

(e) PAYMENT METHODS.—

(1) IN GENERAL.—Payments under this section shall be based on such a method as the Medicare Benefits Administrator determines. The Administrator may establish a payment method by

which interim payments of amounts under this section are made during a year based on the Administrator's best estimate of amounts that will be payable after obtaining all of the information.

(2) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Medicare Prescription Drug Account.

(f) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN DEFINED.—

(1) IN GENERAL.—For purposes of this section, the term "qualified retiree prescription drug plan" means employment-based retiree health coverage (as defined in paragraph (3)(A)) if, with respect to an individual enrolled (or eligible to be enrolled) under this part who is covered under the plan, the following requirements are met:

(A) ASSURANCE.—The sponsor of the plan shall annually attest, and provide such assurances as the Medicare Benefits Administrator may require, that the coverage meets the requirements for qualified prescription drug coverage.

(B) AUDITS.—The sponsor (and the plan) shall maintain, and afford the Medicare Benefits Administrator access to, such records as the Administrator may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage, the accuracy of payments made, and such other matters as may be appropriate.

(C) PROVISION OF CERTIFICATION OF PRESCRIPTION DRUG COVERAGE.—The sponsor of the plan shall provide for issuance of certifications of the type described in section 1860A(c)(2)(D).

(D) OTHER REQUIREMENTS.—The sponsor of the plan shall comply with such other requirements as the Medicare Benefits Administrator finds necessary to administer the program under this section.

(2) LIMITATION ON BENEFIT ELIGIBILITY.—No payment shall be provided under this section with respect to an individual who is enrolled under a qualified retiree prescription drug plan unless the individual is a medicare primary individual who—

(A) is covered under the plan; and

(B) is eligible to obtain qualified prescription drug coverage under section 1860A but did not elect such coverage under this part (either through a prescription drug plan or through a Medicare+Choice plan).

(3) DEFINITIONS.—As used in this section:

(A) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term "employment-based retiree health coverage" means health insurance or other coverage of health care costs for medicare primary individuals (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

(B) EMPLOYER.—The term "employer" has the meaning given such term by section 3(5) of the Employee Retirement Income Security Act of 1974 (except that such term shall include only employers of two or more employees).

(C) SPONSOR.—The term "sponsor" means a plan sponsor, as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

(D) MEDICARE PRIMARY INDIVIDUAL.—The term "medicare primary individual" means, with respect to a plan, an individual who is covered under the plan and with respect to whom the plan is not a primary plan (as defined in section 1862(b)(2)(A)).

(g) GENERAL DEFINITIONS.—For purposes of this section:

(1) QUALIFYING COVERED INDIVIDUAL.—The term "qualifying covered individual" means an individual who—

(A) is enrolled with a prescription drug plan under this part;

(B) is enrolled with a Medicare+Choice plan that provides qualified prescription drug coverage under part C; or

(C) is covered as a medicare primary individual under a qualified retiree prescription drug plan.

(2) COVERAGE YEAR.—The term "coverage year" means a calendar year in which covered outpatient drugs are dispensed if a claim for payment is made under the plan for such drugs, regardless of when the claim is paid.

SEC. 1860I. MEDICARE PRESCRIPTION DRUG ACCOUNT IN FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.

(a) IN GENERAL.—There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1841 an account to be known as the "Medicare Prescription Drug Account" (in this section referred to as the "Account"). The Account shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, such fund as provided in this part. Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund.

(b) PAYMENTS FROM ACCOUNT.—

(1) IN GENERAL.—The Managing Trustee shall pay from time to time from the Account such amounts as the Medicare Benefits Administrator certifies are necessary to make—

(A) payments under section 1860G (relating to low-income subsidy payments);

(B) payments under section 1860H (relating to reinsurance subsidy payments); and

(C) payments with respect to administrative expenses under this part in accordance with section 201(g).

(2) TRANSFERS TO MEDICAID ACCOUNT FOR INCREASED ADMINISTRATIVE COSTS.—The Managing Trustee shall transfer from time to time from the Account to the Grants to States for Medicaid account amounts the Secretary certifies are attributable to increases in payment resulting from the application of a higher Federal matching percentage under section 1935(b).

(3) TREATMENT IN RELATION TO PART B PREMIUM.—Amounts payable from the Account shall not be taken into account in computing actuarial rates or premium amounts under section 1839.

(c) DEPOSITS INTO ACCOUNT.—

(1) MEDICAID TRANSFER.—There is hereby transferred to the Account, from amounts appropriated for Grants to States for Medicaid, amounts equivalent to the aggregate amount of the

reductions in payments under section 1903(a)(1) attributable to the application of section 1935(c).

(2) APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Account, an amount equivalent to the amount of payments made from the Account under subsection (b), reduced by the amount transferred to the Account under paragraph (1).

SEC. 1860J. DEFINITIONS; TREATMENT OF REFERENCES TO PROVISIONS IN PART C.

(a) DEFINITIONS.—For purposes of this part:

(1) COVERED OUTPATIENT DRUGS.—The term "covered outpatient drugs" is defined in section 1860B(f).

(2) INITIAL COVERAGE LIMIT.—The term "initial coverage limit" means the such limit as established under section 1860B(b)(3), or, in the case of coverage that is not standard coverage, the comparable limit (if any) established under the coverage.

(3) MEDICARE PRESCRIPTION DRUG ACCOUNT.—The term "Medicare Prescription Drug Account" means the Account in the Federal Supplementary Medical Insurance Trust Fund created under section 1860I(a).

(4) PDP SPONSOR.—The term "PDP sponsor" means an entity that is certified under this part as meeting the requirements and standards of this part for such a sponsor.

(5) PRESCRIPTION DRUG PLAN.—The term "prescription drug plan" means health benefits coverage that—

(A) is offered under a policy, contract, or plan by a PDP sponsor pursuant to, and in accordance with, a contract between the Medicare Benefits Administrator and the sponsor under section 1860D(b);

(B) provides qualified prescription drug coverage; and

(C) meets the applicable requirements of the section 1860C for a prescription drug plan.

(6) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term "qualified prescription drug coverage" is defined in section 1860B(a).

(7) STANDARD COVERAGE.—The term "standard coverage" is defined in section 1860B(b).

(b) APPLICATION OF MEDICARE+CHOICE PROVISIONS UNDER THIS PART.—For purposes of applying provisions of part C under this part with respect to a prescription drug plan and a PDP sponsor, unless otherwise provided in this part such provisions shall be applied as if—

(1) any reference to a Medicare+Choice plan included a reference to a prescription drug plan;

(2) any reference to a provider-sponsored organization included a reference to a PDP sponsor;

(3) any reference to a contract under section 1857 included a reference to a contract under section 1860D(b); and

(4) any reference to part C included a reference to this part.

PART [D] *E*—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) * * *

* * * * * * *

(s) The term "medical and other health services" means any of the following items or services:

(1) * * *

(2)(A) services and supplies [(including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered)] *(including injectable and infusable drugs and biologicals which are not usually self-administered by the patient)* furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills;

(B) hospital services [(including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered)] *(including injectable and infusable drugs and biologicals which are not usually self-administered by the patient)* incident to physicians' services rendered to outpatients and partial hospitalization services incident to such services;

* * * * * * *

[DETERMINATIONS; APPEALS

[SEC. 1869. (a) The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A or part B, and any other determination with respect to a claim for benefits under part A or a claim for benefits with respect to home health services under part B shall be made by the Secretary in accordance with regulations prescribed by him.

[(b)(1) Any individual dissatisfied with any determination under subsection (a) as to—

[(A) whether he meets the conditions of section 226 of this Act or section 103 of the Social Security Amendments of 1965, or

[(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this title or section 1818,

[(C) the amount of benefits under part A or part B (including a determination where such amount is determined to be zero), or

[(D) any other denial (other than under part B of title XI) of a claim for benefits under part A or a claim for benefits with respect to home health services under part B,

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g), except that, in so applying such sections and in applying section 205(l) thereto, any reference therein to the Commis-

sioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively. Sections 206(a), 1102, and 1871 shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this subsection by a person that furnishes or supplies the individual, directly or indirectly, with services or items solely on the basis that the person furnishes or supplies the individual with such a service or item. Any person that furnishes services or items to an individual may not represent an individual under this subsection with respect to the issue described in section 1879(a)(2) unless the person has waived any rights for payment from the beneficiary with respect to the services or items involved in the appeal. If a person furnishes services or items to an individual and represents the individual under this subsection, the person may not impose any financial liability on such individual in connection with such representation.

[(2) Notwithstanding paragraph (1)(C) and (1)(D), in the case of a claim arising—

[(A) under part A, a hearing shall not be available to an individual under paragraph (1)(C) and (1)(D) if the amount in controversy is less than $100 and judicial review shall not be available to the individual under that paragraph if the amount in controversy is less than $1,000; or—

[(B) under part B, a hearing shall not be available to an individual under paragraph (1)(C) and (1)(D) if the amount in controversy is less than $500 (or $100 in the case of home health services) and judicial review shall not be available to the individual under that paragraph if the aggregate amount in controversy is less than $1,000.

