

107TH CONGRESS  
1ST SESSION

# H. R. 803

To amend title XVIII of the Social Security Act to make the Medicare Program more competitive and efficient, to extend the solvency of the Medicare Program, to provide for a prescription drug benefit under the Medicare Program, to improve quality of care, to make medicare supplemental insurance (Medigap) more affordable, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 28, 2001

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

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## A BILL

To amend title XVIII of the Social Security Act to make the Medicare Program more competitive and efficient, to extend the solvency of the Medicare Program, to provide for a prescription drug benefit under the Medicare Program, to improve quality of care, to make medicare supplemental insurance (Medigap) more affordable, and for other purposes.

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

1 **SECTION 1. SHORT TITLE; REFERENCES IN ACT; TABLE OF**  
 2 **CONTENTS.**

3 (a) **SHORT TITLE.**—This Act may be cited as the  
 4 “Medicare Modernization and Solvency Act of 2001”.

5 (b) **AMENDMENTS TO SOCIAL SECURITY ACT.**—Ex-  
 6 cept as otherwise specifically provided, whenever in this  
 7 Act an amendment is expressed in terms of an amendment  
 8 to or repeal of a section or other provision, the reference  
 9 shall be considered to be made to that section or other  
 10 provision of the Social Security Act.

11 (c) **TABLE OF CONTENTS.**—The table of contents of  
 12 this Act is as follows:

Sec. 1. Short title; references in act; table of contents.

**TITLE I—MAKING MEDICARE MORE COMPETITIVE AND  
 EFFICIENT**

**Subtitle A—Competitive Defined Benefit**

Sec. 101. Competitive defined benefit.

**Subtitle B—Medicare Fee for Service Quality Improvement**

- Sec. 111. Care coordination services.  
 Sec. 112. Establishment of medicare home health care case managers for long  
 term home health spells of illness.  
 Sec. 113. Additional payment amount to rural providers of services who furnish  
 preventive and case manager services.  
 Sec. 114. Disease management services.  
 Sec. 115. Provider and physician collaboration to furnish a bundled, coordi-  
 nated set of services.  
 Sec. 116. Demonstration projects to increase quality of information provided to  
 medicare beneficiaries with respect to treatment options.  
 Sec. 117. Administration of certain private sector purchasing and quality im-  
 provement programs.  
 Sec. 118. Reports to Congress on private sector purchasing and quality im-  
 provement programs.

**Subtitle C—Immediate and Long-Term Payment Reforms for Medicare Fee  
 for Service**

- Sec. 121. Competitive acquisition of items and services.  
 Sec. 122. Preferred participants.

- Sec. 123. Program to improve outcomes and reduce patient morbidity and mortality.
- Sec. 124. Authority to impose sustainable growth rate limitations on payment for certain medicare items and services.
- Sec. 125. Authority to negotiate payment rates in certain areas (most favored customer authority) and expand inherent reasonableness authority.
- Sec. 126. Authorization of basing medicare payment for hospital outpatient department services on payment rates for similar services provided outside the hospital setting.
- Sec. 127. Medicare single, unified prospective payment system for post-care hospital services.
- Sec. 128. Medicare payment adjustment to reflect deviations from generally accepted practice in overserving or underserving medicare beneficiaries.
- Sec. 129. Promoting the use of cost effective medicare noninstitutional services through waiver of benefit limitations.
- Sec. 130. Increased flexibility in contracting for medicare claims processing.
- Sec. 131. Special provisions for funding of activities related to certain overpayment recoveries and provider enrollment and reverification of eligibility.
- Sec. 132. Establishment of medicare administrative fee for submission of paper claims.

#### Subtitle D—Long-Term Hospital Provisions

- Sec. 141. Findings and purposes of subtitle.
- Sec. 142. Reductions in medicare capital payments in case of excess bed supply in hospitals without a plan of adjustment.
- Sec. 143. Special payments to essential hospitals and development of economic recovery plan.
- Sec. 144. Uniform hospital cost reporting.
- Sec. 145. Medicare payments for inpatient hospital services involving emergency care; National Conference on Emergency Care.

### TITLE II—MODERNIZING MEDICARE BENEFITS

#### SUBTITLE A—PRESCRIPTION DRUG BENEFIT

- Sec. 201. Optional medicare outpatient prescription medicine program under title XVIII.

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

- “Sec. 1859. Eligibility; optional enrollment; coverage.
- “Sec. 1859A. Benefits.
- “Sec. 1859B. Premiums.
- “Sec. 1859C. Federal Medicare Prescription Medicine Trust Fund.
- “Sec. 1859D. Administration; quality assurance.
- “Sec. 1859E. Compensation for employers covering retiree medicine costs.
- “Sec. 1859F. Promotion of pharmaceutical research on break-through medicines while providing program cost containment.
- “Sec. 1859G. Coordination with comprehensive State prescription drug programs.
- Sec. 202. Provision of medicare outpatient prescription drug coverage under the Medicare+Choice program.

- Sec. 203. Transitional assistance for low income beneficiaries.
- Sec. 204. Medigap revisions.
- Sec. 205. Rate reduction for medicare eligible Federal annuitants.
- Sec. 206. Part B payment for outpatient drugs based on actual acquisition cost.
- Sec. 207. Coverage of home infusion drug therapy services.
- Sec. 208. Expansion of membership of MedPAC to 19.
- Sec. 209. GAO ongoing studies and reports on program; miscellaneous reports.

#### Subtitle B—Improving Benefits and Preventive Services

- Sec. 221. Authority to provide preventive services under part B of the medicare program.
- Sec. 222. Smoking cessation demonstration.
- Sec. 223. Outreach to prevent blindness.
- Sec. 224. Coverage of substitute adult day care services under medicare.

#### Subtitle C—Rationalizing Payments and Cost Sharing and Medigap

- Sec. 231. Extension of buy-down of copayment on hospital outpatient services.
- Sec. 232. Indexing deductible to inflation.
- Sec. 233. Medicare direct supplemental insurance option.
- Sec. 234. Increasing access to medigap for disabled and ESRD beneficiaries.

#### Subtitle D—Improved Assistance to Low-Income Beneficiaries

- Sec. 241. Increase in slmb eligibility to 135 percent of poverty; presumptive enrollment.
- Sec. 242. Mechanism promoting provision of medicare cost-sharing assistance to individuals who become eligible for such assistance.

#### Subtitle E—Medicare Early Access and Tax Credits

### PART I—ACCESS TO MEDICARE BENEFITS FOR INDIVIDUALS 62-TO-65 YEARS OF AGE

- Sec. 251. Access to medicare benefits for individuals 62-to-65 years of age.

#### “PART E—PURCHASE OF MEDICARE BENEFITS BY CERTAIN INDIVIDUALS AGE 62-TO-65 YEARS OF AGE

- “Sec. 1860. Program benefits; eligibility.
- “Sec. 1860A. Enrollment process; coverage.
- “Sec. 1860B. Premiums.
- “Sec. 1860C. Payment of premiums.
- “Sec. 1860D. Medicare early access trust fund.
- “Sec. 1860E. Oversight and accountability.
- “Sec. 1860F. Administration and miscellaneous.

### PART II—ACCESS TO MEDICARE BENEFITS FOR DISPLACED WORKERS 55-TO-62 YEARS OF AGE

- Sec. 252. Access to medicare benefits for displaced workers 55-to-62 years of age.

### PART III—COBRA PROTECTION FOR EARLY RETIREES

SUBPART A—AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME  
SECURITY ACT OF 1974

Sec. 253. Cobra continuation benefits for certain retired workers who lose re-  
tiree health coverage.

SUBPART B—AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

Sec. 254. Cobra continuation benefits for certain retired workers who lose re-  
tiree health coverage.

SUBPART C—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

Sec. 255. Cobra continuation benefits for certain retired workers who lose re-  
tiree health coverage.

PART IV—50 PERCENT CREDIT AGAINST INCOME TAX FOR MEDICARE BUY-  
IN PREMIUMS AND FOR CERTAIN COBRA CONTINUATION COVERAGE PRE-  
MIUMS

Sec. 256. 50 percent credit for medicare buy-in premiums and for certain cobra  
continuation coverage premiums.

TITLE III—PROTECTING AND EXTENDING MEDICARE SOLVENCY

Subtitle A—Dedication of 20 Percent of Projected Budget Surplus to  
Medicare

- Sec. 301. Transfers to extend medicare solvency.  
Sec. 302. Medicare solvency debt reduction reserve.  
Sec. 303. Protection of medicare solvency debt reduction reserve.

Subtitle B—Additional Revenues

- Sec. 311. Increased Federal excise taxes on tobacco products.  
Sec. 312. Tobacco settlement deposit.  
Sec. 313. Excess profits from medicare tax.  
Sec. 314. Medicare part B percent subsidy included in gross income.  
Sec. 315. Dedication of Federal estate and gift tax receipts, tobacco tax re-  
ceipts, and other revenues to Medicare.

1 **TITLE I—MAKING MEDICARE**  
2 **MORE COMPETITIVE AND EF-**  
3 **FICIENT**

4 **Subtitle A—Competitive Defined**  
5 **Benefit**

6 **SEC. 101. COMPETITIVE DEFINED BENEFIT.**

- 7 (a) PAYMENTS TO MEDICARE+CHOICE ORGANIZA-  
8 TIONS BASED ON RISK-ADJUSTED BIDS.—

1           (1) IN GENERAL.—Section 1853(a)(1) (42  
2 U.S.C. 1395w–23(a)(1)) is amended by striking “the  
3 Secretary shall make” and all that follows and in-  
4 serting “the Secretary shall make, to each  
5 Medicare+Choice organization, with respect to cov-  
6 erage of an individual for a month under this part  
7 in a Medicare+Choice payment area, separate  
8 monthly payments with respect to benefits under  
9 parts A and B combined, and (as applicable) with  
10 respect to benefits under part D, as determined in  
11 accordance with this section.”.

12           (2) ANNUAL DETERMINATION AND ANNOUNCE-  
13 MENT OF PAYMENT FACTORS.—

14           (A) IN GENERAL.—Section 1853(b) (42  
15 U.S.C. 1395w–23(b)) is amended—

16                   (i) in paragraph (1), by striking “the  
17 calendar year concerned” and all that fol-  
18 lows and inserting “the calendar year con-  
19 cerned, the following factors, as defined in  
20 paragraph (4):

21                           “(A) national monthly per capita costs,

22                           “(B) the benchmark amount for each pay-  
23 ment area, and

1           “(C) the health status and demographic  
2 adjustment factors to be used in making pay-  
3 ment for individual enrollees.”;

4           (ii) in paragraph (3), by striking  
5 “monthly adjusted” and all that follows  
6 and inserting “such estimates, factors, and  
7 amounts”; and

8           (iii) by adding at the end the fol-  
9 lowing new paragraphs:

10           “(4) FACTORS USED IN ADJUSTING BIDS FOR  
11 MEDICARE+CHOICE ORGANIZATIONS AND IN DETER-  
12 MINING ENROLLEE PREMIUMS.—

13           “(A) IN GENERAL.—Subject to paragraph  
14 (5), the Secretary shall use, for purposes of ad-  
15 justing plan bids and determining enrollee pre-  
16 miums under this part, the factors specified in  
17 this paragraph, which factors—

18           “(i) shall be calculated separately for  
19 benefits under parts A and B combined,  
20 and under part D; and

21           “(ii) shall be calculated separately  
22 for—

23           “(I) beneficiaries who are aged or  
24 disabled; and

1                   “(II) beneficiaries who have end  
2                   stage renal disease until such time as  
3                   the Secretary establishes an inte-  
4                   grated risk adjustment system for the  
5                   groups specified in subclause (I) and  
6                   this subclause.

7                   “(B) NATIONAL MONTHLY PER CAPITA  
8                   COSTS.—

9                   “(i) IN GENERAL.—The term ‘na-  
10                  tional monthly per capita costs’ means  
11                  (subject to clause (ii)) the projected na-  
12                  tional, monthly, per capita costs of benefits  
13                  under this title and associated claims proc-  
14                  essing costs for individuals entitled to ben-  
15                  efits under part A and individuals enrolled  
16                  in the program under part B.

17                  “(ii) EXCLUSION OF DSH AND GME  
18                  COSTS.—The calculation of costs under  
19                  clause (i) shall not take into account any  
20                  amounts attributable to—

21                  “(I) payment adjustments under  
22                  section 1886(d)(5)(F) for hospitals  
23                  serving a significantly dispropor-  
24                  tionate number of low income pa-  
25                  tients;

1 “(II) payments for costs of grad-  
2 uate medical education under section  
3 1886(h); or

4 “(III) payments for indirect costs  
5 of medical education under section  
6 1886(d)(5)(B).

7 “(C) BENCHMARK AMOUNT.—

8 “(i) The term ‘benchmark amount’  
9 means, for a payment area, an amount  
10 equal to the greater of—

11 “(I) except as provided in clause  
12 (ii),  $\frac{1}{12}$  of the annual  
13 Medicare+Choice capitation rate that  
14 would have applied in that payment  
15 area under section 1853(c) (as in ef-  
16 fect prior to the enactment of the  
17 Medicare Modernization and Solvency  
18 Act of 2001); or

19 “(II) the product of 96 percent  
20 of national monthly per capita costs  
21 and the ratio, for a previous period,  
22 of—

23 “(aa) monthly per capita  
24 costs of Medicare benefits for in-  
25 dividuals entitled to benefits

1 under part A and individuals en-  
2 rolled in the program under part  
3 B in that payment area (adjusted  
4 for relative risk due to health  
5 status and demographic adjust-  
6 ment factors) to—

7 “(bb) the weighted average  
8 for all payment areas of such  
9 monthly per capita costs.

10 “(ii) If the amount calculated under  
11 clause (i)(I) for a year for all payment  
12 areas is equal to either the minimum  
13 amount or the blended capitation rate, for  
14 all subsequent years the Secretary shall  
15 not calculate the rates described in that  
16 clause and the amount under such clause  
17 instead shall be equal to the product of 96  
18 percent of national monthly per capita  
19 costs and the ratio of—

20 “(I) the annual Medicare+Choice  
21 capitation rate for the last year that  
22 such rates were calculated under such  
23 clause to—

1                   “(II) the weighted average of the  
2                   area-specific Medicare+Choice capita-  
3                   tion rates for that same year.

4                   “(D) HEALTH STATUS AND DEMOGRAPHIC  
5                   ADJUSTMENT FACTORS.—The term ‘health sta-  
6                   tus and demographic adjustment factors’ means  
7                   health status and such other risk factors as  
8                   age, disability status, gender, institutional sta-  
9                   tus, and such other factors as the Secretary de-  
10                  termines to be appropriate, so as to ensure ac-  
11                  tualial equivalence. The Secretary may add to,  
12                  modify, or substitute for such factors, if such  
13                  changes will improve the determination of actu-  
14                  arial equivalence, and in that event will make  
15                  comparable adjustments to the benchmark  
16                  amounts.”.

17                  (B) CONFORMING AMENDMENT.—Section  
18                  1853(c)(7) (42 U.S.C. 1395w-23(c)(7)) is relo-  
19                  cated and redesignated as section 1853(b)(5),  
20                  indented accordingly, and amended by striking  
21                  all that follows “shall adjust appropriately” and  
22                  inserting “national monthly per capita costs for  
23                  the following year”.

24                  (3)       SUBMISSION       OF       BIDS       BY  
25                  MEDICARE+CHOICE ORGANIZATIONS.—

1 (A) IN GENERAL.—Section 1853(c) (42  
2 U.S.C. 1395w-23(c)) is amended to read as fol-  
3 lows:

4 “(c) SUBMISSION OF BIDS BY MEDICARE+CHOICE  
5 ORGANIZATIONS.—

6 “(1) IN GENERAL.—Each Medicare+Choice or-  
7 ganization shall submit to the Secretary, in a form  
8 and manner specified by the Secretary and for each  
9 Medicare+Choice plan which it intends to offer in a  
10 service area in the following year—

11 “(A) by July 1, notice of such intent and  
12 information on the service area and plan type  
13 for each plan; and

14 “(B) by August 1—

15 “(i) the information described in para-  
16 graph (2) for the type of plan involved;  
17 and

18 “(ii) the enrollment capacity (if any)  
19 in relation to the plan and area.

20 “(2) INFORMATION REQUIRED FOR COMPETI-  
21 TIVE PLANS.—The information described in this  
22 paragraph, which shall be submitted separately for  
23 combined part A and part B benefits, and for part  
24 D benefits, is as follows:

1           “(A) The monthly plan bid for the provi-  
2 sion of benefits.

3           “(B) The actuarial value of the reduction  
4 in cost-sharing for Medicare benefits included  
5 in each plan bid (which value shall not exceed  
6 15 percent of the value of the balance of the  
7 bid).

8           “(C) A description of the cost-sharing for  
9 Medicare benefits that will apply and the actu-  
10 arial value of such cost-sharing.

11           “(D) For each supplemental benefits pack-  
12 age offered (if any), the adjusted community  
13 rate of the package, the monthly supplemental  
14 premium, a description of cost-sharing and such  
15 other information as the Secretary considers  
16 necessary.

17           “(E) The assumptions used with respect to  
18 numbers, in each payment area, of—

19                   “(i) enrolled individuals who are aged  
20 or disabled; and

21                   “(ii) enrolled individuals who have  
22 end-stage renal disease.”.

23           (B) CONFORMING AMENDMENTS.—

24                   (i) Paragraphs (3) and (5) of section  
25 1854(a) (42 U.S.C. 1395w-24(a)) are relo-

1 cated and redesignated as paragraphs (3)  
2 and (4), respectively, of section 1853(c)  
3 (42 U.S.C. 1395w-23(c)), as amended.

4 (ii) Section 1853(c)(3)(B) (42 U.S.C.  
5 1395w-23(c)(3)(B)), as redesignated, is  
6 amended by striking “beneficiary”.

7 (iii) Section 1853(c)(4)(B) (42 U.S.C.  
8 1395w-23(c)(3)(B)), as redesignated, is  
9 amended by striking “or subparagraphs  
10 (A)(ii) and (B) of paragraph (4)”.

11 (4) SECRETARY’S DETERMINATION OF PAY-  
12 MENT AMOUNT.—Section 1853 (42 U.S.C. 1395w-  
13 23) is further amended—

14 (A) by redesignating subsections (d)  
15 through (h) as subsections (e) through (i), re-  
16 spectively; and

17 (B) by inserting after subsection (c) the  
18 following new subsection:

19 “(d) SECRETARY’S DETERMINATION OF PAYMENT  
20 AMOUNT.—

21 “(1) CONVERSION TO NORMALIZED BIDS.—The  
22 Secretary shall adjust each monthly plan bid sub-  
23 mitted under subsection (c) for the relative risk of  
24 enrollees in such plan based on health status and de-  
25 mographic adjustment factors.