In determining the amount in controversy, the Secretary, under regulations, shall allow two or more claims to be aggregated if the claims involve the delivery of similar or related services to the same individual or involve common issues of law and fact arising from services furnished to two or more individuals.

[(3) Review of any national coverage determination under section 1862(a)(1) respecting whether or not a particular type or class of items or services is covered under this title shall be subject to the following limitations:

[(A) Such a determination shall not be reviewed by any administrative law judge.

[(B) Such a determination shall not be held unlawful or set aside on the ground that a requirement of section 553 of title 5, United States Code, or section 1871(b), relating to publication in the Federal Register or opportunity for public comment, was not satisfied.

[(C) In any case in which a court determines that the record is incomplete or otherwise lacks adequate information to support the validity of the determination, it shall remand the matter to the Secretary for additional proceedings to supplement the record and the court may not determine that an item or service is covered except upon review of the supplemented record.

[(4) A regulation or instruction which relates to a method for determining the amount of payment under part B and which was ini-

tially issued before January 1, 1981, shall not be subject to judicial review.

[(5) In an administrative hearing pursuant to paragraph (1), where the moving party alleges that there are no material issues of fact in dispute, the administrative law judge shall make an expedited determination as to whether any such facts are in dispute and, if not, shall determine the case expeditiously.]

DETERMINATIONS; APPEALS

SEC. 1869. (a) INITIAL DETERMINATIONS.—The Secretary shall promulgate regulations and make initial determinations with respect to benefits under part A or part B in accordance with those regulations for the following:

(1) The initial determination of whether an individual is entitled to benefits under such parts.

(2) The initial determination of the amount of benefits available to the individual under such parts.

(3) Any other initial determination with respect to a claim for benefits under such parts, including an initial determination by the Secretary that payment may not be made, or may no longer be made, for an item or service under such parts, an initial determination made by a utilization and quality control peer review organization under section 1154(a)(2), and an initial determination made by an entity pursuant to a contract with the Secretary to administer provisions of this title or title XI.

(b) APPEAL RIGHTS.—

(1) IN GENERAL.—

(A) RECONSIDERATION OF INITIAL DETERMINATION.—Subject to subparagraph (D), any individual dissatisfied with any initial determination under subsection (a) shall be entitled to reconsideration of the determination, and, subject to subparagraphs (D) and (E), a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(B) REPRESENTATION BY PROVIDER OR SUPPLIER.—

(i) IN GENERAL.—Sections 206(a), 1102, and 1871 shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this section by a person that furnishes or supplies the individual, directly or indirectly, with services or items, solely on the basis that the person furnishes or supplies the individual with such a service or item.

(ii) MANDATORY WAIVER OF RIGHT TO PAYMENT FROM BENEFICIARY.—Any person that furnishes services or items to an individual may not represent an individual under this section with respect to the issue described in section 1879(a)(2) unless the person has waived any rights for payment from the beneficiary with respect to the services or items involved in the appeal.

(iii) PROHIBITION ON PAYMENT FOR REPRESENTATION.—If a person furnishes services or items to an individual and represents the individual under this section, the person may not impose any financial liability

on such individual in connection with such representation.

(iv) REQUIREMENTS FOR REPRESENTATIVES OF A BENEFICIARY.—The provisions of section 205(j) and section 206 (regarding representation of claimants) shall apply to representation of an individual with respect to appeals under this section in the same manner as they apply to representation of an individual under those sections.

(C) SUCCESSION OF RIGHTS IN CASES OF ASSIGNMENT.—The right of an individual to an appeal under this section with respect to an item or service may be assigned to the provider of services or supplier of the item or service upon the written consent of such individual using a standard form established by the Secretary for such an assignment.

(D) TIME LIMITS FOR APPEALS.—

(i) RECONSIDERATIONS.—Reconsideration under subparagraph (A) shall be available only if the individual described subparagraph (A) files notice with the Secretary to request reconsideration by not later than 180 days after the individual receives notice of the initial determination under subsection (a) or within such additional time as the Secretary may allow.

(ii) HEARINGS CONDUCTED BY THE SECRETARY.—The Secretary shall establish in regulations time limits for the filing of a request for a hearing by the Secretary in accordance with provisions in sections 205 and 206.

(E) AMOUNTS IN CONTROVERSY.—

(i) IN GENERAL.—A hearing (by the Secretary) shall not be available to an individual under this section if the amount in controversy is less than $100, and judicial review shall not be available to the individual if the amount in controversy is less than $1,000.

(ii) AGGREGATION OF CLAIMS.—In determining the amount in controversy, the Secretary, under regulations, shall allow 2 or more appeals to be aggregated if the appeals involve—

(I) the delivery of similar or related services to the same individual by one or more providers of services or suppliers, or

(II) common issues of law and fact arising from services furnished to 2 or more individuals by one or more providers of services or suppliers.

(F) EXPEDITED PROCEEDINGS.—

(i) EXPEDITED DETERMINATION.—In the case of an individual who—

(I) has received notice by a provider of services that the provider of services plans to terminate services provided to an individual and a physician certifies that failure to continue the provision of such services is likely to place the individual's health at significant risk, or

(II) has received notice by a provider of services that the provider of services plans to discharge the individual from the provider of services,

the individual may request, in writing or orally, an expedited determination or an expedited reconsideration of an initial determination made under subsection (a), as the case may be, and the Secretary shall provide such expedited determination or expedited reconsideration.

(ii) EXPEDITED HEARING.—In a hearing by the Secretary under this section, in which the moving party alleges that no material issues of fact are in dispute, the Secretary shall make an expedited determination as to whether any such facts are in dispute and, if not, shall render a decision expeditiously.

(G) REOPENING AND REVISION OF DETERMINATIONS.—The Secretary may reopen or revise any initial determination or reconsidered determination described in this subsection under guidelines established by the Secretary in regulations.

(2) REVIEW OF COVERAGE DETERMINATIONS.—

(A) NATIONAL COVERAGE DETERMINATIONS.—

(i) IN GENERAL.—Review of any national coverage determination shall be subject to the following limitations:

(I) Such a determination shall not be reviewed by any administrative law judge.

(II) Such a determination shall not be held unlawful or set aside on the ground that a requirement of section 553 of title 5, United States Code, or section 1871(b) of this title, relating to publication in the Federal Register or opportunity for public comment, was not satisfied.

(III) Upon the filing of a complaint by an aggrieved party, such a determination shall be reviewed by the Departmental Appeals Board of the Department of Health and Human Services. In conducting such a review, the Departmental Appeals Board shall review the record and shall permit discovery and the taking of evidence to evaluate the reasonableness of the determination. In reviewing such a determination, the Departmental Appeals Board shall defer only to the reasonable findings of fact, reasonable interpretations of law, and reasonable applications of fact to law by the Secretary.

(IV) A decision of the Departmental Appeals Board constitutes a final agency action and is subject to judicial review.

(ii) DEFINITION OF NATIONAL COVERAGE DETERMINATION.—For purposes of this section, the term "national coverage determination" means a determination by the Secretary respecting whether or not a particular item or service is covered nationally under this title, including such a determination under 1862(a)(1).

(B) LOCAL COVERAGE DETERMINATION.—In the case of a local coverage determination made by a fiscal intermediary or a carrier under part A or part B respecting whether a particular type

or class of items or services is covered under such parts, the following limitations apply:

(i) Upon the filing of a complaint by an aggrieved party, such a determination shall be reviewed by an administrative law judge of the Social Security Administration. The administrative law judge shall review the record and shall permit discovery and the taking of evidence to evaluate the reasonableness of the determination. In reviewing such a determination, the administrative law judge shall defer only to the reasonable findings of fact, reasonable interpretations of law, and reasonable applications of fact to law by the Secretary.

(ii) Such a determination may be reviewed by the Departmental Appeals Board of the Department of Health and Human Services.

(iii) A decision of the Departmental Appeals Board constitutes a final agency action and is subject to judicial review.

(C) NO MATERIAL ISSUES OF FACT IN DISPUTE.—In the case of review of a determination under subparagraph (A)(i)(III) or (B)(i) where the moving party alleges that there are no material issues of fact in dispute, and alleges that the only issue is the constitutionality of a provision of this title, or that a regulation, determination, or ruling by the Secretary is invalid, the moving party may seek review by a court of competent jurisdiction.

(D) PENDING NATIONAL COVERAGE DETERMINATIONS.—

(i) IN GENERAL.—In the event the Secretary has not issued a national coverage or noncoverage determination with respect to a particular type or class of items or services, an affected party may submit to the Secretary a request to make such a determination with respect to such items or services. By not later than the end of the 90-day period beginning on the date the Secretary receives such a request, the Secretary shall take one of the following actions:

(I) Issue a national coverage determination, with or without limitations.

(II) Issue a national noncoverage determination.

(III) Issue a determination that no national coverage or noncoverage determination is appropriate as of the end of such 90-day period with respect to national coverage of such items or services.

(IV) Issue a notice that states that the Secretary has not completed a review of the request for a national coverage determination and that includes an identification of the remaining steps in the Secretary's review process and a deadline by which the Secretary will complete the review and take an action described in subclause (I), (II), or (III).

(ii) In the case of an action described in clause (i)(IV), if the Secretary fails to take an action referred to in such clause by the deadline specified by the Secretary under such clause, then the Secretary is deemed to have taken an action described in clause (i)(III) as of the deadline.

(iii) When issuing a determination under clause (i), the Secretary shall include an explanation of the basis for the determination. An action taken under clause (i) (other than subclause (IV)) is deemed to be a national coverage determination for purposes of review under subparagraph (A).

(E) ANNUAL REPORT ON NATIONAL COVERAGE DETERMINATIONS.—

(i) IN GENERAL.—Not later than December 1 of each year, beginning in 2001, the Secretary shall submit to Congress a report that sets forth a detailed compilation of the actual time periods that were necessary to complete and fully implement national coverage determinations that were made in the previous fiscal year for items, services, or medical devices not previously covered as a benefit under this title, including, with respect to each new item, service, or medical device, a statement of the time taken by the Secretary to make the necessary coverage, coding, and payment determinations, including the time taken to complete each significant step in the process of making such determinations.

(ii) PUBLICATION OF REPORTS ON THE INTERNET.—The Secretary shall publish each report submitted under clause (i) on the medicare Internet site of the Department of Health and Human Services.

(3) PUBLICATION ON THE INTERNET OF DECISIONS OF HEARINGS OF THE SECRETARY.—Each decision of a hearing by the Secretary shall be made public, and the Secretary shall publish each decision on the Medicare Internet site of the Department of Health and Human Services. The Secretary shall remove from such decision any information that would identify any individual, provider of services, or supplier.

(4) LIMITATION ON REVIEW OF CERTAIN REGULATIONS.—A regulation or instruction which relates to a method for determining the amount of payment under part B and which was initially issued before January 1, 1981, shall not be subject to judicial review.

(5) STANDING.—An action under this section seeking review of a coverage determination (with respect to items and services under this title) may be initiated only by one (or more) of the following aggrieved persons, or classes of persons:

(A) Individuals entitled to benefits under part A, or enrolled under part B, or both, who are in need of the items or services that are the subject of the coverage determination.

(B) Persons, or classes of persons, who make, manufacture, offer, supply, make available, or provide such items and services.

(c) CONDUCT OF RECONSIDERATIONS BY INDEPENDENT CONTRACTORS.—

(1) IN GENERAL.—The Secretary shall enter into contracts with qualified independent contractors to conduct reconsiderations of initial determinations made under paragraphs (2) and (3) of subsection (a). Contracts shall be for an initial term of three years and shall be renewable on a triennial basis thereafter.

(2) QUALIFIED INDEPENDENT CONTRACTOR.—For purposes of this subsection, the term "qualified independent contractor" means an entity or organization that is independent of any organization under contract with the Secretary that makes initial determinations under subsection (a), and that meets the requirements established by the Secretary consistent with paragraph (3).

(3) REQUIREMENTS.—Any qualified independent contractor entering into a contract with the Secretary under this subsection shall meet the following requirements:

(A) IN GENERAL.—The qualified independent contractor shall perform such duties and functions and assume such responsibilities as may be required under regulations of the Secretary promulgated to carry out the provisions of this subsection, and such additional duties, functions, and responsibilities as provided under the contract.

(B) DETERMINATIONS.—The qualified independent contractor shall determine, on the basis of such criteria, guidelines, and policies established by the Secretary and published under subsection (d)(2)(D), whether payment shall be made for items or services under part A or part B and the amount of such payment. Such determination shall constitute the conclusive determination on those issues for purposes of payment under such parts for fiscal intermediaries, carriers, and other entities whose determinations are subject to review by the contractor; except that payment may be made if—

(i) such payment is allowed by reason of section 1879;

(ii) in the case of inpatient hospital services or extended care services, the qualified independent contractor determines that additional time is required in order to arrange for postdischarge care, but payment may be continued under this clause for not more than 2 days, and only in the case in which the provider of such services did not know and could not reasonably have been expected to know (as determined under section 1879) that payment would not otherwise be made for such services under part A or part B prior to notification by the qualified independent contractor under this subsection;

(iii) such determination is changed as the result of any hearing by the Secretary or judicial review of the decision under this section; or

(iv) such payment is authorized under section 1861(v)(1)(G).

(C) DEADLINES FOR DECISIONS.—

(i) DETERMINATIONS.—The qualified independent contractor shall conduct and conclude a determination under subparagraph (B) or an appeal of an initial determination, and mail the notice of the decision by not later than the end of the 45-day period beginning on the date a request for reconsideration has been timely filed.

(ii) CONSEQUENCES OF FAILURE TO MEET DEADLINE.—In the case of a failure by the qualified independent contractor to mail the notice of the decision by the end of the period described in clause (i), the party requesting the reconsideration or appeal may request a hearing before an administrative law judge, notwithstanding any requirements for a reconsidered determination for purposes of the party's right to such hearing.

(iii) EXPEDITED RECONSIDERATIONS.—The qualified independent contractor shall perform an expedited reconsideration under subsection (b)(1)(F) of a notice from a provider of services or supplier that payment may not be made for an item or service furnished by the provider of services or supplier, of a decision by a provider of services to terminate services furnished to an individual, or in accordance with the following:

(I) DEADLINE FOR DECISION.—Notwithstanding section 216(j), not later than 1 day after the date the qualified independent contractor has received a request for such reconsideration and has received such medical or other records needed for such reconsideration, the qualified independent contractor shall provide notice (by telephone and in writing) to the individual and the provider of services and attending physician of the individual of the results of the reconsideration. Such reconsideration shall be conducted regardless of whether the provider of services or supplier will charge the individual for continued services or whether the individual will be liable for payment for such continued services.

(II) CONSULTATION WITH BENEFICIARY.—In such reconsideration, the qualified independent contractor shall solicit the views of the individual involved.

(D) LIMITATION ON INDIVIDUAL REVIEWING DETERMINATIONS.—

(i) PHYSICIANS.—No physician under the employ of a qualified independent contractor may review—

(I) determinations regarding health care services furnished to a patient if the physician was directly responsible for furnishing such services; or

(II) determinations regarding health care services provided in or by an institution, organization, or agency, if the physician or any member of the physician's family has, directly or indirectly, a significant financial interest in such institution, organization, or agency.

(ii) PHYSICIAN'S FAMILY DESCRIBED.—For purposes of this paragraph, a physician's family includes the physician's spouse (other than a spouse who is legally separated from the physician under a decree of divorce or separate maintenance), children (including stepchildren and legally adopted children), grandchildren, parents, and grandparents.

(E) EXPLANATION OF DETERMINATIONS.—Any determination of a qualified independent contractor shall be in writing, and shall include a detailed explanation of the determination as well as a discussion of the pertinent facts and applicable regulations applied in making such determination.

(F) NOTICE REQUIREMENTS.—Whenever a qualified independent contractor makes a determination under this subsection, the qualified independent contractor shall promptly notify such individual and the entity responsible for the payment of claims under part A or part B of such determination.

(G) DISSEMINATION OF INFORMATION.—Each qualified independent contractor shall, using the methodology established by the Secretary under subsection (d)(4), make available all determinations of such qualified independent contractors to fiscal intermediaries (under section 1816), carriers (under section 1842), peer review organizations (under part B of title XI), Medicare+Choice organizations offering Medicare+Choice plans under part C, and other entities under contract with the Secretary to make initial determinations under part A or part B or title XI.

(H) ENSURING CONSISTENCY IN DETERMINATIONS.—Each qualified independent contractor shall monitor its determinations to ensure the consistency of its determinations with respect to requests for reconsideration of similar or related matters.

(I) DATA COLLECTION.—

(i) IN GENERAL.—Consistent with the requirements of clause (ii), a qualified independent contractor shall collect such information relevant to its functions, and keep and maintain such records in such form and manner as the Secretary may require to carry out the purposes of this section and shall permit access to and use of any such information and records as the Secretary may require for such purposes.

(ii) TYPE OF DATA COLLECTED.—Each qualified independent contractor shall keep accurate records of each decision made, consistent with standards established by the Secretary for such purpose. Such records shall be maintained in an electronic database in a manner that provides for identification of the following:

(I) Specific claims that give rise to appeals.

(II) Situations suggesting the need for increased education for providers of services, physicians, or suppliers.

(III) Situations suggesting the need for changes in national or local coverage policy.

(IV) Situations suggesting the need for changes in local medical review policies.

(iii) ANNUAL REPORTING.—Each qualified independent contractor shall submit annually to the Secretary (or otherwise as the Secretary may request) records maintained under this paragraph for the previous year.

(J) HEARINGS BY THE SECRETARY.—The qualified independent contractor shall (i) prepare such information as is required for an appeal of its reconsidered determination to the Secretary for a hearing, including as necessary, explanations of issues involved in the determination and relevant policies, and (ii) participate in such hearings as required by the Secretary.