1           “(2) COMPARISON TO PLAN BENCHMARK  
2 AMOUNT.—

3           “(A) DETERMINATION OF PLAN BENCH-  
4 MARK.—The Secretary shall determine, using  
5 the plan enrollment assumptions included in the  
6 organization’s bid, a plan benchmark amount  
7 for each plan equal to—

8           “(i) (until such time as the Secretary  
9 establishes an integrated risk adjustment  
10 system for individuals who are aged or dis-  
11 abled and for individuals who have end-  
12 stage renal disease)—

13           “(I) the product of the weighted  
14 average of the benchmark amounts for  
15 the payment areas included in the  
16 plan’s service area for individuals who  
17 are aged or disabled and the number  
18 of such individuals in the plan, plus

19           “(II) the product of the weighted  
20 average of the benchmark amounts for  
21 the payment areas included in the  
22 plan’s service area for individuals who  
23 have end-stage renal disease and the  
24 number of such individuals in the  
25 plan,

1 (divided by the total number of individuals  
2 in subclauses (I) and (II); and

3 “(ii) (after such time) the weighted  
4 average of the benchmark amounts for the  
5 payment areas included in the plan’s serv-  
6 ice area.

7 “(B) COMPARISON TO BENCHMARK; DE-  
8 TERMINATION OF PAYMENT AMOUNT.—The  
9 monthly payment to a Medicare+Choice organi-  
10 zation with respect to each individual enrolled  
11 in a plan shall be set as follows:

12 “(i) IF BID DOES NOT EXCEED  
13 BENCHMARK.—If the normalized bid deter-  
14 mined under paragraph (1) does not ex-  
15 ceed the plan benchmark amount deter-  
16 mined under subparagraph (A), the month-  
17 ly payment shall be the normalized bid, ad-  
18 justed to account for the health status and  
19 demographic adjustment factors of the in-  
20 dividual enrollee.

21 “(ii) IF BID EXCEEDS BENCHMARK.—  
22 If the normalized bid determined under  
23 paragraph (1) exceeds the plan benchmark  
24 amount determined under subparagraph  
25 (B), the monthly payment shall be the nor-

1           malized bid, adjusted as described in  
2           clause (i), minus the monthly excess pre-  
3           mium determined under section 1854.”.

4           (b) PREMIUMS.—

5           (1) DETERMINATION OF PREMIUM AMOUNT.—

6           Section 1854 (42 U.S.C. 1395–4) is amended—

7           (A) by striking subsection (a) and redesignig-  
8           nating subsections (b) and (c) as subsections  
9           (a) and (b), respectively; and

10           (B) by adding after subsection (b) as re-  
11           designated the following new subsection:

12           “(c) DETERMINATION OF MEDICARE PREMIUM RE-  
13           DUCTION AND EXCESS PREMIUM.—

14           “(1) IN GENERAL.—Subject to paragraph (2),  
15           the Secretary shall subtract the normalized bid (de-  
16           termined under section 1853(d)(1)) from the plan’s  
17           benchmark amount (determined under section  
18           1853(d)(2)) to determine the Medicare premium re-  
19           duction or monthly excess premium for plan enroll-  
20           ees.

21           “(2) ADJUSTMENT.—If the difference between  
22           the normalized bid and the plan’s benchmark  
23           amount—

24           “(A) is a positive amount, 75 percent of  
25           that amount shall be equal to—

1 “(i) the monthly Medicare premium  
2 reduction for individuals enrolled in the  
3 plan (up to the entire amount of the pre-  
4 mium for part B or part D, as applicable);  
5 and

6 “(ii) the remainder, if any, under  
7 clause (i) shall be equal to the additional  
8 reduction in the actuarial value of plan  
9 cost-sharing for plan enrollees; or

10 “(B) is a negative amount, the absolute  
11 value of that amount shall equal the monthly  
12 excess premium for individuals enrolled in the  
13 plan.”.

14 (2) LIMITATION ON ENROLLEE LIABILITY.—

15 (A) FOR BASIC BENEFITS.—Section  
16 1854(e)(1) (42 U.S.C. 1395w-4(e)(1)) is  
17 amended to read as follows:

18 “(1) FOR BASIC BENEFITS.—The sum of—

19 “(A) the actuarial value of the deductibles,  
20 coinsurance, and copayments applicable on av-  
21 erage to individuals enrolled under this part  
22 with a Medicare+Choice plan described in sec-  
23 tion 1851(a)(2)(A) or (C) of an organization  
24 with respect to benefits described in section  
25 1852(a)(1);

1           “(B) the reduction in cost sharing included  
2           in the plan bid;

3           “(C) the portion, if any, of the monthly  
4           supplemental premium that is in lieu of plan  
5           cost-sharing for Medicare benefits; and

6           “(D) any additional reduction in cost-shar-  
7           ing under subsection (c)(2)(A) (determined sep-  
8           arately with respect to benefits under parts A  
9           and B, and benefits under part D) must equal  
10          the actuarial value of the deductibles, coinsur-  
11          ance, and copayments that would be applicable  
12          on average to individuals entitled to such bene-  
13          fits if they were not members of a  
14          Medicare+Choice organization for the year (ad-  
15          justed as determined appropriate by the Sec-  
16          retary to account for geographic differences and  
17          for plan cost and utilization differences).”.

18           (B) FOR SUPPLEMENTAL BENEFITS.—Sec-  
19          tion 1854(e)(2) (42 U.S.C. 1395w-4(e)(2)) is  
20          amended—

21                   (i) by striking “section  
22                   1851(a)(2)(A)” and inserting “subpara-  
23                   graph (A) or (C) of section 1851(a)(2)”;

24                   (ii) by striking “(multiplied by 12)”;  
25          and

1 (iii) by striking “may not exceed” and  
2 inserting “must equal”.

3 (c) OTHER CHANGES IN PLAN DESIGN.—

4 (1) ALLOWING PLANS TO INCLUDE COST SHAR-  
5 ING REDUCTION IN THEIR BASIC BENEFITS.—Sec-  
6 tion 1852(a)(1)(B) (42 U.S.C. 1395w-22(a)(1)(B))  
7 is amended to read as follows:

8 “(B) at plan option, reduction in cost-shar-  
9 ing for part A and part B benefits, or part D  
10 benefits, that would otherwise be applicable (the  
11 actuarial value of such reduction however shall  
12 not exceed 15 percent of the value of the por-  
13 tion of the bid related to combined part A and  
14 part B benefits, or part D benefits, as applica-  
15 ble).”.

16 (2) ELIMINATION OF MANDATORY SUPPLE-  
17 MENTAL BENEFITS.—Section 1852(a)(3) (42 U.S.C.  
18 1395w-22(a)(3)) is amended by striking subpara-  
19 graph (A) and redesignating subparagraphs (B) and  
20 (C) and subparagraphs (A) and (B), respectively.

21 (d) CONFORMING AMENDMENTS.—

22 (1) PREMIUM REDUCTIONS.—

23 (A) UNDER PART B.—

24 (i) Section 1839(a)(2) (42 U.S.C.  
25 1395r(a)(2)) is amended by striking

1 “shall” and all that follows and inserting  
2 “shall be the amount determined under  
3 paragraph (3), adjusted as required in ac-  
4 cordance with subsections (b), (c), and (f),  
5 and thereafter further modified as required  
6 to comply with section 1854(c)(2)(A).”.

7 (ii) Section 1840 (42 U.S.C. 1395s) is  
8 amended by adding at the end the fol-  
9 lowing:

10 “(i) The Secretary shall provide for necessary adjust-  
11 ments of the Medicare premium for Medicare+Choice en-  
12 rollees determined under section 1854(c)(2)(A). This pre-  
13 mium adjustment may be provided directly or as an ad-  
14 justment to Social Security, Railroad Retirement and Civil  
15 Service Retirement benefits, as appropriate, as the Sec-  
16 retary determines feasible with the concurrence of such  
17 agencies.”.

18 (B) UNDER PART D.—

19 (i) Section 1859D(a)(2)(B) is amend-  
20 ed by inserting “thereafter further modi-  
21 fied as required to comply with section  
22 1854(c)(2)(A),” before “and rounded”.

23 (ii) Section 1859D(b)(1) is amended  
24 by adding at the end the following new  
25 subparagraph:

1           “(C) The Secretary shall provide for nec-  
2           essary adjustments of the Medicare premium  
3           for Medicare+Choice enrollees determined  
4           under section 1854(c)(2)(A). This premium ad-  
5           justment may be provided directly or as an ad-  
6           justment to Social Security, Railroad Retire-  
7           ment and Civil Service Retirement benefits, as  
8           appropriate, as the Secretary determines fea-  
9           sible with the concurrence of such agencies.”.

10           (2) APPROPRIATIONS FOR GOVERNMENT CON-  
11           TRIBUTION.—Section 1844(a)(1) (42 U.S.C.  
12           1395w(a)(1)) is amended by adding after subpara-  
13           graph (B) the following new subparagraph:

14           “(C) an adjustment for the Government  
15           contribution to reflect the savings to the Trust  
16           Fund from enrollment in Medicare+Choice  
17           plans by beneficiaries who receive monthly  
18           Medicare premium reductions in accordance  
19           with section 1854(c)(2)(A).”.

20           (3) Section 1851(b)(1)(B) (42 U.S.C. 1395w-  
21           21(b)(1)(B)) is amended by striking “section  
22           1852(a)(1)(A)” and inserting “section 1852(a)(1)”.

23           (4) Section 1851(d)(2)(A) (42 U.S.C. 1395w-  
24           21(d)(2)(A)) is amended by striking “At least 15  
25           days before” and inserting “Before”.

1           (5) Part C is amended by striking “BENE-  
2           FICLARY” each time it appears immediately before  
3           “PREMIUM” or “PREMIUMS”, and by striking “bene-  
4           ficiary” each time it appears immediately before  
5           “premium” or “premiums”.

6           (6) Section 1851(d)(4)(B) (42 U.S.C. 1395w-  
7           21(d)(4)(B)) is amended—

8                   (A) by inserting “(i)” after “PREMI-  
9                   UMS.—”; and

10                   (B) by inserting before the period “; and  
11                   (ii) the reduction in the part B and part D pre-  
12                   miums, if any”.

13           (7) Section 1851(d)(4)(E) (42 U.S.C. 1395w-  
14           21(d)(4)(E)) is amended by striking “includes man-  
15           datory supplemental benefits in its base benefit  
16           package or”.

17           (8) Section 1852(a)(5) (42 U.S.C. 1395w-  
18           22(a)(5)) is amended by striking “the annual  
19           Medicare+Choice capitation rate” and inserting  
20           “the national monthly per capita costs”.

21           (9) Section 1852(c)(1)(F) (42 U.S.C. 1395w-  
22           22(c)(1)(F)) is amended by striking clause (i) and  
23           redesignating clauses (ii) and (iii) as clauses (i) and  
24           (ii), respectively.

1           (10) Section 1853(a)(1)(B) (42 U.S.C. 1395w–  
2           23(a)(1)(B)) is amended by striking the first and  
3           second sentences.

4           (11) Section 1853(e)(3)(B) (42 U.S.C. 1395w–  
5           23(e)(3)(B)), as redesignated, is amended—

6                   (A) in the caption, by striking “BUDGET  
7                   NEUTRALITY”; and

8                   (B) by striking “adjust the payment rates”  
9                   and all that follows through “that would have  
10                  been made” and inserting “adjust the bench-  
11                  mark amounts otherwise established under this  
12                  section for Medicare+Choice payment areas in  
13                  the State in a manner so that the weighted av-  
14                  erage of the benchmark amounts under this  
15                  section in the State equals the weighted average  
16                  of benchmark amounts that would have been  
17                  applicable”.

18           (12) Section 1853(i)(2) (42 U.S.C. 1395w–  
19           23(i)(2)), as redesignated, is amended—

20                   (A) by inserting “and” at the end of sub-  
21                   paragraph (A);

22                   (B) by striking “; and” at the end of sub-  
23                   paragraph (B) and inserting a period; and

24                   (C) by striking subparagraph (C).

1           (13)(A) Section 1854(a)(2)(A) (42 U.S.C.  
2           1395w-4(a)(2)(A)), as redesignated, is amended by  
3           striking “the amount authorized to be charged” and  
4           all that follows and inserting “the amount required  
5           to be charged under subsection (c)(2)(B) for the  
6           plan.”.

7           (B) Section 1854(a)(2)(B) (42 U.S.C. 1395w-  
8           4(a)(2)(B)), as redesignated, is amended—

9                   (i) by striking “or Medicare+Choice fee-  
10                   for-service plan”, and

11                   (ii) by striking “or (4)(B)”.

12           (14) Section 1854(e) (42 U.S.C. 1395w-4(e)) is  
13           amended by striking paragraph (4).

14           (15)(A) Paragraphs (3) and (4) of section  
15           1854(f) (42 U.S.C. 1395w-4(f)) are relocated and  
16           redesignated as paragraphs (4) and (5) of subsection  
17           (e).

18           (B) Section 1854(e)(4) (42 U.S.C. 1395w-  
19           4(e)(4)), as so redesignated, is amended by striking  
20           “subject to paragraph (4)” and inserting “subject to  
21           paragraph (5)”.

22           (C) Section 1854 (42 U.S.C. 1395w-4) is  
23           amended by striking subsection (f).

1           (16) Section 1858(c), as redesignated by section  
2           201, is amended by striking paragraph (3) and re-  
3           designating paragraph (4) as paragraph (3).

4           (e) EXTENDING MINIMUM MEDICARE+CHOICE CON-  
5 TRACT PERIOD TO 2 YEARS.—

6           (1) IN GENERAL.—Section 1857(c)(1) (42  
7           U.S.C. 1395w-27(c)(1)) is amended by striking “1  
8           year” and inserting “2 years”.

9           (2) EFFECTIVE DATE.—The amendment made  
10          by paragraph (1) shall apply to contracts entered  
11          into on or after the date of the enactment of this  
12          Act.

13          (f) MEDICARE+CHOICE PAYMENT AREAS.—

14          (1) IN GENERAL.—Section 1853(d)(1) (42  
15          U.S.C. 1395w-23(d)(1)) is amended to read as fol-  
16          lows:

17                 “(1) IN GENERAL.—In this part, except as pro-  
18                 vided in paragraph (3), the term ‘Medicare+Choice  
19                 payment area’ means a contiguous area with similar  
20                 costs and patterns of medical practice, which may be  
21                 a multi-county, single country, metropolitan statis-  
22                 tical area, or other combination of geographic units,  
23                 as specified by the Secretary. The Secretary shall  
24                 specify such payment areas in a manner that is de-  
25                 signed to minimize payment variability from year to

1 year and payment discrepancies across similar geo-  
2 graphic units.”.

3 (2) EFFECTIVE DATE.—The amendment made  
4 by paragraph (1) shall take effect on January 1,  
5 2003.

6 (g) EFFECTIVE DATE.—The amendments made by  
7 this section (other than subsections (e) and (f)) shall be  
8 effective for 2005 and succeeding years.

9 **Subtitle B—Medicare Fee for**  
10 **Service Quality Improvement**

11 **SEC. 111. CARE COORDINATION SERVICES.**

12 (a) PROGRAM AUTHORIZED.—Title XVIII (42 U.S.C.  
13 1395 et seq.), as amended by section 412 of the Medicare,  
14 Medicaid, and SCHIP Benefits Improvement and Protec-  
15 tion Act of 2000, as enacted into law by section 1(a)(6)  
16 of Public Law 106–554, is amended by adding after sec-  
17 tion 1866B the following new section:

18 **“SEC. 1866C. CARE COORDINATION SERVICES.**

19 **“(a) IN GENERAL.—**

20 **“(1) PURPOSE.—**The purpose of this section is  
21 to provide assistance to a beneficiary with a non-  
22 chronic serious illness or injury to obtain the appro-  
23 priate level and mix of follow-up care.

24 **“(2) PROGRAM AUTHORITY.—**Beginning in  
25 2004, the Secretary may implement a care coordina-

1       tion services program in accordance with the provi-  
2       sions of this section under which, in appropriate cir-  
3       cumstances, eligible individuals may elect to have  
4       health care services covered under this title managed  
5       and coordinated by a designated care coordinator.

6               “(3) ADMINISTRATION BY CONTRACT.—Except  
7       as otherwise specifically provided, the Secretary may  
8       administer the program under this section in accord-  
9       ance with section 1866F.

10       “(b) ELIGIBILITY CRITERIA; IDENTIFICATION AND  
11 NOTIFICATION OF ELIGIBLE INDIVIDUALS.—

12               “(1) INDIVIDUAL ELIGIBILITY CRITERIA.—The  
13       Secretary shall specify criteria to be used in making  
14       a determination as to whether an individual with a  
15       non-chronic spell of illness or injury may appro-  
16       priately be enrolled in the care coordination services  
17       program under this section, which shall include at  
18       least a finding by the Secretary that for cohorts of  
19       individuals with characteristics identified by the Sec-  
20       retary, professional management and coordination of  
21       care can reasonably be expected to improve proc-  
22       esses or outcomes of health care. The Secretary shall  
23       give priority attention to identifying those cohorts of  
24       individuals who, if they receive care coordination

1 services under this section, such services are likely  
2 to—

3 “(A) reduce total expenditures under the  
4 program with respect to the individual and ill-  
5 ness or injury, or

6 “(B) not increase such total expenditures  
7 with respect to the individual and illness or in-  
8 jury that the Secretary determines would have  
9 been made without the provision of care coordi-  
10 nation services under this section.

11 “(2) PROCEDURES TO FACILITATE ENROLL-  
12 MENT.—The Secretary shall develop and implement  
13 procedures designed to facilitate enrollment of eligi-  
14 ble individuals in the program under this section.

15 “(c) ENROLLMENT OF INDIVIDUALS.—

16 “(1) SECRETARY’S DETERMINATION OF ELIGI-  
17 BILITY.—The Secretary shall determine the eligi-  
18 bility for services under this section of individuals  
19 who are enrolled in the program under this section  
20 and who make application for such services in such  
21 form and manner as the Secretary may prescribe.

22 “(2) ENROLLMENT PERIOD.—

23 “(A) EFFECTIVE DATE AND DURATION.—  
24 Enrollment of an individual in the program  
25 under this section shall be effective as of the

1 first day of the month following the month in  
2 which the Secretary approves the individual's  
3 application under paragraph (1), shall remain  
4 in effect for one month (or such longer period  
5 as the Secretary may specify), and shall be  
6 automatically renewed for additional periods,  
7 unless terminated in accordance with such pro-  
8 cedures as the Secretary shall establish by regu-  
9 lation.

10 “(B) LIMITATION ON REENROLLMENT.—

11 The Secretary may establish limits on an indi-  
12 vidual's eligibility to reenroll in the program  
13 under this section if the individual has  
14 disenrolled from the program more than once  
15 during a specified time period.

16 “(d) PROGRAM.—The care coordination services pro-

17 gram under this section shall include the following ele-  
18 ments:

19 “(1) BASIC CARE COORDINATION SERVICES.—

20 “(A) IN GENERAL.—Subject to the cost-ef-  
21 fectiveness criteria specified in subsection  
22 (b)(1), except as otherwise provided in this sec-  
23 tion, enrolled individuals shall receive services  
24 described in section 1905(t)(1) and may receive

1 additional items and services as described in  
2 subparagraph (B).

3 “(B) ADDITIONAL BENEFITS.—The Sec-  
4 retary may specify additional benefits for which  
5 payment would not otherwise be made under  
6 this title that may be available to individuals  
7 enrolled in the program under this section (sub-  
8 ject to an assessment by the care coordinator of  
9 an individual’s circumstance and need for such  
10 benefits) in order to encourage enrollment in, or  
11 to improve the effectiveness of, such program.