(4) NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—The Secretary shall enter into contracts with not fewer than 12 qualified independent contractors under this subsection.

(5) LIMITATION ON QUALIFIED INDEPENDENT CONTRACTOR LIABILITY.—No qualified independent contractor having a contract with the Secretary under this subsection and no person who is employed by, or who has a fiduciary relationship with, any such qualified independent contractor or who furnishes professional services to such qualified independent contractor, shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this subsection or to a valid contract entered into under this subsection, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) provided due care was exercised in the performance of such duty, function, or activity.

(d) ADMINISTRATIVE PROVISIONS.—

(1) OUTREACH.—The Secretary shall perform such outreach activities as are necessary to inform individuals entitled to benefits under this title and providers of services and suppliers with respect to their rights of, and the process for, appeals made under this section. The Secretary shall use the toll-free telephone number maintained by the Secretary (1–800–MEDICAR(E)) (1–800–633–4227) to provide information regarding appeal rights and respond to inquiries regarding the status of appeals.

(2) GUIDANCE FOR RECONSIDERATIONS AND HEARINGS.—

(A) REGULATIONS.—Not later than 1 year after the date of the enactment of this section, the Secretary shall promulgate regulations governing the processes of reconsiderations of determinations by the Secretary and qualified independent contractors and of hearings by the Secretary. Such regulations shall include such specific criteria and provide such guidance as required to ensure the adequate functioning of the reconsiderations and hearings processes and to ensure consistency in such processes.

(B) DEADLINES FOR ADMINISTRATIVE ACTION.—

(i) HEARING BY ADMINISTRATIVE LAW JUDGE.—

(II) IN GENERAL.—Except as provided in subclause (II), an administrative law judge shall conduct and conclude a hearing on a decision of a qualified independent contractor under subsection (c) and render a decision on such hearing by not later than the end of the 90-day period beginning on the date a request for hearing has been timely filed.

(II) WAIVER OF DEADLINE BY PARTY SEEKING HEARING.—The 90-day period under subclause (i)

shall not apply in the case of a motion or stipulation by the party requesting the hearing to waive such period.

(ii) DEPARTMENTAL APPEALS BOARD REVIEW.—The Departmental Appeals Board of the Department of Health and Human Services shall conduct and conclude a review of the decision on a hearing described in subparagraph (B) and make a decision or remand the case to the administrative law judge for reconsideration by not later than the end of the 90-day period beginning on the date a request for review has been timely filed.

(iii) CONSEQUENCES OF FAILURE TO MEET DEADLINES.—In the case of a failure by an administrative law judge to render a decision by the end of the period described in clause (ii), the party requesting the hearing may request a review by the Departmental Appeals Board of the Department of Health and Human Services, notwithstanding any requirements for a hearing for purposes of the party's right to such a review.

(iv) DAB HEARING PROCEDURE.—In the case of a request described in clause (iii), the Departmental Appeals Board shall review the case de novo.

(C) POLICIES.—The Secretary shall provide such specific criteria and guidance, including all applicable national and local coverage policies and rationale for such policies, as is necessary to assist the qualified independent contractors to make informed decisions in considering appeals under this section. The Secretary shall furnish to the qualified independent contractors the criteria and guidance described in this paragraph in a published format, which may be an electronic format.

(D) PUBLICATION OF MEDICARE COVERAGE POLICIES ON THE INTERNET.—The Secretary shall publish national and local coverage policies under this title on an Internet site maintained by the Secretary.

(E) EFFECT OF FAILURE TO PUBLISH POLICIES.—

(i) NATIONAL AND LOCAL COVERAGE POLICIES.—Qualified independent contractors shall not be bound by any national or local medicare coverage policy established by the Secretary that is not published on the Internet site under subparagraph (D).

(ii) OTHER POLICIES.—With respect to policies established by the Secretary other than the policies described in clause (i), qualified independent contractors shall not be bound by such policies if the Secretary does not furnish to the qualified independent contractor the policies in a published format consistent with subparagraph (C).

(3) CONTINUING EDUCATION REQUIREMENT FOR QUALIFIED INDEPENDENT CONTRACTORS AND ADMINISTRATIVE LAW JUDGES.—

(A) IN GENERAL.—The Secretary shall provide to each qualified independent contractor, and, in consultation with the Commissioner of Social Security, to administrative law

judges that decide appeals of reconsiderations of initial determinations or other decisions or determinations under this section, such continuing education with respect to policies of the Secretary under this title or part B of title XI as is necessary for such qualified independent contractors and administrative law judges to make informed decisions with respect to appeals.

(B) MONITORING OF DECISIONS BY QUALIFIED INDEPENDENT CONTRACTORS AND ADMINISTRATIVE LAW JUDGES.—The Secretary shall monitor determinations made by all qualified independent contractors and administrative law judges under this section and shall provide continuing education and training to such qualified independent contractors and administrative law judges to ensure consistency of determinations with respect to appeals on similar or related matters. To ensure such consistency, the Secretary shall provide for administration and oversight of qualified independent contractors and, in consultation with the Commissioner of Social Security, administrative law judges through a central office of the Department of Health and Human Services. Such administration and oversight may not be delegated to regional offices of the Department.

(4) DISSEMINATION OF DETERMINATIONS.—The Secretary shall establish a methodology under which qualified independent contractors shall carry out subsection (c)(3)(G).

(5) SURVEY.—Not less frequently than every 5 years, the Secretary shall conduct a survey of a valid sample of individuals entitled to benefits under this title, providers of services, and suppliers to determine the satisfaction of such individuals or entities with the process for appeals of determinations provided for under this section and education and training provided by the Secretary with respect to that process. The Secretary shall submit to Congress a report describing the results of the survey, and shall include any recommendations for administrative or legislative actions that the Secretary determines appropriate.

(6) REPORT TO CONGRESS.—The Secretary shall submit to Congress an annual report describing the number of appeals for the previous year, identifying issues that require administrative or legislative actions, and including any recommendations of the Secretary with respect to such actions. The Secretary shall include in such report an analysis of determinations by qualified independent contractors with respect to inconsistent decisions and an analysis of the causes of any such inconsistencies.

OVERPAYMENT ON BEHALF OF INDIVIDUALS AND SETTLEMENT OF CLAIMS FOR BENEFITS ON BEHALF OF DECEASED INDIVIDUALS

SEC. 1870. (a) [Any payment under this title] *Except as provided in section 1879(i), any payment under this title* to any provider of services or other person with respect to any items or services furnished any individual shall be regarded as a payment to such individual.

* * * * * * *

PROVIDER REIMBURSEMENT REVIEW BOARD

SEC. 1878. (a) * * *

* * * * * * *

(f)(1) A decision of the Board shall be final [unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision]. Providers shall have the right to obtain judicial review of any final decision of the Board[, or of any reversal, affirmance, or modification by the Secretary,] *or of any reversal, affirmance, or modification by the Secretary* by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision [and not subject to review by the Secretary]. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5, United States Code, notwithstanding any other provisions in section 205. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

* * * * * * *

(g)(1) * * *

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(3) Findings described in paragraph (1) and determinations and other decisions described in paragraph (2) may be reviewed or appealed under section 1869.

* * * * * * *

LIMITATION ON LIABILITY OF BENEFICIARY WHERE MEDICARE CLAIMS ARE DISALLOWED

SEC. 1879. (a) * * *

* * * * * * *

(i) Notwithstanding any other provision of this Act, an individual who is entitled to benefits under this title and is furnished a service or item is not liable for repayment to the Secretary of amounts with respect to such benefits—

(1) subject to paragraph (2), in the case of a claim for such item or service that is incorrectly paid by the Secretary; and

(2) in the case of payments made to the individual by the Secretary with respect to any claim under paragraph (1), the individual shall be liable for repayment of such amount only up to the amount of payment received by the individual from the Secretary.

(j)(1) An individual who is entitled to benefits under this title and is furnished a service or item is not liable for payment of amounts with respect to such benefits in the following cases:

(A) In the case of a benefit for which an initial determination has not been made by the Secretary under subsection (a) whether payment may be made under this title for such benefit.

(B) In the case of a claim for such item or service that is—

(i) improperly submitted by the provider of services or supplier; or

(ii) rejected by an entity under contract with the Secretary to review or pay claims for services and items furnished under this title, including an entity under contract with the Secretary under section 1857.

(2) The limitation on liability under paragraph (1) shall not apply if the individual signs a waiver provided by the Secretary under subsection (l) of protections under this paragraph, except that any such waiver shall not apply in the case of a denial of a claim for noncompliance with applicable regulations or procedures under this title or title XI.

(k) An individual who is entitled to benefits under this title and is furnished services by a provider of services is not liable for payment of amounts with respect to such services prior to noon of the first working day after the date the individual receives the notice of determination to discharge and notice of appeal rights under paragraph (1), unless the following conditions are met:

(1) The provider of services shall furnish a notice of discharge and appeal rights established by the Secretary under subsection (l) to each individual entitled to benefits under this title to whom such provider of services furnishes services, upon admission of the individual to the provider of services and upon notice of determination to discharge the individual from the provider of services, of the individual's limitations of liability under this section and rights of appeal under section 1869.

(2) If the individual, prior to discharge from the provider of services, appeals the determination to discharge under section 1869 not later than noon of the first working day after the date the individual receives the notice of determination to discharge and notice of appeal rights under paragraph (1), the provider of services shall, by the close of business of such first working

day, provide to the Secretary (or qualified independent contractor under section 1869, as determined by the Secretary) the records required to review the determination.

(l) The Secretary shall develop appropriate standard forms for individuals entitled to benefits under this title to waive limitation of liability protections under subsection (j) and to receive notice of discharge and appeal rights under subsection (k). The forms developed by the Secretary under this subsection shall clearly and in plain language inform such individuals of their limitations on liability, their rights under section 1869(a) to obtain an initial determination by the Secretary of whether payment may be made under part A or part B for such benefit, and their rights of appeal under section 1869(b), and shall inform such individuals that they may obtain further information or file an appeal of the determination by use of the toll-free telephone number (1–800–MEDICAR(E)) (1–800–633–4227) maintained by the Secretary. The forms developed by the Secretary under this subsection shall be the only manner in which such individuals may waive such protections under this title or title XI.

(m) An individual who is entitled to benefits under this title and is furnished an item or service is not liable for payment of cost sharing amounts of more than $50 with respect to such benefits unless the individual has been informed in advance of being furnished the item or service of the estimated amount of the cost sharing for the item or service using a standard form established by the Secretary.

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TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) * * *

* * * * * * *

(64) provide, not later than 1 year after the date of the enactment of this paragraph, a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title; **[**and**]**

(65) provide that the State shall issue provider numbers for all suppliers of medical assistance consisting of durable medical equipment, as defined in section 1861(n), and the State shall not issue or renew such a supplier number for any such supplier unless—

(A) * * *

* * * * * * *

(B) a surety bond in a form specified by the Secretary under section 1834(a)(16)(B) and in an amount that is not less than $50,000 or such comparable surety bond as the Secretary may permit under the second sentence of such section**[**.**]***; and*

(66) provide for making eligibility determinations under section 1935(a).

* * * * * * *

PAYMENT TO STATES

SEC. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g) and (j) of this section and subsection 1923(f)) of the total amount expended during such quarter as medical assistance under the State plan*, reduced by the amount computed under section 1935(c)(1) for the State and the quarter*; plus

* * * * * * *

SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGIBILITY DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—As a condition of its State plan under this title under section 1902(a)(66) and receipt of any Federal financial assistance under section 1903(a) subject to subsection (e), a State shall—

(1) make determinations of eligibility for premium and cost-sharing subsidies under (and in accordance with) section 1860G;

(2) inform the Administrator of the Medicare Benefits Administration of such determinations in cases in which such eligibility is established; and

(3) otherwise provide such Administrator with such information as may be required to carry out part D of title XVIII (including section 1860G).

(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE COSTS.—

(1) IN GENERAL.—The amounts expended by a State in carrying out subsection (a) are, subject to paragraph (2), expenditures reimbursable under the appropriate paragraph of section 1903(a); except that, notwithstanding any other provision of such section, the applicable Federal matching rates with respect to such expenditures under such section shall be increased as follows:

(A) For expenditures attributable to costs incurred during 2003, the otherwise applicable Federal matching rate shall be increased by 20 percent of the percentage otherwise payable (but for this subsection) by the State.

(B) For expenditures attributable to costs incurred during 2004, the otherwise applicable Federal matching rate shall be increased by 40 percent of the percentage otherwise payable (but for this subsection) by the State.

(C) For expenditures attributable to costs incurred during 2005, the otherwise applicable Federal matching rate shall be increased by 60 percent of the percentage otherwise payable (but for this subsection) by the State.

(D) For expenditures attributable to costs incurred during 2006, the otherwise applicable Federal matching rate shall be increased by 80 percent of the percentage otherwise payable (but for this subsection) by the State.

(E) For expenditures attributable to costs incurred after 2006, the otherwise applicable Federal matching rate shall be increased to 100 percent.

(2) COORDINATION.—The State shall provide the Secretary with such information as may be necessary to properly allocate administrative expenditures described in paragraph (1) that may otherwise be made for similar eligibility determinations.

(c) FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION DRUG COSTS FOR DUALLY-ELIGIBLE BENEFICIARIES.—

(1) IN GENERAL.—For purposes of section 1903(a)(1) subject to subsection (e), for a State that is one of the 50 States or the District of Columbia for a calendar quarter in a year (beginning with 2003) the amount computed under this subsection is equal to the product of the following:

(A) MEDICARE SUBSIDIES.—The total amount of payments made in the quarter under section 1860G (relating to premium and cost-sharing prescription drug subsidies for low-income medicare beneficiaries) that are attributable to individuals who are residents of the State and are entitled to benefits with respect to prescribed drugs under the State plan under this title (including such a plan operating under a waiver under section 1115).

(B) STATE MATCHING RATE.—A proportion computed by subtracting from 100 percent the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State and the quarter.

(C) PHASE-OUT PROPORTION.—The phase-out proportion (as defined in paragraph (2)) for the quarter.

(2) PHASE-OUT PROPORTION.—For purposes of paragraph (1)(C), the "phase-out proportion" for a calendar quarter in—

(A) 2003 is 80 percent;

(B) 2004 is 60 percent;

(C) 2005 is 40 percent;

(D) 2006 is 20 percent; or

(E) a year after 2006 is 0 percent.

(d) ADDITIONAL PROVISIONS.—

(1) MEDICAID AS SECONDARY PAYOR.—In the case of an individual dually entitled to qualified prescription drug coverage under a prescription drug plan under part D of title XVIII (or under a Medicare+Choice plan under part C of such title) and medical assistance for prescribed drugs under this title, medical assistance shall continue to be provided under this title for prescribed drugs to the extent payment is not made under the prescription drug plan or the Medicare+Choice plan selected by the individual.

(2) CONDITION.—A State may require, as a condition for the receipt of medical assistance under this title with respect to prescription drug benefits for an individual eligible to obtain qualified prescription drug coverage described in paragraph (1), that the individual elect qualified prescription drug coverage under section 1860A.

(e) TREATMENT OF TERRITORIES.—

(1) IN GENERAL.—In the case of a State, other than the 50 States and the District of Columbia—

(A) the previous provisions of this section shall not apply to residents of such State; and

(B) if the State establishes a plan described in paragraph (2) (for providing medical assistance with respect to the provision of prescription drugs to medicare beneficiaries), the amount otherwise determined under section 1108(f) (as increased under section 1108(g)) for the State shall be increased by the amount specified in paragraph (3).

(2) PLAN.—The plan described in this paragraph is a plan that—

(A) provides medical assistance with respect to the provision of covered outpatient drugs (as defined in section 1860B(f)) to low-income medicare beneficiaries; and

(B) assures that additional amounts received by the State that are attributable to the operation of this subsection are used only for such assistance.

(3) INCREASED AMOUNT.—

(A) IN GENERAL.—The amount specified in this paragraph for a State for a year is equal to the product of—

(i) the aggregate amount specified in subparagraph (B); and

(ii) the amount specified in section 1108(g)(1) for that State, divided by the sum of the amounts specified in such section for all such States.

(B) AGGREGATE AMOUNT.—The aggregate amount specified in this subparagraph for—

(i) 2003, is equal to $20,000,000; or

(ii) a subsequent year, is equal to the aggregate amount specified in this subparagraph for the previous year increased by annual percentage increase specified in section 1860(b)(5) for the year involved.

(4) REPORT.—The Secretary shall submit to Congress a report on the application of this subsection and may include in the report such recommendations as the Secretary deems appropriate.

REFERENCES TO LAWS DIRECTLY AFFECTING MEDICAID PROGRAM

SEC. [1935.] *1936.* (a) AUTHORITY OR REQUIREMENTS TO COVER ADDITIONAL INDIVIDUALS.—For provisions of law which make additional individuals eligible for medical assistance under this title, see the following:

(1) * * *

* * * * * * *

TITLE 5, UNITED STATES CODE

* * * * * * *

CHAPTER 53—PAY RATES AND SYSTEMS

* * * * * * *

SUBCHAPTER II—EXECUTIVE SCHEDULE PAY RATES

* * * * * * *

§ 5314. Positions at level III

Level III of the Executive Schedule applies to the following positions, for which the annual rate of basic pay shall be the rate determined with respect to such level under chapter 11 of title 2, as adjusted by section 5318 of this title:

Solicitor General of the United States.

* * * * * * *

Administrator of the Health Care Financing Administration.

§ 5315. Positions at level IV

Level IV of the Executive Schedule applies to the following positions, for which the annual rate of basic pay shall be the rate determined with respect to such level under chapter 11 of title 2, as adjusted by section 5318 of this title:

Deputy Administrator of General Services.