12 “(2) CARE COORDINATION REQUIREMENT.—  
13 Notwithstanding any other provision of this title, the  
14 Secretary may provide that an individual enrolled in  
15 the program under this section may be entitled to  
16 payment under this title for any specified health  
17 care items or services only if the items or services  
18 have been furnished by the care coordinator, or co-  
19 ordinated through the care coordination services pro-  
20 gram. Under such provision, the Secretary shall pre-  
21 scribe exceptions for emergency medical services as  
22 described in section 1852(d)(3), and other excep-  
23 tions determined by the Secretary for the delivery of  
24 timely and needed care.

1           “(3) REDUCTION OR ELIMINATION OF COST  
2 SHARING.—Notwithstanding any other provision of  
3 law, subject to the cost-effectiveness criteria speci-  
4 fied in subsection (b)(1), the Secretary may provide  
5 for the reduction or elimination of beneficiary cost  
6 sharing (such as deductibles, copayments, and coin-  
7 surance) with respect to any of the items or services  
8 furnished under this title and may limit such reduc-  
9 tion or elimination to particular service areas.

10           “(e) CARE COORDINATORS.—

11           “(1) CONDITIONS OF PARTICIPATION.—In order  
12 to be qualified to furnish care coordination services  
13 under this section, an individual or entity shall—

14           “(A) be a health care professional or entity  
15           (which may include physicians, physician group  
16 practices, or other health care professionals or  
17 entities the Secretary may find appropriate)  
18 meeting such conditions as the Secretary may  
19 specify;

20           “(B) have entered into a care coordination  
21 agreement; and

22           “(C) meet such criteria as the Secretary  
23 may establish (which may include experience in  
24 the provision of care coordination or primary  
25 care physician’s services).

1 “(2) AGREEMENT TERM; PAYMENT.—

2 “(A) DURATION AND RENEWAL.—A care  
3 coordination agreement under this subsection  
4 shall be for one year and may be renewed if the  
5 Secretary is satisfied that the care coordinator  
6 continues to meet the conditions of participa-  
7 tion specified in paragraph (1).

8 “(B) PAYMENT FOR SERVICES.—The Sec-  
9 retary may negotiate or otherwise establish pay-  
10 ment terms and rates for services described in  
11 subsection (d)(1).

12 “(C) TERMS.—In addition to such other  
13 terms as the Secretary may require, an agree-  
14 ment under this section shall include the terms  
15 specified in subparagraphs (A) through (C) of  
16 section 1905(t)(3).”.

17 (b) COVERAGE OF CARE COORDINATION SERVICES  
18 AS A PART B MEDICAL SERVICE.—

19 (1) IN GENERAL.—Section 1861(s) (42 U.S.C.  
20 1395x(s)) is amended—

21 (A) in the second sentence, by redesignig-  
22 nating paragraphs (16) and (17) as clauses (i)  
23 and (ii); and

24 (B) in the first sentence—

1 (i) by striking “and” at the end of  
2 paragraph (14);

3 (ii) by striking the period at the end  
4 of paragraph (15) and inserting “; and”;  
5 and

6 (iii) by adding after paragraph (15)  
7 the following new paragraph:

8 “(16) care coordination services furnished in  
9 accordance with section 1866C.”.

10 (2) CONFORMING AMENDMENTS.—Sections  
11 1864(a) 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) of  
12 such Act (42 U.S.C. 1395aa(a), 1396a(a)(9)(C), and  
13 1396n(a)(1)(B)(ii)(I)) are each amended by striking  
14 “paragraphs (16) and (17)” each place it appears  
15 and inserting “clauses (i) and (ii) of the second sen-  
16 tence”.

17 (3) PART B COINSURANCE AND DEDUCTIBLE  
18 NOT APPLICABLE TO CARE COORDINATION SERV-  
19 ICES.—

20 (A) COINSURANCE.—Section 1833(a)(1)  
21 (42 U.S.C. 1395l(a)(1)), as amended by sec-  
22 tions 105 and 223 of the Medicare, Medicaid,  
23 and SCHIP Benefits Improvement and Protec-  
24 tion Act of 2000, as enacted into law by section  
25 1(a)(6) of Public Law 106–554, is amended—

1 (i) by striking “and” at the end of  
2 subparagraph (T); and

3 (ii) by inserting before the final semi-  
4 colon “, and (V) with respect to care co-  
5 ordination services described in section  
6 1861(s)(16), the amounts paid shall be  
7 100 percent of the payment amount estab-  
8 lished under section 1866C”.

9 (B) DEDUCTIBLE.—Section 1833(b) (42  
10 U.S.C. 1395l(b)) is amended—

11 (i) by striking “and” at the end of  
12 paragraph (5); and

13 (ii) by inserting before the final period  
14 “, and (7) such deductible shall not apply  
15 with respect to care coordination services  
16 (as described in section 1861(s)(16))”.

17 **SEC. 112. ESTABLISHMENT OF MEDICARE HOME HEALTH**  
18 **CARE CASE MANAGERS FOR LONG TERM**  
19 **HOME HEALTH SPELLS OF ILLNESS.**

20 (a) REQUIREMENT FOR CASE MANAGEMENT PLAN  
21 FOR BENEFICIARIES REQUIRING EXTENDED HOME  
22 HEALTH SERVICES.—

23 (1) IN GENERAL.—Section 1861(m) (42 U.S.C.  
24 1395x(m)) is amended, in the matter preceding  
25 paragraph (1), by inserting after “under a plan (for

1       furnishing such items and services to such indi-  
2       vidual) established and periodically reviewed by a  
3       physician” the following: “and, in the case of such  
4       services furnished (or likely to be required to be fur-  
5       nished) for an extended period (as defined by the  
6       Secretary in regulations), under a home health case  
7       management plan (as defined in subsection (ww)(2))  
8       established by a home health case manager (as de-  
9       fined in subsection (ww)(1)) in consultation with the  
10      physician and, if available, the family of the indi-  
11      vidual for an individual who is not participating in  
12      a case or disease management program under any  
13      other provision of this Act”.

14               (2) DEFINITIONS.—Section 1861 (42 U.S.C.  
15      1395x), as amended by sections 102 and 105 of the  
16      Medicare, Medicaid, and SCHIP Benefits Improve-  
17      ment and Protection Act of 2000, as enacted into  
18      law by section 1(a)(6) of Public Law 106–554, is  
19      amended by adding at the end the following new  
20      subsection:

21                       “Home Health Case Manager

22      “(ww)(1) The term ‘home health case manager’  
23      means a public agency or private organization (or a sub-  
24      division thereof) that—

1           “(A) develops, coordinates, and monitors the  
2 delivery of home health services by home health  
3 agencies to an individual;

4           “(B) has experience and expertise in the fur-  
5 nishing of home health services; and

6           “(C) meets such other standards as the Sec-  
7 retary finds necessary for the effective and efficient  
8 development and oversight of home health case man-  
9 agement plans and to ensure the health and safety  
10 of individuals furnished services under such a plan.

11          “(2) The term ‘home health case management plan’  
12 means a structured plan for the delivery of home health  
13 services that is developed by a home health case manager,  
14 after consultation with the physician and, if available, the  
15 family of the individual involved.

16          “(3) The term ‘home health case manager services’  
17 means the development, coordination, and monitoring of  
18 a home health case management plan for an individual  
19 furnished (or likely to be required to be furnished) home  
20 health services for an extended period (as defined by the  
21 Secretary in regulations under subsection (m)) and in-  
22 cludes the periodic review of such a plan.”.

23           (3) GUIDANCE ON INITIATION OF CASE MAN-  
24 AGER SERVICES.—The Secretary of Health and  
25 Human Services shall provide guidance on the proc-

1       ess or processes that may be used to identify Medi-  
2       care beneficiaries requiring home health services for  
3       extended periods and to develop home health case  
4       management plans on a timely basis.

5           (4) LIMITATION ON REFERRALS.—Section 1877  
6       of the Social Security Act (42 U.S.C. 1395nn) shall  
7       apply to a referral by a home health case manager  
8       to a home health agency in the same manner as  
9       such section applies to a referral by a physician to  
10       an entity described in section 1877(a)(2) of such  
11       Act.

12       (b) COVERAGE OF AND PAYMENT FOR HOME  
13       HEALTH CASE MANAGER SERVICES.—

14           (1) PART A.—

15           (A) COVERAGE.—Section 1812(a)(3) (42  
16       U.S.C. 1395d(a)(3)) is amended by inserting  
17       before the semicolon “, and home health case  
18       manager services (as defined in section  
19       1861(w)(3))”.

20           (B) ELIGIBILITY.—Section 1814(a)(2)(C)  
21       (42 U.S.C. 1395f(a)(2)(C)) is amended by in-  
22       serting “and, in the case of such services fur-  
23       nished (or likely to be required to be furnished)  
24       for an extended period (as defined by the Sec-  
25       retary under section 1861(m)), under a home

1 health case management plan that has been es-  
2 tablished and periodically reviewed by a home  
3 health case manager” after “is periodically re-  
4 viewed by a physician”.

5 (C) PAYMENT.—Section 1812 (42 U.S.C.  
6 1395d) is amended by adding at the end the  
7 following new subsection:

8 “(h)(1) Payment under this part for home health  
9 case manager services (as defined in section 1861(w)(3))  
10 shall be made pursuant to the fee schedule established by  
11 the Secretary under section 1834(n).

12 “(2) Payment may be made under this title for home  
13 health case manager services with respect to an individual  
14 only—

15 “(A) for the initial development of the home  
16 health case management plan for the individual, and

17 “(B) for the subsequent review and modifica-  
18 tion of such plan, as provided by the Secretary in  
19 regulations.”.

20 (2) PART B.—

21 (A) COVERAGE.—Section 1832(a)(2)(A)  
22 (42 U.S.C. 1395k(a)(2)(A)) is amended by in-  
23 serting before the semicolon “, and home health  
24 case manager services (as defined in section  
25 1861(w)(3))”.

1           (B) ELIGIBILITY.—Section 1835(a)(2) (42  
2 U.S.C. 1395n(a)(2)) is amended by inserting  
3 “and, in the case of such services furnished (or  
4 likely to be required to be furnished) for an ex-  
5 tended period (as defined by the Secretary  
6 under section 1861(m)), under a home health  
7 case management plan that has been estab-  
8 lished and periodically reviewed by a home  
9 health case manager” after “is periodically re-  
10 viewed by a physician”.

11           (C) PAYMENT.—Section 1833 (42 U.S.C.  
12 1395l) is amended—

13                   (i) in subsection (a)(2)—

14                           (I) by striking “and” at the end  
15 of subparagraph (F);

16                           (II) by adding “and” at the end  
17 of subparagraph (G); and

18                           (III) by adding after subpara-  
19 graph (G) the following new subpara-  
20 graph:

21                           “(H) subject to subsection (u), with re-  
22 spect to home health case manager services (as  
23 defined in section 1861(w)(3), the amount de-  
24 termined under the fee schedule established  
25 under section 1834(n);”, and

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

3 “(u) Payment may be made under this title for home  
4 health case manager services with respect to an individual  
5 only—

6 “(1) for the initial development of the home  
7 health case management plan for the individual, and

8 “(2) for the subsequent review and modification  
9 of such plan, as provided by the Secretary in regula-  
10 tions.”.

11 (3) ESTABLISHMENT OF FEE SCHEDULE.—Sec-  
12 tion 1834 (42 U.S.C. 1395m), as amended by sec-  
13 tion 223 of the Medicare, Medicaid, and SCHIP  
14 Benefits Improvement and Protection Act of 2000,  
15 as enacted into law by section 1(a)(6) of Public Law  
16 106–554, is amended by adding at the end the fol-  
17 lowing new section:

18 “(n) ESTABLISHMENT OF FEE SCHEDULE FOR  
19 HOME HEALTH CASE MANAGER SERVICES.—

20 “(1) IN GENERAL.—The Secretary shall estab-  
21 lish a fee schedule for payment for home health case  
22 manager services. Such schedule may provide for  
23 rates that differ for such services that comprise the  
24 establishment of a home health case management

1 plan and that comprise review and modification of  
2 such a plan.

3 “(2) CONSIDERATIONS.—In establishing such  
4 fee schedule, the Secretary shall consider appro-  
5 priate regional and operational differences and ad-  
6 justments to payment rates to account for inflation  
7 and other relevant factors.

8 “(3) CONSULTATION.—In establishing the fee  
9 schedule for home health case manager services  
10 under this subsection, the Secretary shall consult  
11 with appropriate organizations representing individ-  
12 uals and entities who furnish referral services for  
13 home health services and share with such organiza-  
14 tions relevant data in establishing such schedule.

15 “(4) ALTERNATIVE PAYMENT UNDER COMPETI-  
16 TIVE BIDDING.—

17 “(A) IN GENERAL.—Notwithstanding the  
18 preceding provisions of this subsection, the Sec-  
19 retary may, by region, use a competitive process  
20 to contract with home health case managers for  
21 furnishing home health case manager services.

22 “(B) PAYMENT.—Payment under this  
23 paragraph shall be made on the basis of nego-  
24 tiated all-inclusive rates. The amount of pay-  
25 ment made by the Secretary to a home health

1 case manager for home health case manager  
2 services under this title for services covered  
3 under a contract shall be less than the aggregate  
4 amount of the payments that the Secretary  
5 would have otherwise made for the services.

6 “(C) CONTRACT PERIOD.—A contract period  
7 shall be three years (subject to renewal), as  
8 long as the entity continues to meet quality and  
9 other contractual standards.”.

10 (c) EFFECTIVE DATE.—The amendments made by  
11 this section apply with respect to home health services furnished  
12 on or after October 1, 2004.

13 **SEC. 113. ADDITIONAL PAYMENT AMOUNT TO RURAL PROVIDERS OF SERVICES WHO FURNISH PREVENTIVE AND CASE MANAGER SERVICES.**

16 (a) AUTHORITY TO PROVIDE ADDITIONAL PAYMENT  
17 FOR RURAL CASE MANAGER SERVICES.—

18 (1) FINDINGS.—The Congress finds as follows:

19 (A) Medicare beneficiaries who live in rural  
20 and frontier areas receive fewer preventive care  
21 services.

22 (B) Medicare+Choice plans that offer preventive care services and other additional benefits are not likely to be established in rural or  
23 frontier areas.  
24  
25

1           (C) Long travel distances and times create  
2           special problems for providers of services and  
3           physicians to follow up on courses of treatment  
4           for medicare beneficiaries residing in rural  
5           areas who require additional case management  
6           and other services.

7           (2) AUTHORITY.—In the case of a provider of  
8           services or a physician that furnishes services to  
9           Medicare beneficiaries in a rural area, the Secretary  
10          of Health and Human Services may provide for an  
11          additional payment under the Medicare Program for  
12          rural case manager services furnished by such pro-  
13          vider or physician to Medicare beneficiaries.

14          (b) REQUIREMENT FOR RURAL CASE MANAGEMENT  
15          PLAN.—No payment may be made under subsection (a)  
16          for rural case manager services furnished to a Medicare  
17          beneficiary unless such provider or physician establishes,  
18          and periodically reviews, a rural case management plan  
19          for furnishing preventive services and items and services  
20          for the treatment of the illness or injury of the Medicare  
21          beneficiary. The Secretary shall establish such standards  
22          as the Secretary finds necessary for the effective and effi-  
23          cient development and oversight of rural case manager  
24          services and rural case management plans to ensure the

1 health and safety of Medicare beneficiaries furnished serv-  
2 ices under such a plan.

3 (c) PAYMENT.—

4 (1) IN GENERAL.—Payment may be made  
5 under this section for rural case manager services  
6 with respect to a Medicare beneficiary only—

7 (A) for the initial development of the rural  
8 case management plan for the individual, and

9 (B) for the subsequent review and modi-  
10 fication of such plan, as provided by the Sec-  
11 retary in regulations.

12 (2) PAYMENT UNDER FEE SCHEDULE.—Pay-  
13 ment under this section for rural case manager serv-  
14 ices shall be made pursuant to the fee schedule es-  
15 tablished by the Secretary.

16 (3) ESTABLISHMENT OF FEE SCHEDULE.—

17 (A) IN GENERAL.—The Secretary shall es-  
18 tablish a fee schedule for payment for rural  
19 case manager services. Such schedule may pro-  
20 vide for rates that differ for such services that  
21 comprise the establishment of a rural case man-  
22 agement plan and that comprise review and  
23 modification of such a plan.

24 (B) CONSIDERATIONS.—In establishing  
25 such fee schedule, the Secretary shall consider

1 appropriate regional and operational differences  
2 and adjustments to payment rates to account  
3 for travel and transportation of the provider  
4 and beneficiary, inflation, and other relevant  
5 factors.

6 (C) CONSULTATION.—In establishing the  
7 fee schedule for rural case manager services  
8 under this subsection, the Secretary shall con-  
9 sult with appropriate organizations representing  
10 individuals and entities who furnish referral  
11 services in rural areas for health care items and  
12 services furnished and share with such organi-  
13 zations relevant data in establishing such sched-  
14 ule.

15 (d) GUIDANCE ON INITIATION OF CASE MANAGER  
16 SERVICES.—The Secretary of Health and Human Services  
17 shall provide guidance on the process or processes that  
18 may be used to develop rural case management plans on  
19 a timely basis.

20 (e) LIMITATION ON REFERRALS.—Section 1877 of  
21 the Social Security Act (42 U.S.C. 1395nn) shall apply  
22 to a referral by a rural case manager to a rural agency  
23 in the same manner as such section applies to a referral  
24 by a physician to an entity described in section 1877(a)(2)  
25 of such Act.

1 (f) DEFINITIONS.—In this section:

2 (1) The term “rural case manager services”  
3 means the development, coordination, and moni-  
4 toring of a rural case management plan for an indi-  
5 vidual furnished items and services for the preven-  
6 tion of illness and for the diagnosis and treatment  
7 of an illness or injury, and includes such home visits  
8 as are medically necessary and the periodic review of  
9 such a plan.

10 (2) The term “rural case management plan”  
11 means a structured plan for the delivery of items  
12 and services that is developed by a rural case man-  
13 ager, after consultation with the physician and, if  
14 available, the family of the individual involved.

15 (3) The term “provider of service” has the  
16 meaning given that term in section 1861(u) of the  
17 Social Security Act (42 U.S.C. 1395x(u)).

18 (4) The term “physician” has the meaning  
19 given that term in section 1861(r) of such Act (42  
20 U.S.C. 1395x(r)).

21 (5) The term “rural area” means an area des-  
22 ignated as a rural area under section 1886(d)(2)(D)  
23 of such Act (42 U.S.C. 1395ww(d)(2)(D)).

24 (6) The term “Medicare beneficiary” means an  
25 individual entitled to benefits under part A of title

1 XVIII of such Act, or enrolled under part B of such  
2 title, or both.

3 (7) The term “Medicare Program” means the  
4 insurance program established under title XVIII of  
5 the Social Security Act.

6 (g) EFFECTIVE DATE.—This section shall take effect  
7 on January 1, 2004, and apply with respect to rural serv-  
8 ices furnished on or after January 1, 2004.

9 **SEC. 114. DISEASE MANAGEMENT SERVICES.**

10 (a) PROGRAM AUTHORIZED.—Title XVIII (42 U.S.C.  
11 1395 et seq.), as previously amended by this subtitle, is  
12 further amended by adding after section 1866C the fol-  
13 lowing new section:

14 **“SEC. 1866D. DISEASE MANAGEMENT SERVICES.**

15 “(a) IN GENERAL.—

16 “(1) PURPOSE.—The purpose of this section is  
17 to assist beneficiaries with a chronic or advanced ill-  
18 ness or injury to obtain the appropriate level and  
19 mix of follow-up care.