* * * * * * *

[Administrator of the Health Care Financing Administration.**]**

* * * * * * *

VII. DISSENTING VIEWS

The bill ordered reported from this Committee solely by its Republican Members is a failure. It is a political placebo—the creature of a desperate poll-driven desire to appear to accomplish something. All it does is help the drug makers and the Medicare Health Maintenance Organizations.

By rejecting the Democratic substitute, the Committee missed a golden opportunity to provide a real, defined, dependable prescription medicine benefit in Medicare.

The Republican bill is not a true Medicare entitlement. In fact, there is no "there" there in the Republican plan:

there is no certainty of the benefit;

there is no certainty of the premium, other than it being too high.

there is no certainty that the medicine your doctor orders will be delivered to you.

There is certainty that our nation's elderly and disabled who sign up for this Rube Goldberg scheme (see diagram No. 1) will be hassled by the private insurance companies who will seek to sell them the equivalent of drug medigap programs and then, to save money, hound doctors and pharmacies not to deliver. There is certainty that many rural and community pharmacies will be driven to the wall of bankruptcy.

In the Republican pseudo-plan, there will be no stability from year to year. Premiums and formularies will oscillate. Rx drug plans will enter and leave the program annually, just as they do under Medicare+Choice.

Millions of seniors and disabled won't participate and will continue to go without coverage. The frailest elderly and those with Alzheimer's and other dementia will be particularly vulnerable, as they face these bad choices.

DEFEAT THE REPUBLICAN BILL AND PASS THE DEMOCRATIC PLAN

The Republican bill should be defeated in favor of the Democratic substitute.

Passing the Democratic substitute would enact the President's proposal, as described in his radio address of June 24th.[1] We propose a defined benefit

with no deductible;

with Medicare paying half of the first $2000 in Rx expenses in 2003 and 2004, with the benefit rising to $5000 in 2009;

[1] The only notable difference between the Democratic substitute offered in Committee and the President's radio address is he proposes starting in 2002 rather than as originally proposed, 2003.

with beneficiaries' premium starting at $25 per month in 2003 and with increases limited to the growth in medication spending;

with a catastrophic out-of-pocket protection of $4000, the cost of which is not included in the premium (thus effectively lowering the beneficiaries total share of the cost of the program to below 50%); and

with administration through Medicare contractors (who would obtain discounts off of current Rx prices) in a way that would ensure everyone would get the medicines prescribed by their doctors, and those medicines would be available from convenient neighborhood pharmacies at lower prices.

includes a package of $3.6 billion in relief for rural Medicare HMOs, a major improvement in the Medicare appeals process, and the President's proposal for $21 billion in adjustments to the Balanced Budget Act of 1997, helping rural and urban hospitals, managed care plans, nursing homes, home health agencies, and others.

ALL A MATTER OF BUDGET PRIORITIES: DEMOCRATS WANT TO DO MORE FOR THE RETIRED AND DISABLED. REPUBLICANS WANT TO DO MORE FOR THE WEALTHY

We admit that the cost of our Medicare program expansion to seniors and the disabled is more than twice the cost of the Republican gift to drug companies and HMOs. We are proud to be doing more for the most vulnerable in our society. The $40 billion over five years allowed for a drug benefit by the Republicans' FY 2001 Congressional Budget Resolution is a prescription for failure. No one can enact a decent Rx benefit for so little.

Our substitute is a clear statement to the world: the Republican budget priorities are a total failure: they want to give tens of billions in tax relief to the richest people in our society, rather than help the disabled and retired in their hour of sickness.

BACKGROUND

Prescription drugs are an integral part of modern medical treatment. Access to these pharmaceuticals should be a Medicare benefit, treated no differently than Medicare treats doctor visits or surgical procedures. The task of the Committee was to pass a bill that satisfied the needs of the ⅔ of the nation's seniors who have no prescription drug coverage or only inadequate and unreliable insurance.

Rather than pursue real dialogue and negotiations to define the best path to providing a good Medicare drug benefit to improve the health of retirees and the disabled, the Republican majority has chosen instead to push for a complex plan that puts HMO's and drug industry interests before those of beneficiaries.

While Medicare remains the cornerstone of financial security for the elderly by virtue of its success in eliminating major illness as a cause of financial ruin, it does not cover the cost of outpatient prescription drugs. The 87% of beneficiaries taking such medications face a bewildering and potentially expensive series of alternatives. They must

join a Medicare-HMO that may offer drug benefits temporarily;

if lucky, rely on retiree health plan drug benefits from their former employer or union;

purchase, on their own, supplemental coverage through Medigap;

rely on Medicaid if they qualify; or

pay the highest retail drug prices in the world (since they do not get the discounts offered to insurers and other large purchasers).

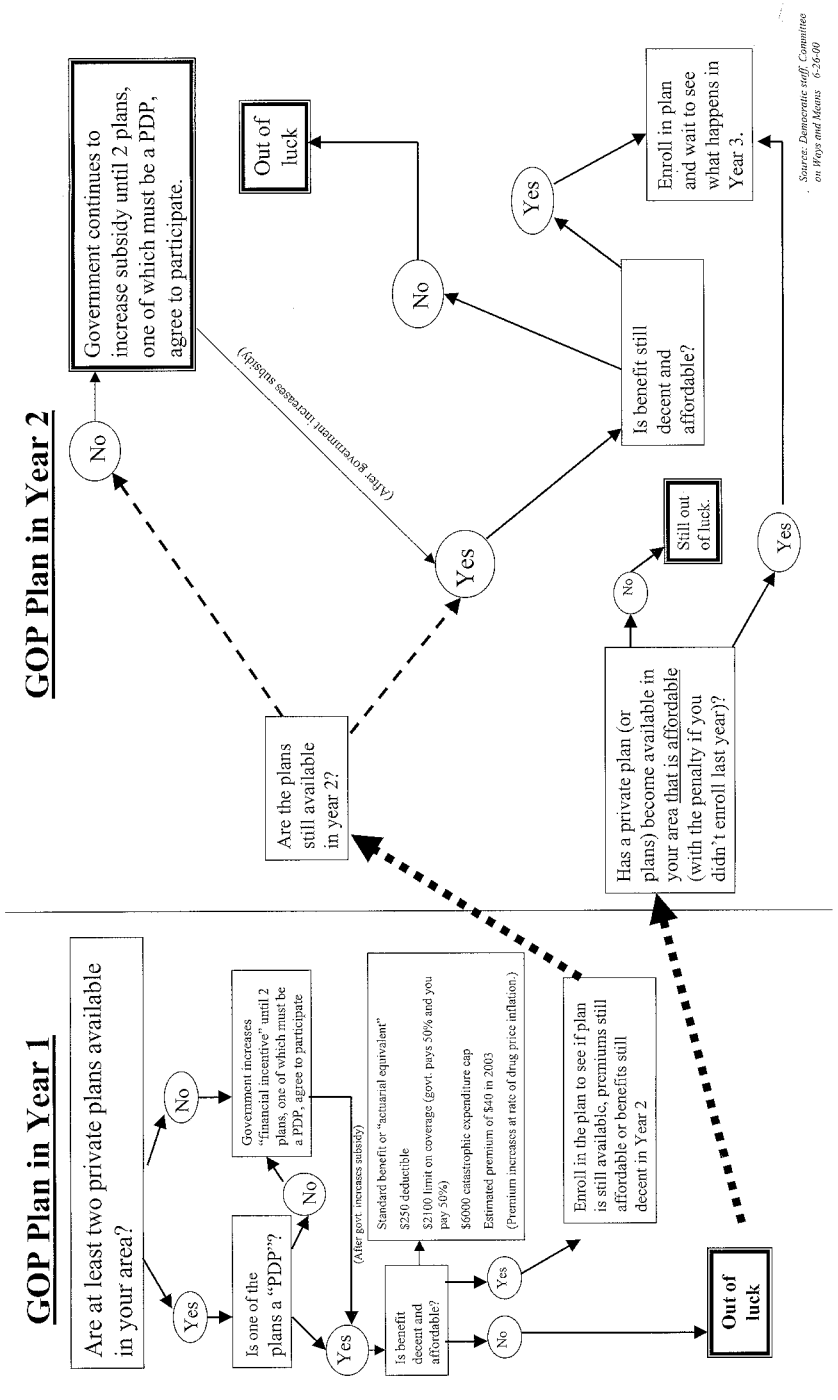
The situation facing seniors and the disabled has reached crisis proportions: the price of medications has soared, and HMOs and employers are daily scaling-back or canceling coverage and Medigap policies are becoming prohibitively expensive.

Under the Thomas Republican plan, Medicare will *not* provide guaranteed access to a reasonably priced drug plan, without regard to where beneficiaries live, independent of private health insurance company business decisions (which can reduce or eliminate benefits).

The question is how to provide a defined, guaranteed Rx benefit and ensure it is available in rural America.

The question is not whether to provide a Medicare drug benefit, but how to do it. How does the Thomas Republican plan fail beneficiaries, while benefiting drug companies and promoting HMO's?

By relying on Medicare managed care programs (HMOs) or a new private insurance product the Republicans fail or offer stability and predictability. The following diagram (No. 1) shows why:


GOP Plan in Year 1
Are at least two private plans available in your area?
Yes
No
Is one of the plans a "PDP"?
Yes
No
Government increases "financial incentive" until 2 plans, one of which must be a PDP, agree to participate
(After govt. increases subsidy)
Is benefit decent and affordable?
Yes
No
Standard benefit or "actuarial equivalent"
$250 deductible
$2100 limit on coverage (govt. pays 50% and you pay 50%)
$6000 catastrophic expenditure cap
Estimated premium of $40 in 2003
(Premium increases at rate of drug price inflation.)
Enroll in the plan to see if plan is still available, premiums still affordable or benefits still decent in Year 2
Out of luck
GOP Plan in Year 2
Are the plans still available in year 2?
No
Government continues to increase subsidy until 2 plans, one of which must be a PDP, agree to participate.
(After government increases subsidy)
Yes
Is benefit still decent and affordable?
No
Out of luck
Yes
Enroll in plan and wait to see what happens in Year 3.
Has a private plan (or plans) become available in your area that is affordable (with the penalty if you didn't enroll last year)?
No
Still out of luck.
Yes
Source: Democratic staff, Committee on Ways and Means 6-26-06

One just has to look at the daily news to see reports of Health Maintenance Organizations abandoning seniors in region after region and cutting back or canceling the voluntary Rx benefits they have been offering in the past. Hundreds of thousands of seniors will lose their Medicare+Choice (M+C) plans as plans exit the program effective January 2001. The Thomas Republican plan takes money intended to purchase pharmaceuticals for seniors and spends billions on payment reforms for M+C plans (raising the floor, increasing payment updates) without the requirement that each of those managed care plans provide any decent, affordable, defined Rx benefit to beneficiaries.

Rather than spending money to prop up private plans, Congress should add the requirement of a good drug benefit to the basic Medicare package, so that it is available to everyone:

to those in HMOs,
to those in fee-for-service Medicare,
to those in rural America, and
to those in our cities.

A Rx requirement in all of Medicare would allow M+C plans to compete on the basis of their ability to manage care, rather than on how deftly they can market themselves by using the excess from payments intended to cover basic Medicare benefits to offer prescription drug coverage. An explicit drug benefit "eliminates the extreme regional variation in Medicare+Choice drug coverage, in which only 23 percent of rural beneficiaries with access to Medicare+Choice have access to prescription drug coverage, compared to 86 percent of urban beneficiaries."[2]

Will a stand-alone private health insurance market prescription drug plan be offered on an equitable basis to all beneficiaries?

The Thomas Republican plan appears to rely heavily on participation by private insurers. Testimony by Mr. Charles Kahn,[3] the president of the Health Insurance Association of America, has made it clear that such stand-alone, drug-only policies would not work in practice: "Designing a theoretical drug coverage model through legislative language does not guarantee that private insurers will develop that product in the market." He points out that there are significant economic barriers, including:

> the costs of development, marketing and administration. Premiums for the policy would have to reflect these costs. Adding to these administrative expenses is the inherent difficulty of developing a sustainable premium structure for a benefit that is so widely used and for which the costs are rising so dramatically.

Adverse selection will further drive up premiums. HIAA projects that ⅓ of seniors will have drug costs under $250 in the year 2000, with their average cost estimated at $68. These seniors are unlikely to purchase any type of private drug coverage, given that the

[2] Statement of Nancy-Ann DeParle, Administrator, Health Care Financing Administration before the House Ways and Means Committee during a public hearing on Medicare Prescription Drug Coverage. June 13, 2000.

[3] Testimony of Charles N. Kahn III, President-Health Insurance Association of America, during a public hearing on "Medicare Prescription Drug Coverage" before the U.S. House Committee on Ways and Means. June 13, 2000.

additional premium for such a policy would be about 10 times higher than their average annual drug costs.

Medicare Administrator Nancy Ann DeParle observed

> subsidizing private insurers instead of establishing a reliable Medicare benefit means that out patient prescription drugs would not be part of the Medicare benefits package like doctor or hospital care. Beneficiary premiums would pay for expensive, private Medigap plans whose administrative costs are on average more than 10 times higher than Medicare's, according to the National Association of Insurance Commissioners statistics, rather than an affordable Medicare option. Furthermore, Medigap plans have little experience negotiating with drug manufacturers and relying on numerous plans does not pool the purchasing power of seniors; both elements are needed to keep the benefit affordable.[4]

The Administrator pointed out that developing a new private insurance product market would be difficult in sparsely populated rural areas, where risk pools are smaller and costs often higher.

Even if coverage is offered, insurers would be likely to come in and out of the market, move to profitable areas and significantly modify benefit design from year to year based on the prior year's experience. This could result in the same pull-outs and uncertainty seen in the M+C plans.

It is quite possible that with enough subsidies from the taxpayer that private insurers will participate in this Republican scheme. But the questions remain:

—at what extra price to taxpayers in wasted overhead?
—at what extra cost to beneficiaries?
—at what level of stability and certainty?

Is the drug coverage available and affordable to all beneficiaries?

Under the Thomas Republican bill, the monthly premiums for these new private insurance (medigap-like) Prescription Drug Plans remain unspecified, subject to negotiation by a new Medicare Benefits Administration. They can and will vary significantly by region of the country. CBO (at the time of writing) estimated the Republican plan would enroll about 2.4 million fewer seniors than the Democratic plan.

We suspect that many of those left out will be lower-income individuals, because the Republican plan lets States enroll people for low-income premium and co-payment assistance only through State welfare offices, rather than sign them up with less hassle through Social Security offices. Without assistance in paying premiums and copays, millions will be unable to afford the Republican plan.

The Republican plan does not provide direct premium subsidies to those with incomes above 150 percent of poverty.[5] In testimony before the Ways and Means Committee on June 13, 2000, the representative of the Older Women's League emphasized that access to prescription drugs is not simply a problem for the poor. While

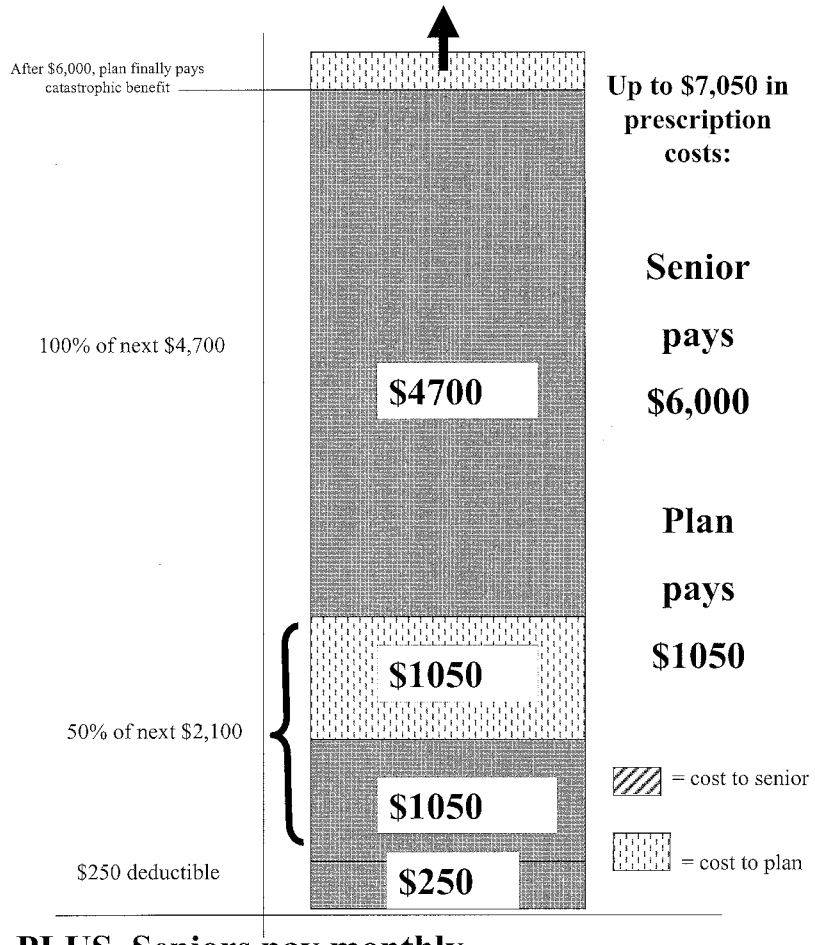
[4] Statement before the House Ways and Means Committee during public hearing on Medicare Prescription Drug Coverage. June 13, 2000.

[5] In contrast, the Democratic substitute would provide a premium subsidy for all participating beneficiaries of greater than 50%.

older Americans comprise only 13 percent of the U.S. population, they account for ⅓ of prescription drug spending. After premium payments, drugs account for the single largest component of out-of-pocket spending for non-institutionalized Medicare beneficiaries age 65 and older. Thus many seniors with moderate incomes also are finding the higher cost of drugs to be out of reach. Middle income seniors are finding their retirement security undermined by the high cost of pharmaceuticals. A simply Medicaid enhancement does not solve the full scope of the problem.