20 “(2) PROGRAM AUTHORITY.—Beginning in  
21 2004, the Secretary may implement a program in  
22 accordance with the provisions of this section under  
23 which certain eligible individuals may, in appropriate  
24 circumstances, receive disease management services  
25 for chronic and advanced illness from entities des-

1       ignated by the Secretary with respect to diagnoses  
2       that the Secretary determines are amenable to such  
3       management.

4               “(3) ADMINISTRATION BY CONTRACT.—Except  
5       as otherwise specifically provided, the Secretary may  
6       administer the program under this section in accord-  
7       ance with section 1866F.

8               “(b) INDIVIDUALS WHO MAY RECEIVE DISEASE  
9       MANAGEMENT SERVICES.—No individual shall be eligible  
10      for enrollment in a disease management program under  
11      this section unless the Secretary finds the following with  
12      respect to the individual:

13               “(1) DIAGNOSIS AND RELATED CHARACTERIS-  
14      TICS.—

15               “(A) IN GENERAL.—The individual has  
16      been diagnosed with congestive heart failure,  
17      chronic obstructive pulmonary disease, diabetes,  
18      schizophrenia, or any other diagnosis (physical  
19      or mental), if the Secretary has determined  
20      with respect to such diagnoses that there is evi-  
21      dence that the provision of disease management  
22      services, over clinically relevant time-periods, to  
23      cohorts of individuals with such diagnoses can  
24      reasonably be expected to improve processes or  
25      outcomes of health care for the Medicare popu-

1           lation and to reduce aggregate costs to the pro-  
2           grams under this title.

3           “(B) ADDITIONAL FACTORS.—Where re-  
4           quired by the Secretary, the individual also has  
5           certain clinical characteristics or conditions, ex-  
6           hibits certain patterns of utilization, or mani-  
7           fests other factors indicating the need for and  
8           potential effectiveness of disease management.

9           “(2) REFERRAL BY QUALIFIED INDIVIDUAL OR  
10          ENTITY.—The individual has been referred for con-  
11          sideration for such services by an individual or entity  
12          furnishing health care items or services, or by an en-  
13          tity administering benefits under this title.

14          “(c) PROCEDURES TO FACILITATE ENROLLMENT.—  
15          The Secretary shall develop and implement procedures de-  
16          signed to facilitate enrollment of eligible individuals in the  
17          program under this section.

18          “(d) ENROLLMENT OF INDIVIDUALS WITH DISEASE  
19          MANAGEMENT ORGANIZATIONS.—

20                 “(1) EFFECTIVE DATE AND DURATION.—En-  
21                 rollment of an individual in the program under this  
22                 section shall remain in effect for one month (or such  
23                 longer period as the Secretary may specify), and  
24                 shall be automatically renewed for additional peri-  
25                 ods, unless terminated in accordance with such pro-

1 cedures as the Secretary shall establish by regula-  
2 tion.

3 “(2) LIMITATION ON REENROLLMENT.—The  
4 Secretary may establish limits on an individual’s eli-  
5 gibility to reenroll in the program under this section  
6 if the individual has disenrolled from the program  
7 more than once during a specified time period.

8 “(e) DISEASE MANAGEMENT REQUIREMENT.—Not-  
9 withstanding any other provision of this title, the Sec-  
10 retary may provide that an individual enrolled in the pro-  
11 gram under this section may be entitled to payment under  
12 this title for any specified health care items or services  
13 only if the items or services have been furnished by the  
14 disease management organization, or coordinated through  
15 the disease management services program. Under such  
16 provision, the Secretary shall prescribe exceptions for  
17 emergency medical services as described in section  
18 1852(d)(3), and other exceptions determined by the Sec-  
19 retary for the delivery of timely and needed care.

20 “(f) DISEASE MANAGEMENT SERVICES.—

21 “(1) IN GENERAL.—Subject to the cost-effec-  
22 tiveness criteria specified in subsection (b)(1), dis-  
23 ease management services provided to an individual  
24 under this section may include—

1           “(A) initial and periodic health screening  
2           and assessment;

3           “(B) management (including coordination  
4           with other providers) of, and referral for, med-  
5           ical and other health services related to the  
6           managed diagnosis (which may include referral  
7           for provision of such services by the disease  
8           management organization);

9           “(C) monitoring and control of medications  
10          (including coordination with the entity man-  
11          aging benefits for the individual under part D);

12          “(D) patient education and counseling, in-  
13          cluding advanced illness counseling (as defined  
14          in subsection (j));

15          “(E) nursing or other health professional  
16          home visits, as appropriate;

17          “(F) providing access for consultations by  
18          telephone with physicians or other appropriate  
19          medical professionals, including 24-hour avail-  
20          ability for emergency consultations;

21          “(G) managing and facilitating the transi-  
22          tion to other care arrangements in preparation  
23          for termination of the disease management en-  
24          rollment; and

1           “(H) such other services for which pay-  
2           ment would not otherwise be made under this  
3           title as the Secretary shall determine to be ap-  
4           propriate.

5           “(2) VARIATIONS IN SERVICE PACKAGES.—The  
6           types and combinations of disease management serv-  
7           ices furnished under agreements under this section  
8           may vary (as permitted or required by the Sec-  
9           retary) according to the types of diagnoses, condi-  
10          tions, patient profiles being managed, expertise of  
11          the disease management organization, and other fac-  
12          tors the Secretary finds appropriate.

13          “(3) REDUCTION OR ELIMINATION OF COST  
14          SHARING.—Notwithstanding any other provision of  
15          law, subject to the cost-effectiveness criteria speci-  
16          fied in subsection (b)(1), the Secretary may provide  
17          for the reduction or elimination of beneficiary cost  
18          sharing (such as deductibles, copayments, and coin-  
19          surance) with respect to any of the items or services  
20          furnished under this title (other than those fur-  
21          nished under a service package developed under  
22          paragraph (2)), and may limit such reduction or  
23          elimination to particular service areas.

24          “(g) AGREEMENTS WITH DISEASE MANAGEMENT  
25          ORGANIZATIONS.—

1           “(1) ENTITIES ELIGIBLE.—Entities qualified to  
2 enter into agreements with the Secretary for the  
3 provision of disease management services under this  
4 section include entities that have demonstrated the  
5 ability to meet the performance standards and other  
6 criteria established by the Secretary with respect  
7 to—

8           “(A) the management of each diagnosis  
9 and condition with respect to which the entity,  
10 if designated, would furnish disease manage-  
11 ment services under this section; and

12           “(B) the implementation of each disease  
13 management approach that the entity, if des-  
14 ignated, would implement under this section.

15           “(2) CONDITIONS OF PARTICIPATION.—In order  
16 to be eligible to provide disease management services  
17 under this section, an entity shall—

18           “(A) have in effect an agreement with the  
19 Secretary setting forth such obligations of the  
20 entity as a disease management organization  
21 under this section as the Secretary shall pre-  
22 scribe;

23           “(B) meet the standards established by the  
24 Secretary under subsection (h); and

1           “(C) meet such other conditions as the  
2           Secretary may establish.

3           “(3) SECRETARY’S OPTION FOR NONCOMPETI-  
4           TIVE DESIGNATION.—The Secretary may designate  
5           an entity to provide disease management services  
6           under this section without regard to the require-  
7           ments of section 5 of title 41, United States Code.

8           “(h) STANDARDS.—

9           “(1) QUALITY.—The Secretary shall establish  
10          standards for, and procedures for assessing, the  
11          quality of care provided by disease management or-  
12          ganizations under this section, which shall include—

13               “(A) performance standards with respect  
14               to the processes or outcomes of health care or  
15               the health status of enrolled individuals, includ-  
16               ing procedures for establishing a baseline and  
17               measuring changes in health care processes or  
18               health outcomes with respect to managed dis-  
19               eases or health conditions;

20               “(B) such other quality standards, includ-  
21               ing patient satisfaction, as the Secretary may  
22               find appropriate; and

23               “(C) a requirement that the organization  
24               meet such licensure and other accreditation

1 standards as the Secretary may find appro-  
2 priate.

3 “(2) COST MANAGEMENT.—The Secretary shall  
4 establish a performance standard with respect to  
5 management or reduction of the aggregate costs of  
6 health care items and services related to managed  
7 health conditions furnished to enrolled individuals,  
8 including procedures for establishing a baseline and  
9 measuring changes in costs for such items and serv-  
10 ices.

11 “(i) PAYMENT.—

12 “(1) TERMS OF PAYMENT.—The Secretary may  
13 negotiate or otherwise establish payment terms and  
14 rates for service packages developed under sub-  
15 section (f)(2).

16 “(2) WITHHOLDING OF PAYMENTS.—An agree-  
17 ment under subsection (g) may provide that the Sec-  
18 retary may withhold up to ten percent of the amount  
19 due a disease management organization under the  
20 basis of payment established under paragraph (1)  
21 until such time as such organization meets a stand-  
22 ard or standards specified in such agreement.

23 “(j) ADVANCED ILLNESS COUNSELING DEFINED.—

24 For purposes of this section, the term ‘advanced illness  
25 counseling’ means counseling to individuals (and a spouse

1 or principal caregiver of such an individual) with ad-  
2 vanced, chronic, or terminal illnesses about treatment op-  
3 tions available from various providers, including (where  
4 appropriate) hospice programs.”.

5 (b) COVERAGE OF DISEASE MANAGEMENT SERVICES  
6 AS A PART B MEDICAL SERVICE.—

7 (1) IN GENERAL.—Section 1861(s), as amended  
8 by section 111, is further amended—

9 (A) by striking “and” at the end of para-  
10 graph (15);

11 (B) by striking the period at the end of  
12 paragraph (16) and inserting “and”; and

13 (C) by adding after paragraph (16) the fol-  
14 lowing new paragraph:

15 “(17) disease management services furnished in  
16 accordance with section 1866D.”.

17 (2) PART B COINSURANCE AND DEDUCTIBLE  
18 NOT APPLICABLE TO DISEASE MANAGEMENT SERV-  
19 ICES.—

20 (A) COINSURANCE.—Section  
21 1833(a)(1)(T) (42 U.S.C. 1395l(a)(1)(T)), as  
22 added by section 111(b)(2)(A), is amended to  
23 read as follows: “(T) with respect to care co-  
24 ordination services described in section  
25 1861(s)(16) and disease management services

1 described in section 1861(s)(17), the amounts  
 2 paid shall be 100 percent of the payment  
 3 amounts established under sections 1866C and  
 4 1866D, respectively;”.

5 (B) DEDUCTIBLE.—Section 1833(b) (42  
 6 U.S.C. 1395l(b)), as amended by section  
 7 111(b)(2)(A), is further amended by inserting  
 8 before the final period “or to disease manage-  
 9 ment services (as described in section  
 10 1861(s)(17))”.

11 **SEC. 115. PROVIDER AND PHYSICIAN COLLABORATION TO**  
 12 **FURNISH A BUNDLED, COORDINATED SET OF**  
 13 **SERVICES.**

14 Title XVIII (42 U.S.C. 1395 et seq.), as previously  
 15 amended by this subtitle, is further amended by adding  
 16 after section 1866D the following new section:

17 **“SEC. 1866E. PROVIDER AND PHYSICIAN COLLABORATIONS.**

18 “(a) IN GENERAL.—

19 “(1) PURPOSE.—The purpose of this section is  
 20 to assist a beneficiary with a complex or sophisti-  
 21 cated illness or injury to obtain a coordinated, high  
 22 quality bundled package of items and services under  
 23 this title.

24 “(2) PROGRAM AUTHORITY.—Beginning in  
 25 2004, the Secretary may enter into agreements with

1 specific quality providers, suppliers, or other individ-  
2 uals or entities for the furnishing of bundled items  
3 and services in selected sites of service or related to  
4 specific medical conditions or needs for an episode of  
5 care. The services may include any items or services  
6 covered under this title that the Secretary deter-  
7 mines to be appropriate, including post-hospital  
8 services.

9 “(3) ADMINISTRATION BY CONTRACT.—Except  
10 as otherwise specifically provided, the Secretary may  
11 administer the program under this section in accord-  
12 ance with section 1866F.

13 “(b) BASIS OF SELECTION.—The Secretary shall se-  
14 lect entities for agreements under this section on the basis  
15 of ability to provide services more efficiently, to provide  
16 improved coordination of care, to offer additional benefits,  
17 and to meet quality and other standards and beneficiary  
18 protections and other requirements set by the Secretary.

19 “(c) PAYMENT.—Payment under this section shall be  
20 made on the basis of all-inclusive rates. The all-inclusive  
21 rate paid to an entity for bundled items and services fur-  
22 nished during an episode of care under this section shall  
23 be less than the estimated amount of the payments that  
24 the Secretary would have otherwise made for the items  
25 and services.

1       “(d) TERM OF AGREEMENT.—Agreements under this  
2 section shall be for periods that the Secretary may deter-  
3 mine.

4       “(e) INCENTIVES TO BENEFICIARIES FOR USE OF  
5 CONTRACTING ENTITIES.—Notwithstanding any other  
6 provision of law, entities under a contract under this sec-  
7 tion may furnish additional services or waive part or all  
8 beneficiary cost sharing (such as deductibles, copayments,  
9 and coinsurance) with respect to any of the items or serv-  
10 ices furnished under this section.

11       “(f) BENEFICIARY ELECTION.—An individual enti-  
12 tled to benefits under this title who elects to obtain serv-  
13 ices under an agreement under this section shall agree to  
14 receive under such agreement all benefits related to the  
15 episode of care covered by the agreement (subject to such  
16 exceptions for emergency services and as the Secretary  
17 otherwise may specify).”.

18 **SEC. 116. DEMONSTRATION PROJECTS TO INCREASE QUAL-**  
19 **ITY OF INFORMATION PROVIDED TO MEDI-**  
20 **CARE BENEFICIARIES WITH RESPECT TO**  
21 **TREATMENT OPTIONS.**

22       (a) ESTABLISHMENT OF PROJECT.—

23           (1) IN GENERAL.—Not later than January 1,  
24 2003, the Secretary of Health and Human Services  
25 shall establish demonstration projects (in this sec-

1       tion referred to as the “projects”) under which the  
2       Secretary shall furnish to providers of services and  
3       physicians participating in the Medicare Program  
4       under title XVIII of the Social Security Act informa-  
5       tional videotapes (as described in subsection (b)) to  
6       present to a Medicare beneficiary diagnosed with a  
7       particular disease, injury, or advanced illness (as  
8       identified by the Secretary pursuant to subsection  
9       (c)) before the beneficiary elects a course of treat-  
10      ment for that disease, injury, or advanced illness.  
11      The Secretary shall furnish such informational vid-  
12      eotapes at no cost to such providers and physicians.

13           (2) PROJECT AREAS.—The projects shall be  
14      conducted in five separate counties of which 3 shall  
15      be in urban areas and 2 shall be in rural areas.

16      (b) INFORMATIONAL VIDEOTAPE DESCRIBED.—

17           (1) IN GENERAL.—The Institute of Medicine, in  
18      consultation with the National Institutes of Health  
19      and other medical experts (as determined by the  
20      Secretary), shall develop a videotape presentation to  
21      provide a Medicare beneficiary diagnosed as having  
22      the disease, injury, or advanced illness identified  
23      under subsection (c) with the following information:

24           (A) A description of the disease, injury, or  
25      advanced illness.

1           (B) The possible courses of treatment for  
2           the disease, injury, or advanced illness.

3           (C) The likely consequences of each such  
4           course of treatment or of the decision not to  
5           pursue any course of treatment.

6           (2) CONCLUDING STATEMENT.—Any such vid-  
7           eotape presentation shall conclude with a statement  
8           that the Medicare beneficiary may elect any course  
9           of treatment or not to pursue any course of treat-  
10          ment, that the Medicare beneficiary should consult  
11          with a physician, and that the Medicare beneficiary  
12          may seek a referral to a physician who furnishes  
13          services consisting of the course of treatment that  
14          the beneficiary elects.

15          (3) UPDATING OF VIDEOTAPE.—Any such vid-  
16          eotape presentation shall be updated to reflect new  
17          findings based on the best scientific evidence avail-  
18          able, as determined by the Institute of Medicine, in  
19          consultation with the National Institutes of Health  
20          and such other medical experts, about the disease,  
21          injury, or advanced illness, and various courses of  
22          treatment.

23          (c) SELECTION OF DISEASE, INJURY, OR ADVANCED  
24          ILLNESS.—

1           (1) IN GENERAL.—For purposes of selecting a  
2           particular disease, injury, or advanced illness for  
3           which an informational videotape shall be provided  
4           under the projects, the Secretary shall identify dis-  
5           eases, injuries, or advanced illnesses for which there  
6           is a wide variation in treatment of that disease, in-  
7           jury, or advanced illness throughout the United  
8           States.

9           (2) MANDATORY DESIGNATION OF PROSTATE  
10          ENLARGEMENT FOR ONE PROJECT.—The disease, in-  
11          jury, or advanced illness for which an informational  
12          videotape is provided in one of the projects con-  
13          ducted under this section shall be benign and malign-  
14          nant prostate enlargement.

15          (d) PAYMENT.—(1) The Secretary shall establish a  
16          payment amount to be made to a provider of services or  
17          a physician under title XVIII of the Social Security Act  
18          to reflect services consisting of the presentation of an in-  
19          formational videotape to and consultation with a Medicare  
20          beneficiary after such presentation.

21          (2) For purposes of the payment amount under para-  
22          graph (1), no payment may be made for the purchase or  
23          rental of equipment or office space for purposes of making  
24          such presentation.

1       (e) WAIVER AUTHORITY.—The Secretary may waive  
2 such requirements of title XVIII of such Act as may be  
3 necessary for the purposes of carrying out the project.

4       (f) REPORTS.—Not later than June 1, 2006, the Sec-  
5 retary shall submit to Congress a report on the following  
6 matters:

7           (1) A description of courses of treatment for  
8 the diseases, injuries, or advanced illnesses identified  
9 under subsection (c) selected by Medicare bene-  
10 ficiaries during the three year period ending on De-  
11 cember 31, 2005.

12           (2) A comparison between courses of treatment  
13 described in paragraph (1) and courses of treatment  
14 selected by the Medicare beneficiaries participating  
15 in the project.

16           (3) An analysis of the effect on costs to the  
17 Medicare program due to any change in selection of  
18 courses of treatment.

19       (g) DURATION.—A demonstration project under this  
20 section shall be conducted for a 3-year period.

1 **SEC. 117. ADMINISTRATION OF CERTAIN PRIVATE SECTOR**  
2 **PURCHASING AND QUALITY IMPROVEMENT**  
3 **PROGRAMS.**

4 Title XVIII (42 U.S.C. 1395 et seq.), as amended  
5 by this subtitle, is further amended by adding after section  
6 1866E the following new section:

7 **“SEC. 1866F. GENERAL PROVISIONS FOR ADMINISTRATION**  
8 **OF CERTAIN PRIVATE SECTOR PURCHASING**  
9 **AND QUALITY IMPROVEMENT PROGRAMS.**

10 “(a) IN GENERAL.—Except as otherwise specifically  
11 provided, the provisions of this section apply to the pro-  
12 grams under the following provisions of this title:

13 “(1) section 1866C (care coordination services);

14 “(2) section 1866D (disease management serv-  
15 ices);

16 “(3) section 1866E (provider and physician col-  
17 laborations);

18 “(4) section 1866G (competitive acquisition of  
19 items and services);

20 “(5) section 1866H (preferred participants);  
21 and

22 “(6) section 1866I (program to improve out-  
23 comes and reduce patient morbidity and mortality).

24 “(b) PROVISIONS GENERALLY APPLICABLE TO DES-  
25 IGNATED PROGRAMS.—The following provisions apply to

1 programs specified in subsection (a), except as otherwise  
2 specifically provided:

3 “(1) BENEFICIARY ELIGIBILITY.—Except as  
4 otherwise provided by the Secretary, an individual  
5 shall only be eligible to receive benefits under a pro-  
6 gram specified in subsection (a) if such individual—

7 “(A) is enrolled in under the program  
8 under part B;

9 “(B) is not enrolled in a Medicare+Choice  
10 plan under part C, an eligible organization  
11 under a contract under section 1876 (or a simi-  
12 lar organization operating under a demonstra-  
13 tion project authority), an organization with an  
14 agreement under section 1833(a)(1)(A), or a  
15 PACE program under section 1894; and

16 “(C) in the case of the programs specified  
17 in paragraphs (1), (2), (4), and (6) of sub-  
18 section (a), is entitled to benefits under part A.

19 “(2) SECRETARY’S DISCRETION AS TO SCOPE  
20 OF PROGRAM.—The Secretary may limit the imple-  
21 mentation of a program specified in subsection (a)  
22 to—

23 “(A) a geographic area (or areas) that the  
24 Secretary designates for purposes of the pro-

1           gram, based upon such criteria as the Secretary  
2           finds appropriate;

3           “(B) a subgroup (or subgroups) of bene-  
4           ficiaries or individuals and entities furnishing  
5           items or services (otherwise eligible to partici-  
6           pate in the program), selected on the basis of  
7           the number of such participants that the Sec-  
8           retary finds consistent with the effective and ef-  
9           ficient implementation of the program;

10           “(C) an element (or elements) of the pro-  
11           gram that the Secretary determines to be suit-  
12           able for implementation; or

13           “(D) any combination of any of the limits  
14           described in subparagraphs (A) through (C).

15           “(3) VOLUNTARY RECEIPT OF ITEMS AND  
16           SERVICES.—Except as provided in the authority for  
17           the program specified in subsection (a)(3), items and  
18           services shall be furnished to an individual under the  
19           programs specified in subsection (a) only at the indi-  
20           vidual’s election.

21           “(4) AGREEMENTS.—The Secretary is author-  
22           ized to enter into agreements with individuals and  
23           entities to furnish health care items and services to  
24           beneficiaries under the programs specified in sub-  
25           section (a).

1           “(5) PROGRAM STANDARDS AND CRITERIA.—

2           The Secretary shall establish performance standards  
3           for the programs specified in subsection (a) includ-  
4           ing, as applicable, standards for quality of health  
5           care items and services, cost-effectiveness, bene-  
6           ficiary satisfaction, and such other factors as the  
7           Secretary finds appropriate. The eligibility of indi-  
8           viduals or entities for the initial award, continuation,  
9           and renewal of agreements to provide health care  
10          items and services under the program shall be condi-  
11          tioned, at a minimum, on performance that meets or  
12          exceeds such standards.

13           “(6) ADMINISTRATIVE REVIEW OF ADVERSE  
14          DECISION.—

15           “(A) DECISIONS AFFECTING INDIVIDUALS  
16          AND ENTITIES FURNISHING SERVICES UNDER  
17          PROGRAMS.—An individual or entity furnishing  
18          services under a program specified in subsection  
19          (a) shall be entitled to a review by the program  
20          administrator (or, if the Secretary has not con-  
21          tracted with a program administrator, by the  
22          Secretary) of a decision not to enter into, or to  
23          terminate, or not to renew, an agreement with  
24          the individual or entity to provide health care  
25          items or services under such program.

1           “(B) DECISIONS AFFECTING BENE-  
2           FICIARIES UNDER CARE COORDINATION SERV-  
3           ICES OR DISEASE MANAGEMENT SERVICES PRO-  
4           GRAMS.—

5           “(i) DETERMINATION OF INELIGI-  
6           BILITY.—An individual shall be entitled to  
7           a review by the program administrator (or,  
8           if the Secretary has not contracted with a  
9           program administrator, by the Secretary)  
10          of a determination that the individual does  
11          not meet the criteria for eligibility to par-  
12          ticipate in a program specified in para-  
13          graph (1) or (2) of subsection (a).

14          “(ii) DENIAL OF PAYMENT FOR ITEMS  
15          OR SERVICES.—A beneficiary shall be enti-  
16          tled to a reconsideration or appeal of a de-  
17          nial of payment under section 1866C(d)(2)  
18          or 1866D(e) in accordance with the provi-  
19          sions of section 1869, as if such section  
20          applied to this clause.

21          “(7) SECRETARY’S REVIEW OF MARKETING MA-  
22          TERIALS.—An agreement with an individual or enti-  
23          ty furnishing services under a program specified in  
24          subsection (a) shall require the individual or entity  
25          to guarantee that it will not distribute materials

1 marketing items or services under such program  
2 without the Secretary's prior review and approval;

3 “(8) PAYMENT IN FULL.—

4 “(A) IN GENERAL.—Except as provided in  
5 subparagraph (B), an individual or entity re-  
6 ceiving payment from the Secretary under a  
7 contract or agreement under a program speci-  
8 fied in subsection (a) shall agree to accept such  
9 payment as payment in full, and such payment  
10 shall be in lieu of any payments to which the  
11 individual or entity would otherwise be entitled  
12 under this title.

13 “(B) COLLECTION OF DEDUCTIBLES AND  
14 COINSURANCE.—Such individual or entity may  
15 collect any applicable deductible or coinsurance  
16 amount from a beneficiary.

17 “(c) CONTRACTS FOR PROGRAM ADMINISTRATION.—

18 “(1) IN GENERAL.—The Secretary may admin-  
19 ister a program specified in subsection (a) through  
20 a contract with a program administrator in accord-  
21 ance with the provisions of this subsection.

22 “(2) SCOPE OF PROGRAM ADMINISTRATOR CON-  
23 TRACTS.—A contract under this subsection may, at  
24 the Secretary's discretion, relate to administration of  
25 any or all of the programs specified in subsection

1 (a). The Secretary may enter into such contracts for  
2 a limited geographic area, or on a regional or na-  
3 tional basis.

4 “(3) ELIGIBLE CONTRACTORS.—The Secretary  
5 may contract for the administration of the program  
6 with—

7 “(A) an entity that, under a contract  
8 under section 1816 or 1842, determines the  
9 amount of and makes payments for health care  
10 items and services furnished under this title; or

11 “(B) any other entity with substantial ex-  
12 perience in managing the type of program con-  
13 cerned.

14 “(4) CONTRACT AWARD, DURATION, AND RE-  
15 NEWAL.—

16 “(A) IN GENERAL.—A contract under this  
17 subsection shall be for an initial term of up to  
18 three years, renewable for additional terms of  
19 up to three years.

20 “(B) NONCOMPETITIVE AWARD AND RE-  
21 NEWAL FOR ENTITIES ADMINISTERING PART A  
22 OR PART B PAYMENTS.—The Secretary may  
23 enter or renew a contract under this subsection  
24 with an entity described in paragraph (3)(A)

1 without regard to the requirements of section 5  
2 of title 41, United States Code.

3 “(5) APPLICABILITY OF FEDERAL ACQUISITION  
4 REGULATION.—The Federal Acquisition Regulation  
5 shall apply to program administration contracts  
6 under this subsection.

7 “(6) PERFORMANCE STANDARDS.—The Sec-  
8 retary shall establish performance standards for the  
9 program administrator including, as applicable,  
10 standards for the quality and cost-effectiveness of  
11 the program administered, and such other factors as  
12 the Secretary finds appropriate. The eligibility of en-  
13 tities for the initial award, continuation, and renewal  
14 of program administration contracts shall be condi-  
15 tioned, at a minimum, on performance that meets or  
16 exceeds such standards.

17 “(7) FUNCTIONS OF PROGRAM ADMINIS-  
18 TRATOR.—A program administrator shall perform  
19 any or all of the following functions, as specified by  
20 the Secretary:

21 “(A) AGREEMENTS WITH INDIVIDUALS OR  
22 ENTITIES FURNISHING HEALTH CARE ITEMS  
23 AND SERVICES.—Determine the qualifications  
24 of individuals or entities seeking to enter or  
25 renew agreements to provide services under a

1 program specified in subsection (a), and as ap-  
2 propriate enter or renew (or refuse to enter or  
3 renew) such agreements on behalf of the Sec-  
4 retary.

5 “(B) ESTABLISHMENT OF PAYMENT  
6 RATES.—Negotiate or otherwise establish, sub-  
7 ject to the Secretary’s approval, payment rates  
8 for covered health care items and services.

9 “(C) PAYMENT OF CLAIMS OR FEES.—Ad-  
10 minister payments for health care items or serv-  
11 ices furnished under any such program.

12 “(D) PAYMENT OF BONUSES.—Using such  
13 guidelines as the Secretary shall establish, and  
14 subject to the approval of the Secretary, make  
15 bonus payments as described in subsection  
16 (d)(2)(A)(ii) to individuals and entities fur-  
17 nishing items or services for which payment  
18 may be made under any such program.

19 “(E) LIST OF PROGRAM PARTICIPANTS.—  
20 Maintain and regularly update a list of individ-  
21 uals or entities with agreements to provide  
22 health care items and services under any such  
23 program, and ensure that such list, in electronic  
24 and hard copy formats, is readily available, as  
25 applicable, to—

1           “(i) individuals residing in the service  
2           area who are entitled to benefits under  
3           part A or enrolled in the program under  
4           part B;

5           “(ii) the entities responsible under  
6           sections 1816 and 1842 for administering  
7           payments for health care items and serv-  
8           ices furnished; and

9           “(iii) individuals and entities pro-  
10          viding health care items and services in the  
11          service area.

12          “(F) BENEFICIARY ENROLLMENT.—Deter-  
13          mine eligibility of individuals to enroll under a  
14          program specified in subsection (a) and provide  
15          enrollment-related services (but only if the Sec-  
16          retary finds that the program administrator has  
17          no conflict of interest caused by a financial re-  
18          lationship with any individual or entity fur-  
19          nishing items or services for which payment  
20          may be made under any such program, or any  
21          other conflict of interest with respect to such  
22          function).

23          “(G) OVERSIGHT.—Monitor the compli-  
24          ance of individuals and entities with agreements

1 under any such program with the conditions of  
2 participation.

3 “(H) ADMINISTRATIVE REVIEW.—Conduct  
4 reviews of adverse determinations specified in  
5 subparagraph (A) and in subsection (b)(6).

6 “(I) REVIEW OF MARKETING MATE-  
7 RIALS.—Conduct a review of marketing mate-  
8 rials proposed by an individual or entity fur-  
9 nishing services under any such program.

10 “(J) ADDITIONAL FUNCTIONS.—Perform  
11 such other functions as the Secretary may  
12 specify.

13 “(8) LIMITATION OF LIABILITY.—The provi-  
14 sions of section 1157(b) shall apply with respect to  
15 activities of contractors and their officers, employ-  
16 ees, and agents under a contract under this sub-  
17 section.

18 “(9) INFORMATION SHARING.—Notwithstanding  
19 section 1106 and section 552a of title 5, United  
20 States Code, the Secretary is authorized to disclose  
21 to an entity with a program administration contract  
22 under this subsection such information (including  
23 medical information) on individuals receiving health  
24 care items and services under the program as the  
25 entity may require to carry out its responsibilities

1 under the contract. Nothing in this paragraph shall  
2 be construed as exempting such an entity from  
3 maintaining the confidentiality of such information  
4 consistent with applicable privacy laws.

5 “(d) RULES APPLICABLE TO BOTH PROGRAM  
6 AGREEMENTS AND PROGRAM ADMINISTRATION CON-  
7 TRACTS.—

8 “(1) RECORDS, REPORTS, AND AUDITS.—The  
9 Secretary is authorized to require individuals and  
10 entities with agreements to provide health care items  
11 or services under programs specified under sub-  
12 section (a), and entities with program administration  
13 contracts under subsection (c), to maintain adequate  
14 records, to afford the Secretary access to such  
15 records (including for audit purposes), and to fur-  
16 nish such reports and other materials (including au-  
17 dited financial statements and performance data) as  
18 the Secretary may require for purposes of implemen-  
19 tation, oversight, and evaluation of such program  
20 and of individuals’ and entities’ effectiveness in per-  
21 formance of such agreements or contracts.

22 “(2) BONUSSES.—Notwithstanding any other  
23 provision of law, but subject to subparagraph  
24 (B)(ii), the Secretary may make bonus payments  
25 under a program specified in subsection (a) from the

1 Health Insurance and Supplementary Medical Insur-  
2 ance Trust Funds in amounts that do not exceed 50  
3 percent of the savings to such Trust Funds attrib-  
4 utable to such programs (or in the case of the pro-  
5 gram specified in subsection (a)(7), in amounts au-  
6 thorized under such program), in accordance with  
7 the following:

8 “(A) PAYMENTS TO PROGRAM ADMINIS-  
9 TRATORS.—The Secretary may make bonus  
10 payments under each program specified in sub-  
11 section (a) to program administrators.

12 “(B) PAYMENTS TO INDIVIDUALS AND EN-  
13 TITIES FURNISHING SERVICES.—

14 “(i) IN GENERAL.—Subject to clause  
15 (ii), the Secretary may make bonus pay-  
16 ments to individuals or entities furnishing  
17 items or services for which payment may  
18 be made under the programs specified in  
19 paragraphs (1), (2), and (5) of subsection  
20 (a), or may authorize a program adminis-  
21 trator to make such bonus payments in ac-  
22 cordance with such guidelines as the Sec-  
23 retary shall establish and subject to the  
24 Secretary’s approval.

1                   “(ii) LIMITATIONS.—The Secretary  
2                   may limit bonus payments under clause (i)  
3                   to particular service areas, types of individ-  
4                   uals or entities furnishing items or services  
5                   under a program, or kinds of items or  
6                   services, and may condition such payments  
7                   on the achievement of such standards re-  
8                   lated to efficiency, improvement in proc-  
9                   esses or outcomes of care, or such other  
10                  factors as the Secretary determines to be  
11                  appropriate.

12                  “(3) ANTIDISCRIMINATION LIMITATION.—

13                  “(A) IN GENERAL.—The Secretary shall  
14                  not enter into an agreement with an individual  
15                  or entity to provide health care items or serv-  
16                  ices under a program specified under subsection  
17                  (a), or with an entity to administer such a pro-  
18                  gram, unless such individual or entity guaran-  
19                  tees that it will not deny, limit, or condition the  
20                  coverage or provision of benefits under such  
21                  program, for individuals eligible to be enrolled  
22                  under such program, based on any health sta-  
23                  tus-related factor described in section  
24                  2702(a)(1) of the Public Health Service Act.

1           “(B) CONSTRUCTION.—Subparagraph (A)  
2           shall not be construed to prohibit such indi-  
3           vidual or entity from taking any action explic-  
4           itly authorized by the provisions of section  
5           1866C (care coordination services) or section  
6           1866D (disease management services).

7           “(e) LIMITATIONS ON JUDICIAL REVIEW.—The fol-  
8           lowing actions and determinations with respect to a pro-  
9           gram specified in subsection (a) shall not be subject to  
10          review by a judicial or administrative tribunal:

11           “(1) A limitation on the implementation of a  
12          program under subsection (b)(2).

13           “(2) The establishment of program participa-  
14          tion standards under subsection (b)(5); or the denial  
15          or termination of, or refusal to renew, an agreement  
16          with an individual or entity to provide health care  
17          items and services under the program.

18           “(3) The determination of a beneficiary’s eligi-  
19          bility under subsection (b)(6)(B).

20           “(4) The establishment of program administra-  
21          tion contract performance standards under sub-  
22          section (c)(6); or the refusal to renew a program ad-  
23          ministration contract; or the noncompetitive award  
24          or renewal of a program administration contract  
25          under subsection (c)(4)(B).

1           “(5) The establishment of payment rates,  
2 through negotiation or otherwise, under a program  
3 agreement or a program administration contract.

4           “(6) A determination with respect to a program  
5 (where specifically authorized by the program au-  
6 thority or by subsection (d)(2))—

7                   “(A) as to whether cost savings have been  
8 achieved, and the amount of savings;

9                   “(B) as to whether, to whom, and in what  
10 amounts bonuses will be paid; or

11                   “(C) as to whether to reduce or eliminate  
12 beneficiary cost-sharing.

13           “(f) APPLICATION LIMITED TO PARTS A AND B.—  
14 None of the provisions of this section or of the programs  
15 specified in subsection (a) shall apply to the programs  
16 under parts C and D.”.

17           (b) EXCEPTION TO LIMITS ON PHYSICIAN REFER-  
18 RALS.—Section 1877(b) (42 U.S.C. 1395nn(b)) is  
19 amended—

20                   (1) by redesignating paragraph (4) as para-  
21 graph (5); and

22                   (2) by inserting after paragraph (3) the fol-  
23 lowing new paragraph:

24                   “(4) PRIVATE SECTOR PURCHASING AND QUAL-  
25 ITY IMPROVEMENT TOOLS FOR ORIGINAL MEDI-

1 CARE.—In the case of a designated health service, if  
2 the designated health service is—

3 “(A) included in the services under section  
4 1866C, 1866D, 1866E, or 1866I; and

5 “(B) is provided by an individual or entity  
6 meeting such criteria related to quality assur-  
7 ance, financial disclosure, and other factors as  
8 the Secretary may find appropriate.”.

9 **SEC. 118. REPORTS TO CONGRESS ON PRIVATE SECTOR**  
10 **PURCHASING AND QUALITY IMPROVEMENT**  
11 **PROGRAMS.**

12 Not later than five years after the date of the enact-  
13 ment of the Medicare Modernization and Solvency Act of  
14 2001, and biennially thereafter for six years, the Secretary  
15 of Health and Human Services shall report to the Con-  
16 gress on the use of authorities enacted by sections 111,  
17 114, 115, 121, 122, and 123 of this Act. Each report shall  
18 address the impact of the use of those authorities on qual-  
19 ity, access, and expenditures under the programs under  
20 title XVIII of the Social Security Act.

1 **Subtitle C—Immediate and Long-**  
2 **term Payment Reforms for**  
3 **Medicare Fee for Service**

4 **SEC. 121. COMPETITIVE ACQUISITION OF ITEMS AND SERV-**  
5 **ICES.**

6 (a) PROGRAM AUTHORIZED.—Title XVIII (42 U.S.C.  
7 1395 et seq.), as previously amended by part B, is further  
8 amended by inserting after section 1866F the following  
9 new section:

10 **“SEC. 1866G. COMPETITIVE ACQUISITION OF ITEMS AND**  
11 **SERVICES.**

12 “(a) IN GENERAL.—

13 “(1) PROGRAM AUTHORITY.—The Secretary  
14 shall implement a program to purchase, on behalf of  
15 individuals enrolled under this part certain competi-  
16 tively priced quality items and services for which  
17 payment may be made under part B.