The following table shows how inadequate the Republican drug benefit is:

Republican Drug Bill: SENIORS PAY MOST



PLUS, Seniors pay monthly premium of at least $37/month

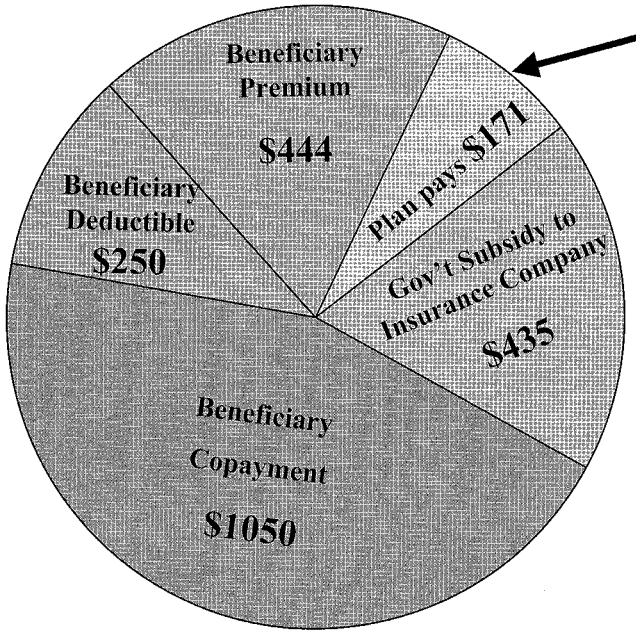
Prepared by the Democratic staff of the committee on Ways and Means 6-23-00

The Thomas Republican bill would subsidize insurers for part of the cost of the most expensive enrollees, claiming that this will result in the "trickle down" effect of lower premiums for all; this "trickle down benefit" is not mandated and is far, far from assured. Table 3 explains how the Republican plan is a gift to the companies, rather than the beneficiaries:

Republican Bill Subsidizes Insurance Companies – Not Senor Citizens

FOR STANDARD $2350 BENEFIT

Beneficiary Pays $1744



Plan Pays $171

Prepared by the Democratic Staff of the
Committee on Ways and Means 6-26-00

Will the Republican bill guarantee a meaningful benefit?

The Thomas bill specifies a dollar amount—an actuarial equivalent [6]—and not a true defined benefit. Private insurers could define deductibles, co-pays and benefit limits. They could change significantly the benefit package year by year. Only the catastrophic coverage is clearly delineated. This is an invitation to beneficiary confusion and benefit packages designed by for-profit companies for "cherry picking" of low-cost, healthy enrollees. For example, insurers could offer no deductible, low co-pays and a low benefit cap that would leave an even larger gap before the catastrohic stop-loss became effective. This represents a retreat from the Medigap reforms of the early 1990's that stndardized benefits, thus ensuring that plans compete on price and quality and not on consumer confusion.

The plan also seems to require a formal appeals process before a beneficiary could get off-formulary drugs or to file any grievance. Such a mechanism could limit access by the "hassling" of doctros and beneficiaries. Furthermore, this plan's multi-insurer approach reduces the pooled purcahsing power of seniors, encouraging insuers to control costs through restrictive formularies and limited pharmacy choice.

Bye-bye corner drugstore?

Finally, the Republican bill offers no guarantee that a beneficiary will be able to obtain needed pharmaceuticals from his or her local pharmacy, only that access be "convenient."

Will the approach proposed by the Republican plan offer any remedies for rising drug prices?

We believe the Congressional Budget Office may say (we do not have their letter of analysis at the time of writing) that the Republican bill would achieve deeper drug price savings than the Democratic plan, but that those savings are largely offset by marketing costs and the cost of second-guessing and hassling doctors to switch medicines. Indeed, those savings may not be passed through to beneficiaries.

Policies that rely primarily on restrictive formularies, fewer retail outlets, and excluding access to needed medications in an attempt to control costs are unacceptable to seniors and the disabled.

Remember the laughter and cheers in theaters all across America when the heroine in "As Good As It Gets" expresses her true feelings about HMOs? Wait 'til seniors experience the hassle of the Republican Rx private insurers!

They won't be laughing.

They will be begging every Member of Congress for help.

REPUBLICAN PLAN CREATES NEW BUREAUCRACIES AND ADDS INEFFICIENCY AND EXPENSE

Ironically, the Thomas Republican bill creates yet another governmental entity. Within the Department of Health and Human Services, there would be established a new Medicare Benefits Administration (MBA), exempt from normal Civil Service pay scales

[6] Members of Congress may get a lot of questions, when they try to explain "actuarial equivalent" at a Town Meeting. Unfortunately, it is just not possible to explain the Republican plan simply!

(but with a limit of $122,400 per employee), the conflict of interest rules that govern the civil service, and co-existing with HCFA.

PRINCIPLES WE SUPPORT

The Republican scheme is described accurately by Ranking Health Subcommittee member Pete Stark as, "basically a hoax, a prescription for failure." It fails to offer the option of affordable prescription drug insurance to all Medicare beneficiaries.

Democratic amendments offered in the attempt to remedy the failures in the Thomas plan were rejected.

Defeated by a series of votes along party lines were

—a proposal by Rep. Cardin to institute a government-guaranteed safety-net Rx plan to supplement the private market plans. Mr. Cardin pointed out, "there is no guarantee of any particular benefit that our constituents will get if the Republican bill is enacted. The Republicans say this would be an entitlement program, but there is no specific benefit to which seniors are entitled."

—an amendment by Reps. Thurman and Doggett to guarantee to seniors the same drug discounts that drug manufacturers give their best or most favored customers. This version of Rep. Tom Allen's price discount bill was defeated by the Republican majority.

—Rep. McDermott's effort to eliminate the need for low-income beneficiaries to go to State Medicaid (welfare) offices in order to apply for and receive the premium and co-insurance assistance to which they are "entitled." The Republicans likely opposed this provision because they knew that if we permitted enrollment through Social Security offices, more low income seniors and disabled would participate and costs would go up.

—Rep. Tanner's amendment to ensure that any local pharmacy that wants to participate in the program can do so. This amendment was proposed in order to guarantee access to benefits for all beneficiaries, especially those in rural areas. The amendment drew one Republican vote, but was defeated by all the rest of the Republicans.

Seniors need and deserve stability, equity, continuity and predictability in their health care plans. They do not get this from for-profit managed care as presently structured. They will not get this from private insurance policies with premiums, co-pays, benefits or even coverage open to change on an annual basis.

The Rx plan we enact should be simple. Our plan is simple: the following chart says it all:

Democratic Plan in Year 1

Choice of traditional Medicare or Medicare HMO with defined benefit (or keep your current employer-provided retiree coverage).

Defined benefit :

- No deductible
- Plan pays 50% cost up to $2,000 (increasing to $5,000 in 2009)
- Premium of $25/month in 2003 (increases limited to rate of drug price inflation)
- Seniors pay maximum of $4,000 (catastrophic out-of-pocket protection)

Democratic Plan in Year 2

Same defined benefit as Year 1

Under the Democrats plan, beneficiaries can volunteer to receive, as part of Medicare, universal, defined-benefit prescription medicine coverage. With negotiated price discounts and private sector administration (like Medicare is administered today) the plan will be affordable to beneficiaries and to taxpayers.

As stated by Ways and Means Committee Ranking Member Rangel, "The Republicans have no confidence in providing assistance directly to our aged. Rather, they want to subsidize the private sector, the HMOs and the insurance companies."

The Democratic substitute amendment would help those who need it.

HELP FOR MEDICARE PROVIDERS AND THE SPECIAL NEEDS OF RURAL AMERICA

Our substitute also demonstrates a commitment to supporting the President on the need for corrections to the Balanced Budget Act of 1997. We propose adjustments along the lines suggested by the President.

We propose to return to the people who serve Medicare beneficiaries the same amount he has proposed: $21 billion over five years. This package includes major adjustments to rural and urban hospitals, teaching hospitals, hospitals that serve a higher proportion of low-income patients, skilled nursing facilities, home health agencies, end-stage renal disease facilities, and others.

We include in this package Rep. Tanner's special rural hospital amendment to provide a full inflation update and to pay more for rural hospital outpatient services.

At the request of Reps. McDermott, Thurman, and Cardin, we include a $3.6 billion package of assistance to stabilize and encourage the growth of Medicare HMOs and managed care in rural and lower-paid counties.

Like the President, we leave slightly more than half the $21 billion unspecified—but with the commitment that we will work with all our colleagues in the coming weeks to determine the areas of remaining unaddressed critical need. We will work to enact a final Balanced Budget Refinement Act II this summer.

CONCLUSION

Members of Congress should defeat the Republican Rx hoax and vote for a real, defined benefit in Medicare. They should enact the Democatic substitute.

PETE STARK.
JIM MCDERMOTT.
XAVIER BECERRA.
WILLIAM J. COYNE.
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ROBERT T. MATSUI.
JOHN S. TANNER.
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JERRY KLECZKA.
RICHARD E. NEAL.
JOHN LEWIS.
BEN CARDIN.

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