18 “(2) ADMINISTRATION BY CONTRACT.—Except  
19 as otherwise specifically provided, the Secretary may  
20 administer the program under this section in accord-  
21 ance with section 1866F.

22 “(b) ESTABLISHMENT OF COMPETITIVE ACQUI-  
23 SITION AREAS.—

24 “(1) IN GENERAL.—The Secretary shall estab-  
25 lish one or more competitive acquisition areas for

1 agreement award purposes for the furnishing under  
2 part B of the items and services described in sub-  
3 section (d) after 2004. The Secretary may establish  
4 different competitive acquisition areas under this  
5 subsection for different classes of items and services  
6 or may establish a single, national competition for  
7 non-complex items.

8 “(2) CRITERIA FOR ESTABLISHMENT.—The  
9 competitive acquisition areas established under para-  
10 graph (1) shall be chosen based on the availability  
11 and accessibility of individuals and entities able to  
12 furnish items and services, and the estimated sav-  
13 ings to be realized by the use of competitive acquisi-  
14 tion in the furnishing of items and services in the  
15 area.

16 “(c) AWARDING OF AGREEMENTS IN COMPETITIVE  
17 ACQUISITION AREAS.—

18 “(1) IN GENERAL.—The Secretary shall con-  
19 duct a competition among individuals and entities  
20 supplying items and services described in subsection  
21 (d) for each competitive acquisition area established  
22 under subsection (b) for each class of items and  
23 services.

24 “(2) CONDITIONS FOR AWARDING AGREE-  
25 MENT.—The Secretary may not enter an agreement

1 with any entity under the competition conducted  
2 pursuant to paragraph (1) to furnish an item or  
3 service unless the Secretary finds that the entity  
4 meets quality standards specified by the Secretary,  
5 and that the aggregate amounts to be paid under  
6 the agreement are expected to be less than the ag-  
7 gregate amounts that would otherwise be paid.

8 “(3) TERMS OF AGREEMENT.—An agreement  
9 entered into with an entity under the competition  
10 conducted pursuant to paragraph (1) is subject to  
11 terms and conditions that the Secretary may specify.

12 “(d) SERVICES DESCRIBED.—The items and services  
13 to which this section applies are all items and services de-  
14 scribed in paragraphs (5) through (9) of section 1861(s)  
15 (other than custom fabricated prostheses, as defined by  
16 the Secretary), and such other items or services reim-  
17 bursed under this title as the Secretary may specify.”

18 (b) ITEMS AND SERVICES TO BE FURNISHED ONLY  
19 THROUGH COMPETITIVE ACQUISITION.—Section 1862(a)  
20 (42 U.S.C. 1395y(a)) is amended—

21 (1) by striking “or” at the end of paragraph  
22 (20),

23 (2) by striking the period at the end of para-  
24 graph (21) and inserting “; or”, and

1           (3) by adding after paragraph (21) the fol-  
2           lowing:

3           “(22) where the expenses are for an item or  
4           service furnished in a competitive acquisition area  
5           (as established by the Secretary under section  
6           1866G(a)) by an entity other than an entity with  
7           which the Secretary has entered into an agreement  
8           under section 1866G(c) for the furnishing of such  
9           an item or service in that area, except in such cases  
10          of emergency or urgent need as the Secretary shall  
11          prescribe.”.

12          (c) EFFECTIVE DATE.—The amendments made by  
13          subsections (a) and (b) apply to items and services fur-  
14          nished after 2004.

15          **SEC. 122. PREFERRED PARTICIPANTS.**

16          (a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et  
17          seq.), as previously amended by this subtitle, is further  
18          amended by inserting after section 1866G the following  
19          new section:

20          **“SEC. 1866H. PREFERRED PARTICIPANTS.**

21                 “(a) PROGRAM AUTHORITY.—

22                         “(1) IN GENERAL.—

23                                 “(A) DISCRETIONARY AUTHORITY.—Begin-  
24                                 ning in 2004, the Secretary may implement a  
25                                 preferred participant program, under which the

1 Secretary enters into agreements for the fur-  
2 nishing of health care items and services by in-  
3 dividuals and entities participating in the pro-  
4 gram under part A or B of this title that pro-  
5 vide high-quality, efficient health care.

6 “(B) MANDATORY IMPLEMENTATION.—Be-  
7 ginning in 2010, the Secretary of Health and  
8 Human Services shall implement such a pro-  
9 gram in any geographic area (which may in-  
10 clude a hospital referral region, as defined by  
11 the latest determination of the Center for the  
12 Evaluative Clinical Services of the Dartmouth  
13 Medical School) where the intensity of pattern  
14 of practice (represented by the number of serv-  
15 ices) and cost of service is determined to be in  
16 the most expensive 10 percent of the nation, as  
17 adjusted for severity and other factors of the  
18 population as the Secretary determines to be  
19 appropriate.

20 “(2) LIMITATION.—The Secretary shall not im-  
21 plement the program under this section with respect  
22 to a service area, or with respect to a category of in-  
23 dividuals and entities furnishing items and services  
24 in such service area, unless the Secretary estimates

1 that to do so will improve the quality and reduce the  
2 cost of the programs under this title.

3 “(3) ADMINISTRATION BY CONTRACT.—Except  
4 as otherwise specifically provided, the Secretary shall  
5 administer the program under this section in accord-  
6 ance with section 1866F.

7 “(b) PREFERRED PARTICIPANT AGREEMENT.—

8 “(1) CRITERIA AND TERMS.—In order to be eli-  
9 gible to participate in the program under part A or  
10 B as a preferred participant, an individual or entity  
11 shall meet the following conditions:

12 “(A) PARTICIPATION CRITERIA.—The indi-  
13 vidual or entity shall meet the criteria estab-  
14 lished by the Secretary under section  
15 1866F(b)(5) (relating to quality, cost-effective-  
16 ness, categories of participants in service area,  
17 and such other standards or criteria as the Sec-  
18 retary may establish).

19 “(B) PAYMENT RATE.—The individual or  
20 entity shall agree to accept payment, for cov-  
21 ered health care items and services furnished  
22 during the term of the agreement, at the rates  
23 established under this section (which may in-  
24 clude rates in effect under part A or B, dis-

1           counted rates, or such other rates as the Sec-  
2           retary may find appropriate).

3           “(2) DURATION.—A preferred participant agreement  
4           under this section shall be for a calendar year (or,  
5           in the case of an agreement commencing after the  
6           first day of January (or such later date as the Sec-  
7           retary may specify), for the remainder of such cal-  
8           endar year), and shall be annually renewable, at the  
9           option of the participant, while the participant con-  
10          tinues to meet all applicable conditions of participa-  
11          tion.

12          “(c) OPTION TO REDUCE COST SHARING.—Notwith-  
13          standing any other provision of law, subject to the cost-  
14          effectiveness criteria specified in subsection (a)(2), the  
15          Secretary may—

16                 “(1) provide for the reduction or elimination of  
17                 beneficiary cost sharing (such as deductibles, copay-  
18                 ments, and coinsurance) with respect to any of the  
19                 items or services furnished under this section, and  
20                 may limit such reduction or elimination to particular  
21                 service areas; and

22                 “(2) permit individuals or entities under an  
23                 agreement under this section to waive part or all of  
24                 such beneficiary cost sharing.”.

1 (b) DEFINITIONS.—Section 1861 (42 U.S.C. 1395x),  
2 as amended by section 112, is amended by adding at the  
3 end the following new subsection:

4 “(xx) PREFERRED PARTICIPANT.—The term ‘pre-  
5 ferred participant’ means an individual or entity that fur-  
6 nishes health care items or services under part A or B  
7 and that has in effect an agreement under section  
8 1866H(b).”.

9 **SEC. 123. PROGRAM TO IMPROVE OUTCOMES AND REDUCE**  
10 **PATIENT MORBIDITY AND MORTALITY.**

11 Title XVIII (42 U.S.C. 1395 et seq.), as previously  
12 amended by this subtitle, is further amended by inserting  
13 after section 1866H the following new section:

14 **“SEC. 1866I. PROGRAM TO IMPROVE OUTCOMES AND RE-**  
15 **DUCE PATIENT MORBIDITY AND MORTALITY.**

16 “(a) IN GENERAL.—

17 “(1) COMPETITION TO FURNISH BUNDLED  
18 ITEMS AND SERVICES.—Beginning in 2004, the Sec-  
19 retary shall use a competitive process to enter into  
20 agreements with specific hospitals or other entities  
21 for the furnishing of bundled groups of items and  
22 services related to certain surgical procedures, and  
23 of other bundled groups of items and services (unre-  
24 lated to surgical procedures) specified by the Sec-  
25 retary furnished during an episode of care (as de-

1        fined by the Secretary). Such items and services may  
2        include any items or services covered under this title  
3        that the Secretary determines to be appropriate. The  
4        Secretary shall give special emphasis to including  
5        under this program those procedures where the Sec-  
6        retary determines evidence exists that morbidity and  
7        mortality of beneficiaries can be reduced by the use  
8        of the program.

9            “(2) ADMINISTRATION BY CONTRACT.—Except  
10        as otherwise specifically provided, the Secretary may  
11        administer the program under this section in accord-  
12        ance with section 1866F.

13        “(b) ELIGIBILITY CRITERIA.—In order to be eligible  
14        for an agreement under this section, an entity shall—

15            “(1) meet quality standards established by the  
16        Secretary;

17            “(2) implement an ongoing quality assurance  
18        program approved by the Secretary; and

19            “(3) meet such other requirements as the Sec-  
20        retary may establish.

21        “(c) PAYMENT.—

22            “(1) IN GENERAL.—The Secretary shall estab-  
23        lish criteria for identifying the health care items and  
24        services furnished by a center with an agreement  
25        under this section during an episode of care that are

1 to be bundled together and for which payment shall  
2 be made on the basis of an all-inclusive rate.

3 “(2) PAYMENT LIMITATION.—

4 “(A) LIMITATION ON AGGREGATE PAY-  
5 MENTS TO ENTITIES.—The estimated amount  
6 of aggregate payments to all entities under this  
7 section for a year shall be less than the esti-  
8 mated amount of aggregate payments that the  
9 Secretary would otherwise have made for such  
10 year, adjusted for changes in the number of in-  
11 dividuals receiving services.

12 “(B) LIMITATION ON PAYMENTS TO PAR-  
13 TICULAR ENTITIES.—In no case shall the all-in-  
14 clusive rate paid to an entity for items and  
15 services furnished during an episode of care  
16 under this section exceed the estimated amount  
17 of the payments that the Secretary would other-  
18 wise have made for such items and services.

19 “(d) AGREEMENT PERIOD.—An agreement period  
20 shall be for up to three years (subject to renewal).

21 “(e) INCENTIVES FOR USE OF CENTERS.—Notwith-  
22 standing any other provision of law, the Secretary may  
23 permit entities under an agreement under this section to  
24 furnish additional services (including family and caregiver  
25 support services) or to waive part or all beneficiary cost

1 sharing (such as deductibles, copayments, and coinsur-  
2 ance) with respect to any of the items or services furnished  
3 under this section.

4 “(f) **BENEFICIARY ELECTION.**—Notwithstanding any  
5 other provision of this title, an individual who voluntarily  
6 elects to receive items and services under an arrangement  
7 described in subsection (a)(1) with respect to an episode  
8 of care shall not be entitled to payment under this title  
9 for any such item or service furnished with respect to such  
10 episode of care other than through such arrangement, sub-  
11 ject to such exceptions as the Secretary may prescribe for  
12 emergency medical services as described in section  
13 1852(d)(3) and other cases of urgent need.”.

14 **SEC. 124. AUTHORITY TO IMPOSE SUSTAINABLE GROWTH**  
15 **RATE LIMITATIONS ON PAYMENT FOR CER-**  
16 **TAIN MEDICARE ITEMS AND SERVICES.**

17 (a) **IN GENERAL.**—In the case of unusual increases  
18 in costs to the medicare program (as determined by the  
19 Secretary of Health and Human Services) attributable to  
20 unjustified increases in the amount or intensity of items  
21 and services furnished under the program, the Secretary  
22 shall modify the payment update and/or methodology with  
23 respect to such items and services from the update and/  
24 or methodology which permitted or resulted in such un-  
25 usual increases in costs to an update and/or methodology

1 that imposes a sustainable growth rate for such items and  
2 services similar to the sustainable growth rate applied with  
3 respect to payment for physicians services under section  
4 1848(f) of the Social Security Act (42 U.S.C. 1395w-  
5 4(f)).

6 (b) **AUTHORITY TO VARY BY REGION.**—Any sustain-  
7 able growth rate recommended by the Secretary may pro-  
8 vide for the determination of such rate on a uniform na-  
9 tional basis, by Metropolitan Statistical Area, by State,  
10 or by any other region that the Secretary determines ap-  
11 propriate.

12 **SEC. 125. AUTHORITY TO NEGOTIATE PAYMENT RATES IN**  
13 **CERTAIN AREAS (MOST FAVORED CUSTOMER**  
14 **AUTHORITY) AND EXPAND INHERENT REA-**  
15 **SONABLENESS AUTHORITY.**

16 (a) **FINDINGS; PURPOSE.**—

17 (1) **FINDING.**—The Congress finds as follows:

18 (A) The medicare program is the largest  
19 single purchaser of health care services in the  
20 United States.

21 (B) It is inappropriate for the medicare  
22 program to in effect subsidize lower prices of-  
23 fered by providers of services and suppliers to  
24 smaller volume purchasers of health care serv-  
25 ices.

1           (2) PURPOSE.—The purpose of this section is  
2           to require the treatment of the medicare program as  
3           a preferred or volume buyer of health care services  
4           in the United States by requiring the Secretary of  
5           Health and Human Services to negotiate a lower  
6           rate for items and services for which reimbursement  
7           is made under the program.

8           (b) MANDATE TO NEGOTIATE.—In the case of a  
9           service area (as determined by the Secretary) where pay-  
10          ment rates under the medicare program for items and  
11          services furnished exceed the rates charged by such health  
12          care provider for such items and services for which pay-  
13          ment is made other than under the medicare program, the  
14          Secretary shall negotiate a similar, lower customer rate  
15          with such health care provider for such items and services  
16          under the medicare program.

17          (c) ADJUSTMENT.—In negotiating such similar, lower  
18          customer rate under subsection (a), the Secretary shall  
19          take into account costs uniquely associated with the provi-  
20          sion of items and services under the medicare program.

21          (d) WAIVER AUTHORITY.—The Secretary may waive  
22          such requirements of title XVIII of the Social Security Act  
23          as may be necessary for the purposes of carrying out this  
24          Act.

25          (e) DEFINITIONS.—In this section:

1           (1) MEDICARE PROGRAM.—The term “medicare  
2           program” means the program established under title  
3           XVIII of the Social Security Act (42 U.S.C. 1395 et  
4           seq.).

5           (2) HEALTH CARE PROVIDER.—The term  
6           “health care provider” means a provider of services,  
7           a physician, or a supplier who furnishes items or  
8           services for which payment is made under the medi-  
9           care program.

10          (3) PROVIDER OF SERVICES.—The term “pro-  
11          vider of services” has the meaning given that term  
12          under section 1861(u) of the Social Security Act (42  
13          U.S.C. 1395x(u)).

14          (4) PHYSICIAN.—The term “physician” has the  
15          meaning given that term under section 1861(r) of  
16          such Act (42 U.S.C. 1395x(r)).

17          (f) Section 1842(b)(8) is amended to strike “15 per-  
18          cent” each place it appears and substitute “30 percent”.

19   **SEC. 126. AUTHORIZATION OF BASING MEDICARE PAYMENT**  
20                   **FOR HOSPITAL OUTPATIENT DEPARTMENT**  
21                   **SERVICES ON PAYMENT RATES FOR SIMILAR**  
22                   **SERVICES PROVIDED OUTSIDE THE HOS-**  
23                   **PITAL SETTING.**

24          (a) IN GENERAL.—Section 1833(t)(1) (42 U.S.C.  
25          1395l(t)(1)) is amended—

1           (1) in subparagraph (A), by inserting  
2           “subject to subparagraph (C),” after “1999,”  
3           and

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

6           “(C) USE OF RATES IN NON-HOSPITAL  
7           SETTINGS.—The Secretary shall review dif-  
8           ferentials in total medicare payments for non-  
9           inpatient services furnished in and outside hos-  
10          pitals. With respect to covered OPD services  
11          furnished on or after January 1, 2010, where  
12          the Secretary determines that there is no dan-  
13          ger to quality of care or outcomes, the Sec-  
14          retary shall adjust payment rates for covered  
15          OPD services (including any facility-related  
16          component to such services) to pay no more  
17          than the lowest rate in any setting for similar  
18          services.”.

19          (b) CONFORMING AMENDMENT.—The fifth sentence  
20          of section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is  
21          amended by inserting “, or in the case described in section  
22          1833(t)(1)(C), the coinsurance amount that would other-  
23          wise apply with respect to the provision of the similar serv-  
24          ices referred to in such section” before the period at the  
25          end.

1 **SEC. 127. MEDICARE SINGLE, UNIFIED PROSPECTIVE PAY-**  
2 **MENT SYSTEM FOR POST-CARE HOSPITAL**  
3 **SERVICES.**

4 (a) DEVELOPMENT OF PAYMENT SYSTEM.—

5 (1) IN GENERAL.—By not later than January  
6 1, 2010, the Secretary of Health and Human Serv-  
7 ices shall develop and transmit to Congress a plan  
8 to provide for a single, unified system for the pay-  
9 ment under a prospective payment system for post-  
10 acute care hospital services (including professional  
11 services) within a course of treatment under the  
12 Medicare Program under title XVIII of the Social  
13 Security Act.

14 (2) ADJUSTMENTS FOR AREA VARIATIONS IN  
15 COSTS AND OUTLIERS.—Such a system shall provide  
16 for appropriate adjustments to take into account—

17 (A) appropriate variations in the costs of  
18 wages and such other input costs as the Sec-  
19 retary finds appropriate; and

20 (B) outliers that reflect bona fide vari-  
21 ations in the case mix and severity of patients  
22 being served.

23 (b) IMPLEMENTATION.—Unless Congress provides  
24 otherwise, the Secretary shall implement the system devel-  
25 oped under subsection (a) for items and services furnished  
26 on or after January 1, 2012.

1           (c) RELATION TO CURRENT PAYMENT METHODOLO-  
2 GIES.—The system under this section shall be designed  
3 and implemented so as to supersede the various different  
4 prospective payment system for such services, which use  
5 different payment, risk adjustment, and other criteria,  
6 under the Medicare Program.

7 **SEC. 128. MEDICARE PAYMENT ADJUSTMENT TO REFLECT**  
8                           **DEVIATIONS FROM GENERALLY ACCEPTED**  
9                           **PRACTICE IN OVERSERVING OR UNDER-**  
10                           **SERVING MEDICARE BENEFICIARIES.**

11           (a) FINDINGS.—The Congress finds as follows:

12                   (1) The intensity and cost of the practice of  
13 medicine varies by more than 200 percent across  
14 various regions of the United States and, in the case  
15 of certain medical procedures, by that percent or  
16 more among some adjoining counties.

17                   (2) Such variations in cost and intensity do not  
18 appear to be related to the severity of illness or the  
19 underlying health of the population of the United  
20 States.

21                   (3) If the pattern of practice of medicine in the  
22 State of Minnesota (one of the States with the high-  
23 est quality of health of residents) were adopted na-  
24 tionwide, the financial stability of the medicare pro-  
25 gram would be assured.

1           (4) For both quality of care and financial pur-  
2           poses, it is the purpose of this section to encourage  
3           best patterns of practice of medicine.

4           (b) ESTABLISHMENT OF PRACTICE PROFILES.—

5           (1) IN GENERAL.—By not later than January  
6           1, 2010, the Secretary of Health and Human Serv-  
7           ices shall establish clinical profiles of the practice  
8           patterns of health care providers (including both in-  
9           stitutional providers, health care professionals, and  
10          Medicare+Choice organizations) providing items and  
11          services under the Medicare program under title  
12          XVIII of the Social Security Act in order to deter-  
13          mine how their practice patterns compare to each  
14          other, on a local, State, and national basis. In estab-  
15          lishing such profiles, the Secretary shall take into  
16          account differences in the case mix and severity of  
17          patients served by such providers and shall take into  
18          account, to the extent practicable, the medical out-  
19          comes resulting from such practices.

20          (2) DISSEMINATION OF INFORMATION.—The  
21          Secretary shall establish a method for disseminating  
22          summary information to the public on the clinical  
23          profiles established under paragraph (1). No infor-  
24          mation that identifies (or permits the identification  
25          of) an individual patient shall be disseminated.

1           (c) AUTHORITY TO MAKE PAYMENT ADJUST-  
2 MENTS.—For items and services furnished on or after  
3 January 1, 2020, the Secretary of Health and Human  
4 Services may adjust the amount of the payments made  
5 under the Medicare program to health care providers in  
6 order to encourage their provision of services in a medi-  
7 cally appropriate manner and to discourage significant de-  
8 viations in underservice or overservice from generally ac-  
9 cepted norms of best medical practice. Such adjustments  
10 shall be made on the basis of provider profiles established  
11 under subsection (b) and shall be made only after taking  
12 into account variations among providers in the case mix  
13 and severity of patients served.

14           (d) REQUIREMENT TO MAKE PAYMENT ADJUST-  
15 MENTS.—

16           (1) IN GENERAL.—For items and services fur-  
17 nished on or after January 1, 2025, the Secretary  
18 of Health and Human Services shall reduce by 10  
19 percent the amount of the payments made under the  
20 Medicare program to health care providers described  
21 in paragraph (2).

22           (2) HEALTH CARE PROVIDERS DESCRIBED.—  
23 For purposes of paragraph (1), a health care pro-  
24 vider described in this paragraph is a provider—

1 (A) that furnishes services in a hospital re-  
2 ferral region (as defined by the latest deter-  
3 mination of the Center for the Evaluative Clin-  
4 ical Services of the Dartmouth Medical School  
5 where the intensity of pattern of practice (as  
6 represented by the number of services) and the  
7 cost of services is determined by the Secretary  
8 to be in the most expensive 20 percent of all  
9 such services in the United States, as adjusted  
10 for severity and such other factors as the Sec-  
11 retary determines appropriate;

12 (B) with respect to which the Secretary is  
13 unable to identify improved quality care or out-  
14 comes as a result of such higher intensity serv-  
15 ices or costs;

16 (C) that has a pattern of practice which is  
17 among the top 20 percent of providers in the  
18 region in terms of intensity and costs; and

19 (D) that does not serve a patient popu-  
20 lation that is preponderately among the 20 per-  
21 cent most severely ill in the region.

1 **SEC. 129. PROMOTING THE USE OF COST EFFECTIVE MEDI-**  
2 **CARE NONINSTITUTIONAL SERVICES**  
3 **THROUGH WAIVER OF BENEFIT LIMITA-**  
4 **TIONS.**

5 (a) IN GENERAL.—If the Secretary of Health and  
6 Human Services estimates that treatment in a non-hos-  
7 pital or non-institutional setting under the medicare pro-  
8 gram under title XVIII of the Social Security Act is likely  
9 to provide similar or better quality care and outcomes at  
10 a lower cost to the program, the Secretary of Health and  
11 Human Services may waive requirements described in sub-  
12 section (b) which discourage or prevent treatment in such  
13 a setting.

14 (b) REQUIREMENTS WAIVABLE.—

15 (1) IN GENERAL.—Subject to paragraph (2),  
16 the requirements that may be waived include the fol-  
17 lowing:

18 (A) The requirement, for the receipt of  
19 benefits for extended care services, that the  
20 services be post-hospital extended care services.

21 (B) Cost sharing (including deductibles,  
22 coinsurance, and copayments) that may be ap-  
23 plicable.

24 (2) NONWAIVABLE PROVISIONS.—The Secretary  
25 of Health and Human Services may not under this  
26 section provide for coverage of services for which no

1 payment is otherwise provided under the medicare  
2 program.

3 (c) LIMITATION.—The Secretary may not provide for  
4 such a waiver in the case of an individual unless there  
5 are satisfactory assurances that the medicare beneficiary  
6 has not received (and is not likely to receive) medicare  
7 benefits for hospital services for the treatment with re-  
8 spect to which the waiver applies.

9 **SEC. 130. INCREASED FLEXIBILITY IN CONTRACTING FOR**  
10 **MEDICARE CLAIMS PROCESSING.**

11 (a) CARRIERS TO INCLUDE ENTITIES THAT ARE  
12 NOT INSURANCE COMPANIES.—

13 (1) The matter in section 1842(a) (42 U.S.C.  
14 1395u(a)) preceding paragraph (1) is amended by  
15 striking “with carriers” and inserting “with agencies  
16 and organizations (referred to as carriers)”.

17 (2) Section 1842(f) (42 U.S.C. 1395u(f)) is re-  
18 pealed.

19 (b) SECRETARIAL FLEXIBILITY IN CONTRACTING  
20 FOR AND IN ASSIGNING FISCAL INTERMEDIARY AND CAR-  
21 RIER FUNCTIONS.—

22 (1) Section 1816 (42 U.S.C. 1395h) is amended  
23 by striking everything after the heading but before  
24 subsection (b) and inserting the following:

1       “SEC. 1816. (a)(1) The Secretary may enter into con-  
2 tracts with agencies or organizations to perform any or  
3 all of the following functions, or parts of those functions  
4 (or, to the extent provided in a contract, to secure per-  
5 formance thereof by other organizations):

6           “(A) Determine (subject to the provisions of  
7 section 1878 and to such review by the Secretary as  
8 may be provided for by the contracts) the amount of  
9 the payments required pursuant to this part to be  
10 made to providers of services.

11           “(B) Make payments described in subparagraph  
12 (A).

13           “(C) Provide consultative services to institu-  
14 tions or agencies to enable them to establish and  
15 maintain fiscal records necessary for purposes of  
16 this part and otherwise to qualify as providers of  
17 services.

18           “(D) Serve as a center for, and communicate to  
19 individuals entitled to benefits under this part and  
20 to providers of services, any information or instruc-  
21 tions furnished to the agency or organization by the  
22 Secretary, and serve as a channel of communication  
23 from individuals entitled to benefits under this part  
24 and from providers of services to the Secretary.

1           “(E) Make such audits of the records of pro-  
2           viders of services as may be necessary to insure that  
3           proper payments are made under this part.

4           “(F) Perform the functions described in sub-  
5           section (d).

6           “(G) Perform such other functions as are nec-  
7           essary to carry out the purposes of this part.

8           “(2) As used in this title and title XI, the term ‘fiscal  
9           intermediary’ means an agency or organization with a con-  
10          tract under this section.”.

11           (2) Subsections (d) and (e) of section 1816 (42  
12          U.S.C. 1395h) are amended to read as follows:

13           “(d) Each provider of services shall have a fiscal  
14          intermediary that—

15           “(1) acts as a single point of contact for the  
16          provider of services under this part,

17           “(2) makes its services sufficiently available to  
18          meet the needs of the provider of services, and

19           “(3) is responsible and accountable for arrang-  
20          ing the resolution of issues raised under this part by  
21          the provider of services.

22           “(e) The Secretary, in evaluating the performance of  
23          a fiscal intermediary, may solicit comments from providers  
24          of services.”.

1           (3)(A) Section 1816(b)(1)(A) (42 U.S.C.  
2           1395h(b)(1)(A)) is amended by striking “after ap-  
3           plying the standards, criteria, and procedures” and  
4           inserting “after evaluating the ability of the agency  
5           or organization to fulfill the contract performance  
6           requirements”.

7           (B) Section 1816(f)(1) (42 U.S.C. 1395h(f)(1))  
8           is amended to read as follows:

9           “(f)(1) The Secretary may consult with  
10          Medicare+Choice organizations under part C of this title,  
11          providers of services and other persons who furnish items  
12          or services for which payment may be made under this  
13          title, and organizations and agencies performing functions  
14          necessary to carry out the purposes of this part with re-  
15          spect to performance requirements for contracts under  
16          subsection (a).”.

17          (C) The second sentence of section  
18          1842(b)(2)(A) (42 U.S.C. 1395u(b)(2)(A)) is  
19          amended to read as follows: “The Secretary may  
20          consult with Medicare+Choice organizations under  
21          part C of this title, providers of services and other  
22          persons who furnish items or services for which pay-  
23          ment may be made under this title, and organiza-  
24          tions and agencies performing functions necessary to  
25          carry out the purposes of this part with respect to

1 performance requirements for contracts under sub-  
2 section (a).”.

3 (D) Section 1842(b)(2)(A) (42 U.S.C.  
4 1395u(b)(2)(A)) is amended by striking the third  
5 sentence.

6 (E) The matter in section 1842(b)(2)(B) (42  
7 U.S.C. 1395u(b)(2)(B)) preceding clause (i) is  
8 amended by striking “establish standards” and in-  
9 serting “develop contract performance require-  
10 ments”.

11 (F) Section 1842(b)(2)(D) (42 U.S.C.  
12 1395u(b)(2)(D)) is amended by striking “standards  
13 and criteria” each place it occurs and inserting  
14 “contract performance requirements”.

15 (4)(A) The matter in section 1816(b) (42  
16 U.S.C. 1395h(b)) preceding paragraph (1) is amend-  
17 ed by striking “an agreement” and inserting “a con-  
18 tract”.

19 (B) Paragraphs (1)(B) and (2)(A) of section  
20 1816(b) (42 U.S.C. 1395h(b)) are each amended by  
21 striking “agreement” and inserting “contract”.

22 (C) The first sentence of section 1816(c)(1) (42  
23 U.S.C. 1395h(c)(1)) is amended by striking “An  
24 agreement” and inserting “A contract”.

1 (D) The last sentence of section 1816(c)(1) (42  
2 U.S.C. 1395h(c)(1)) is amended by striking “an  
3 agreement” and inserting “a contract”.

4 (E) The matter in section 1816(c)(2)(A) (42  
5 U.S.C. 1395h(c)(2)(A)) preceding clause (i) is  
6 amended by striking “agreement” and inserting  
7 “contract”.

8 (F) Section 1816(c)(3)(A) (42 U.S.C.  
9 1395h(c)(3)(A)) is amended by striking “agree-  
10 ment” and inserting “contract”.

11 (G) Section 1816(h) (42 U.S.C. 1395h(h)) is  
12 amended—

13 (i) by striking “An agreement” and insert-  
14 ing “A contract”, and

15 (ii) by striking “the agreement” each place  
16 it occurs and inserting “the contract”.

17 (H) Section 1816(i)(1) (42 U.S.C. 1395h(i)(1))  
18 is amended by striking “an agreement” and insert-  
19 ing “a contract”.

20 (I) Section 1816(j) (42 U.S.C. 1395h(j)) is  
21 amended by striking “An agreement” and inserting  
22 “A contract”.

23 (J) Section 1816(k) (42 U.S.C. 1395h(k)) is  
24 amended by striking “An agreement” and inserting  
25 “A contract”.

1           (K) Section 1816(l) (42 U.S.C. 1395h(l)) is  
2 amended by striking “an agreement” and inserting  
3 “a contract”.

4           (L) The matter in section 1842(a) (42 U.S.C.  
5 1395u(a)) preceding paragraph (1) is amended by  
6 striking “agreements” and inserting “contracts”.

7           (M) Section 1842(h)(3)(A) (42 U.S.C.  
8 1395u(h)(3)(A)) is amended by striking “an agree-  
9 ment” and inserting “a contract”.

10           (5)(A) The matter in section 1816(c)(2)(A) (42  
11 U.S.C. 1395h(c)(2)(A)) preceding clause (i) is  
12 amended by inserting “that provides for making  
13 payments under this part” after “this section”.

14           (B) Section 1816(c)(3)(A) (42 U.S.C.  
15 1395h(c)(3)(A)) is amended by inserting “that pro-  
16 vides for making payments under this part” after  
17 “this section”.

18           (C) Section 1816(k) (42 U.S.C. 1395h(k)) is  
19 amended by inserting “(as appropriate)” after “sub-  
20 mit”.

21           (D) The matter in section 1842(a) (42 U.S.C.  
22 1395u(a)) preceding paragraph (1) is amended by  
23 striking “some or all of the following functions” and  
24 inserting “any or all of the following functions, or  
25 parts of those functions”.

1           (E) The first sentence of section 1842(b)(2)(C)  
2           (42 U.S.C. 1395u(b)(2)(C)) is amended by inserting  
3           “(as appropriate)” after “carriers”.

4           (F) The matter preceding subparagraph (A) in  
5           the first sentence of section 1842(b)(3) (42 U.S.C.  
6           1395u(b)(3)) is amended by inserting “(as appro-  
7           priate)” after “contract”.

8           (G) The matter in section 1842(b)(7)(A) (42  
9           U.S.C. 1395u(b)(7)(A)) preceding clause (i) is  
10          amended by striking “the carrier” and inserting “a  
11          carrier”.

12          (H) The matter in section 1842(b)(11)(A) (42  
13          U.S.C. 1395u(b)(11)(A)) preceding clause (i) is  
14          amended by inserting “(as appropriate)” after “each  
15          carrier”.

16          (I) The first sentence of section 1842(h)(2) (42  
17          U.S.C. 1395u(h)(2)) is amended by inserting “(as  
18          appropriate)” after “shall”.

19          (J) Section 1842(h)(5)(A) (42 U.S.C.  
20          1395u(h)(5)(A)) is amended by inserting “(as ap-  
21          propriate)” after “carriers”.

22          (6)(A) Section 1816(e)(2)(C) (42 U.S.C.  
23          1395h(e)(2)(C)) is amended by striking “hospital,  
24          rural primary care hospital, skilled nursing facility,  
25          home health agency, hospice program, comprehen-

1 sive outpatient rehabilitation facility, or rehabilita-  
2 tion agency” and inserting “provider of services”.

3 (B) The matter in section 1816(j) (42 U.S.C.  
4 1395h(j)) preceding paragraph (1) is amended by  
5 striking “for home health services, extended care  
6 services, or post-hospital extended care services”.

7 (7) Section 1842(a)(3) (42 U.S.C. 1395u(a)(3))  
8 is amended by inserting “(to and from individuals  
9 enrolled under this part and to and from physicians  
10 and other entities that furnish items and services)”  
11 after “communication”.

12 (8) The matter in section 1842(a) (42 U.S.C.  
13 1395u(a)) preceding paragraph (1), as amended by  
14 subsection (b)(4)(L), is amended by striking “car-  
15 riers with which contracts” and inserting “single  
16 contracts under section 1816 and this section to-  
17 gether, or separate contracts with eligible agencies  
18 and organizations with which contracts”.

19 (c) ELIMINATION OF SPECIAL PROVISIONS FOR TER-  
20 MINATIONS OF CONTRACTS.—

21 (1) The matter in section 1816(b) (42 U.S.C.  
22 1395h(b)) preceding paragraph (1) is amended by  
23 striking “or renew”.

1           (2) The last sentence of section 1816(c)(1) (42  
2           U.S.C. 1395h(c)(1)) is amended by striking “or re-  
3           newing”.

4           (3) Section 1816(g) (42 U.S.C. 1395h(g)) is re-  
5           pealed.

6           (4) The last sentence of section 1842(b)(2)(A)  
7           (42 U.S.C. 1395u(b)(2)(A)) is amended by striking  
8           “or renewing”.

9           (5) Section 1842(b) (42 U.S.C. 1395u(b)) is  
10          amended by striking paragraph (5).

11          (d) REPEAL OF FISCAL INTERMEDIARY REQUIRE-  
12          MENTS THAT ARE NOT COST-EFFECTIVE.—Section  
13          1816(f)(2) (42 U.S.C. 1395h(f)(2)) is amended to read  
14          as follows:

15          “(2) The contract performance requirements de-  
16          scribed in paragraph (1) shall include, with respect to  
17          claims for services furnished under this part by any pro-  
18          vider of services other than a hospital, whether such agen-  
19          cy or organization is able to process 75 percent of recon-  
20          siderations within 60 days and 90 percent of reconsider-  
21          ations within 90 days.”.

22          (e) REPEAL OF COST REIMBURSEMENT REQUIRE-  
23          MENTS.—

24                 (1) The first sentence of section 1816(c)(1) (42  
25                 U.S.C. 1395h(c)(1)) is amended—

1 (A) by striking the comma after “appro-  
2 priate” and inserting “and”, and

3 (B) by striking everything after “sub-  
4 section (a)” up to the period.

5 (2) Section 1816(c)(1) (42 U.S.C. 1395h(c)(1))  
6 is further amended by striking the second and third  
7 sentences.

8 (3) The first sentence of section 1842(c)(1) (42  
9 U.S.C. 1395h(c)(1)) is amended—

10 (A) by striking “shall provide” the first  
11 place it occurs and inserting “may provide”,  
12 and

13 (B) by striking everything after “this  
14 part” up to the period.

15 (4) Section 1842(c)(1) (42 U.S.C. 1395h(c)(1))  
16 is further amended by striking the remaining sen-  
17 tences.

18 (5) Section 2326(a) of the Deficit Reduction  
19 Act of 1984 (42 U.S.C. 1395h note) is repealed.

20 (f) SECRETARIAL FLEXIBILITY WITH RESPECT TO  
21 RENEWING CONTRACTS AND TRANSFER OF FUNC-  
22 TIONS.—

23 (1) Section 1816(c) (42 U.S.C. 1395h(c)) is  
24 amended by adding at the end the following:

1           “(4)(A) Except as provided in laws with general  
2 applicability to Federal acquisition and procurement  
3 or in subparagraph (B), the Secretary shall use com-  
4 petitive procedures when entering into contracts  
5 under this section.

6           “(B)(i) The Secretary may renew a contract  
7 with a fiscal intermediary under this section from  
8 term to term without regard to section 5 of title 41,  
9 United States Code, or any other provision of law  
10 requiring competition, if the fiscal intermediary has  
11 met or exceeded the performance requirements es-  
12 tablished in the current contract.

13           “(ii) Functions may be transferred among fiscal  
14 intermediaries without regard to any provision of  
15 law requiring competition. However, the Secretary  
16 shall ensure that performance quality is considered  
17 in such transfers.”.

18           (2) Section 1842(b) (42 U.S.C. 1395u(b)) is  
19 amended by striking everything before paragraph (2)  
20 and inserting the following:

21           “(b)(1)(A) Except as provided in laws with general  
22 applicability to Federal acquisition and procurement or in  
23 subparagraph (B), the Secretary shall use competitive pro-  
24 cedures when entering into contracts under this section.

1 “(B)(i) The Secretary may renew a contract with a  
2 carrier under subsection (a) from term to term without  
3 regard to section 5 of title 41, United States Code, or any  
4 other provision of law requiring competition, if the carrier  
5 has met or exceeded the performance requirements estab-  
6 lished in the current contract.

7 “(ii) Functions may be transferred among carriers  
8 without regard to any provision of law requiring competi-  
9 tion. However, the Secretary shall ensure that perform-  
10 ance quality is considered in such transfers.”.

11 (g) WAIVER OF COMPETITIVE REQUIREMENTS FOR  
12 INITIAL CONTRACTS.—

13 (1) Contracts under section 1816(a) of the So-  
14 cial Security Act (42 U.S.C. 1395h(a)) or 1842(a)  
15 of such Act (42 U.S.C. 1395u(a)) whose periods  
16 begin before or during the one year period that be-  
17 gins on the first day of the fourth calendar month  
18 that begins after the date of enactment of this sec-  
19 tion may be entered into without regard to any pro-  
20 vision of law requiring competition.

21 (2) The amendments made by subsection (f)  
22 apply to contracts whose periods begin after the end  
23 of the one year period specified in paragraph (1) of  
24 this subsection.

25 (h) EFFECTIVE DATES.—

1           (1) The amendments made by subsection (c)  
2           apply to contracts whose periods end at, or after, the  
3           end of the sixth calendar month that begins after  
4           the date of enactment of this section.

5           (2) The amendments made by subsections (a),  
6           (b), (d), and (e) apply to contracts whose periods  
7           begin after the sixth calendar month that begins  
8           after the date of enactment of this section.

9   **SEC. 131. SPECIAL PROVISIONS FOR FUNDING OF ACTIVI-**  
10                   **TIES RELATED TO CERTAIN OVERPAYMENT**  
11                   **RECOVERIES AND PROVIDER ENROLLMENT**  
12                   **AND REVERIFICATION OF ELIGIBILITY.**

13           (a) FUNDING AVAILABLE UNDER THE MEDICARE IN-  
14   TEGRITY PROGRAM (MIP) APPROPRIATION FOR PRO-  
15   VIDER ENROLLMENT ACTIVITIES PERFORMED BY FISCAL  
16   INTERMEDIARIES AND CARRIERS.—Section 1817(k)(4)  
17   (42 U.S.C. 1395i(k)(4)) is amended—

18           (1) in subparagraph (A), by inserting “and the  
19           activities specified in subparagraph (C)” after “the  
20           Medicare Integrity Program under section 1893”;  
21           and

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

24                   “(C)(i) Of the amounts appropriated under  
25                   subparagraph (A), the amounts specified in

1 clause (iii) shall be available to the Secretary  
2 for payment of the costs of the activities de-  
3 scribed in clause (ii) which are performed by  
4 entities with contracts under section 1816 or  
5 1842.

6 “(ii) For purposes of clause (i), the activi-  
7 ties specified in this paragraph are—

8 “(I) determinations as to whether  
9 overpayments were made to an individual  
10 or entity furnishing items or services for  
11 which payment may be made under this  
12 title and recovery of any such overpay-  
13 ments; and

14 “(II) activities related to enrolling  
15 such individuals and entities under the  
16 program under this title, including estab-  
17 lishing billing privileges and records sys-  
18 tems, processing applications, background  
19 investigations, and related activities.

20 “(iii) For purposes of clause (i), the  
21 amount specified under this clause is the lesser  
22 of the amounts necessary to perform the activi-  
23 ties described in clause (ii) or—

24 “(I) for fiscal year 2003,  
25 \$14,000,000; and

1           “(II) for fiscal years 2004 and 2005,  
2           the amount for the preceding year, in-  
3           creased by 30 percent of the difference be-  
4           tween the maximum amount specified in  
5           subparagraph (B) for such year and the  
6           maximum amount so specified for the pre-  
7           ceding year.

8           “(iv) Amounts available under this sub-  
9           paragraph for the activities described in clause  
10          (ii) shall be in addition to any amounts that  
11          may otherwise be available to carry out such ac-  
12          tivities.”.

13          (b) ADDITIONAL FUNCTIONS TO BE PERFORMED BY  
14          MIP CONTRACTORS.—

15                (1) REVERIFICATION OF ELIGIBILITY FUNC-  
16                TION.—Section 1893(b) (42 U.S.C. 1395ddd(b)) is  
17                amended by adding at the end the following new  
18                paragraph:

19                “(6) activities related to reverifying the eligi-  
20                bility of individuals and entities described in para-  
21                graph (1) to participate under the program under  
22                this title, and related activities.”.

23                (2) PROVIDER ENROLLMENT AND OVERPAY-  
24                MENT RECOVERY FUNCTIONS ADDED AS MIP CON-  
25                TRACTOR FUNCTIONS AFTER PHASE-IN PERIOD.—

1 Section 1893(b) (42 U.S.C. 1395ddd(b)) is amended  
2 by adding at the end the following new paragraphs:

3 “(7) Activities related to enrolling individuals  
4 and entities described in paragraph (1) under the  
5 program under this title, including establishing bill-  
6 ing privileges and records systems, processing appli-  
7 cations, background investigations, and related ac-  
8 tivities.

9 “(8) Determinations with respect to overpay-  
10 ments made under this title that are discovered pur-  
11 suant to the performance of an activity described in  
12 paragraph (1) or (2), and recovery of any such over-  
13 payments.”.

14 (3) EFFECTIVE DATES.—The amendment made  
15 by paragraph (1) shall be effective on and after Oc-  
16 tober 1, 2002. The amendment made by paragraph  
17 (2) shall be effective on and after October 1, 2005.

18 **SEC. 132. ESTABLISHMENT OF MEDICARE ADMINISTRATIVE**

19 **FEE FOR SUBMISSION OF PAPER CLAIMS.**

20 (a) IMPOSITION OF FEE.—Notwithstanding any  
21 other provision of law, the Secretary of Health and  
22 Human Services shall establish (in the form of a separate  
23 fee or reduction of payment otherwise made under the  
24 medicare program under title XVIII of the Social Security  
25 Act) an administrative fee of \$1 for the submission of a

1 claim in a paper or non-electronic form for items or serv-  
2 ices for which payment is sought under such title.

3 (b) EXCEPTION AUTHORITY.—The Secretary—

4 (1) shall waive the imposition of a fee under  
5 subsection (a) in cases in which there is no method  
6 available for the submission of claims other than in  
7 a written form; and

8 (2) may waive the imposition of such a fee in  
9 such unusual cases as the Secretary finds appro-  
10 priate.

11 (c) EFFECTIVE DATE.—Subsection (a) applies to  
12 claims submitted on or after January 1, 2005.

13 (d) The Secretary shall make available at no charge,  
14 public domain software to facilitate the filing of electronic  
15 forms and claims under title XVIII and XIX of the Social  
16 Security Act.

## 17 **Subtitle D—Long-Term Hospital** 18 **Provisions**

### 19 **SEC. 141. FINDINGS AND PURPOSES OF SUBTITLE.**

20 (a) FINDINGS.—Congress finds the following:

21 (1) The use of inpatient hospital services has  
22 been declining, and is likely to continue to decline,  
23 with the advent of new pharmaceuticals, tech-  
24 nologies, and outpatient services.

1           (2) In many areas hospitals are often half occu-  
2           pied.

3           (3) The quality of care among hospitals may  
4           vary significantly, with evidence that complicated  
5           and difficult procedures carried out in a hospital  
6           that does not perform a large volume of such proce-  
7           dures may create problems with outcomes.

8           (4) Regions and communities expect a full  
9           range of quality medical services in an area so as to  
10          ensure that hospitalized individuals are near family  
11          and friends—a goal which may compound the qual-  
12          ity outcomes problem described in paragraph (3).

13          (5) Hospitals have been, and increasingly will  
14          be, faced, with cost control pressures from public  
15          and private programs.

16          (6) Hospital emergency rooms furnish essential  
17          life-saving services and must be available in all  
18          areas. But they frequently provide uncompensated  
19          care, which increases financial pressure on hospitals.

20          (7) There are approximately 3 million rural  
21          residents living more than 30 minutes from the  
22          nearest emergency room, and it is increasingly clear  
23          that the nation needs a coordinated emergency room  
24          (ER) policy.

1           (8) There is a need for a major increase in  
2           medical information technology investment so as to  
3           improve quality, reduce paperwork, and ensure the  
4           best patterns of practice.

5           (b) PURPOSE.—It is the purpose of this subtitle to  
6           use medicare to encourage the development of a national  
7           hospital policy that delivers more efficient and better qual-  
8           ity care, ensures access to emergency room services to all  
9           citizens in a timely manner, and provides necessary re-  
10          gional quality hospital services.

11       **SEC. 142. REDUCTIONS IN MEDICARE CAPITAL PAYMENTS**  
12                               **IN CASE OF EXCESS BED SUPPLY IN HOS-**  
13                               **PITALS WITHOUT A PLAN OF ADJUSTMENT.**

14          (a) IN GENERAL.—Notwithstanding any other provi-  
15          sion of law, the Secretary of Health and Human Services  
16          may, for cost reporting periods and discharges occurring  
17          on or after October 1, 2005, reduce by 25 percent medi-  
18          care capital payments for a hospital located in a hospital  
19          catchment area if—

20               (1) the hospital bed ratio for the area for that  
21               type of hospital is higher than the national average  
22               hospital bed ratio for that type of hospital; and

23               (2) the average hospital occupancy rate for the  
24               hospital is below the average hospital occupancy rate  
25               for that type of hospital.

1 (b) LIMITATION ON AMOUNT OF REDUCTION.—The  
2 reduction in payment under subsection (a) may not exceed  
3 25 percent of the amount of the medicare capital pay-  
4 ments.

5 (c) EXCEPTIONS.—The Secretary shall not make a  
6 reduction under subsection (a) insofar as the Secretary de-  
7 termines that such reduction would be inappropriate as—

8 (1) it would adversely effect an ongoing plan for  
9 the hospital to reduce the number of acute care in-  
10 patient hospital beds, whether directly or through  
11 closure or merger with another hospital and such  
12 plan has been developed through public hearings,  
13 with community input, and has a schedule for imple-  
14 mentation;

15 (2) additional capacity will be required to meet  
16 the needs of an underserved population, such as a  
17 growing suburban area and the governor of the  
18 State attests to such requirement; or

19 (3) the hospital has been certified as a critical  
20 access hospital under section 1820(e) of the Social  
21 Security Act (42 U.S.C. 1395i–4(e)) and is part of  
22 a State rural health care plan.

23 (d) DEFINITIONS.—For purposes of this section:

24 (1) PPS HOSPITAL; PPS-EXEMPT HOSPITAL.—  
25 The term “PPS hospital” has the meaning given the

1 term “subsection (d) hospital” in section  
2 1886(d)(1)(B) of the Social Security Act (42 U.S.C.  
3 1395ww(d)(1)(B)), and the term “PPS-exempt hos-  
4 pital” means a hospital other than a PPS hospital.

5 (2) TYPE OF HOSPITAL.—The term “type of  
6 hospital” means PPS hospitals and each type of hos-  
7 pital described in a clause of section 1886(d)(1)(B)  
8 of the Social Security Act (42 U.S.C.  
9 1395ww(d)(1)(B)).

10 (3) HOSPITAL CATCHMENT AREA.—The term  
11 “hospital catchment area” means a standard metro-  
12 politan statistical area or such area as the Secretary  
13 determines appropriate.

14 (4) HOSPITAL BED RATIO.—

15 (A) IN GENERAL.—The term “hospital bed  
16 ratio” means, for an area and a type of hospital  
17 and as determined by the Secretary, the ratio  
18 of—

19 (i) the number of licensed inpatient  
20 hospital beds for that type of hospital in  
21 the area, to

22 (ii) the population of the area.

23 (B) CASE MIX ADJUSTMENT AUTHORITY.—

24 In determining a hospital bed ratio, the Sec-  
25 retary may provide for such adjustment as may

1           be appropriate to take into account differences  
2           in the case mix of the population served by the  
3           hospital.

4           (5) HOSPITAL OCCUPANCY RATE.—The term  
5           “hospital occupancy rate” means, for a hospital and  
6           period and as determined by the Secretary, the aver-  
7           age number of inpatient beds in the hospital which  
8           are occupied on any day in that period, divided by  
9           the average total number of licensed inpatient beds  
10          in the hospital on any day in that period.

11          (6) MEDICARE CAPITAL PAYMENTS.—The term  
12          “medicare capital payments” means payments to a  
13          hospital under section 1886 of the Social Security  
14          Act (42 U.S.C. 1395ww) for capital-related costs,  
15          and includes payments under section 1886(g) of  
16          such Act, but does not include payments for a re-  
17          turn on equity capital.

18          (7) SECRETARY.—The term “Secretary” means  
19          the Secretary of Health and Human Services.

20 **SEC. 143. SPECIAL PAYMENTS TO ESSENTIAL HOSPITALS**  
21                                   **AND DEVELOPMENT OF ECONOMIC RECOV-**  
22                                   **ERY PLAN.**

23          (a) IN GENERAL.—Section 1886(g) (42 U.S.C.  
24 1395ww(g)) is amended by adding at the end the fol-  
25 lowing:

1       “(5)(A) Effective beginning October 1, 2003, in the  
2 case of a deemed hospital (as defined in subparagraph  
3 (B)), the Secretary shall increase all payments for all serv-  
4 ices provided under this title by such deemed hospital (in-  
5 cluding in-patient, out-patient, skilled nursing facility,  
6 home health agency, hospice, and end-stage renal disease,  
7 and other covered services provided by such deemed hos-  
8 pital) by 10 percent for a period of 5 fiscal years, subject  
9 to the conditions under paragraph (6).

10       “(B) For purposes of this paragraph and paragraphs  
11 (6) and (7), a ‘deemed hospital’ is a hospital in a hospital  
12 referral region—

13               “(i) that is defined by the The Center for the  
14 Evaluative Clinical Sciences, Dartmouth Medical  
15 School (popularly known as the ‘Dartmouth Atlas of  
16 Health Care’), and as may be updated by such Cen-  
17 ter, except that the Secretary may by regulation pro-  
18 vide for criteria to adjust the hospitals to be in-  
19 cluded or excluded from such a hospital referral re-  
20 gion;

21               “(ii) that has 75 percent of the hospitals in the  
22 region, for the last completed cost report period,  
23 having had negative medicare operating margins and  
24 negative total operating margins; and

1           “(iii) that has a medicare-eligible beneficiary  
2           patient discharge percentage for hospitals in the re-  
3           gion exceeding 40 percent;  
4 but only if the hospital had agreed to participate in the  
5 development of a cooperative economic recovery plan de-  
6 scribed in paragraph (6).

7 Such hospitals in a referral region shall be deemed to be  
8 essential hospitals necessary for the delivery of health care  
9 to all medicare and other residents of the region.

10          “(6)(A) Within one year of receiving deemed status  
11 and higher medicare payments under paragraph (5), each  
12 hospital in the referral region, either individually or (not-  
13 withstanding any other provision of law) cooperatively,  
14 shall submit an economic recovery plan to the Secretary  
15 for long-range (post-deemed status) financial viability  
16 after the end of increased payments under paragraph (5).  
17 The Secretary shall offer assistance in the development  
18 of such plan or plans.

19          “(B) Such plan may include capital payments and op-  
20 erating payments to—

21               “(i) right-size capacity;

22               “(ii) coordinate and share high cost services;

23               “(iii) ensure a viable regional emergency room  
24           network and access;

1           “(iv) convert unused acute care beds to skilled  
2           nursing facility, intermediate care facility, or as-  
3           sisted living facility support facilities;

4           “(v) assist in the conversion of unused acute  
5           care beds to psychiatric, long-term care, or rehabili-  
6           tation care hospital services as are determined to be  
7           in short supply;

8           “(vi) finance the development and implementa-  
9           tion of medical information technology systems that  
10          are compatible within the region and the nation and  
11          which improve quality of care and reduce paperwork  
12          cost and burdens; and

13          “(vii) such other adjustments to the current  
14          acute care hospital facility as shall ensure the long-  
15          term economic viability of the facility and the con-  
16          tinuation of essential health care services to the  
17          community.

18          “(C) The Secretary shall review such economic recov-  
19          ery plans, provide assistance in the improvement and  
20          modification of such plans, and within one year of receipt  
21          of a plan which the Secretary determines has a reasonable  
22          opportunity of ensuring the long term viability of the facil-  
23          ity or facilities, the Secretary shall further increase the  
24          Medicare payment increases described in paragraph (5) by  
25          such additional amount as to ensure the successful com-

1 pletion of the economic recovery plan or plans under this  
2 paragraph.

3 “(7) Notwithstanding any other provision of law, the  
4 additional payments made to deemed hospitals under  
5 paragraphs (5) and (6) shall not result in payment reduc-  
6 tions to any non-deemed hospital or provider under this  
7 title.”.

8 **SEC. 144. UNIFORM HOSPITAL COST REPORTING.**

9 Each hospital, as a requirement under a participation  
10 agreement under section 1866(a) of the Social Security  
11 Act (42 U.S.C. 1395cc(a)) for each cost reporting period  
12 beginning during or after fiscal year 2003, shall provide  
13 for the reporting of cost information to the Secretary of  
14 Health and Human Services with respect to any hospital  
15 care provided in a uniform manner consistent with stand-  
16 ards established by the Secretary to carry out section  
17 4007(c) of the Omnibus Budget Reconciliation Act of  
18 1987 and in an electronic form consistent with standards  
19 established by the Secretary.

20 **SEC. 145. MEDICARE PAYMENTS FOR INPATIENT HOSPITAL**  
21 **SERVICES INVOLVING EMERGENCY CARE; NA-**  
22 **TIONAL CONFERENCE ON EMERGENCY CARE.**

23 (a) MEDPAC REPORT ON DRG WEIGHTING FAC-  
24 TORS.—The Medicare Payment Advisory Commission  
25 shall submit a report to Congress and the Secretary of

1 Health and Human Services, by January 1, 2003, on  
2 whether the DRG weighting factors under section  
3 1886(d)(4)(B) of the Social Security Act for diagnosis-re-  
4 lated groups associated with emergency care are adequate  
5 to cover the costs of emergency room use within discharges  
6 classified within such groups.

7 (b) ADJUSTMENT OF WEIGHTING FACTORS.—Taking  
8 into account the report submitted under subsection (a),  
9 the Secretary of Health and Human Services shall make  
10 appropriate adjustments in the DRG weighting factors de-  
11 scribed in subsection (a) for discharges occurring on or  
12 after January 1, 2004, as may be appropriate to ensure  
13 that hospital emergency room costs attributable to medi-  
14 care patients are appropriately covered.

15 (c) NATIONAL CONFERENCE ON ER POLICY.—Not  
16 later than 1 year after the date of the enactment of this  
17 Act, the Secretary of Health and Human Services shall  
18 convene a National Conference on the State of Emergency  
19 Room Care and Access in the United States. Such con-  
20 ference shall explore the current state of emergency room  
21 care, future trends, and make recommendations on wheth-  
22 er a national emergency room policy should be developed  
23 to ensure timely access to emergency rooms for all resi-  
24 dents of the United States. The conference shall be open  
25 to the public and the Secretary shall appoint up to 30

1 members of the public, the provider community, and other  
 2 stakeholders to participate in the development of the con-  
 3 ference report and shall designate one to serve as chair-  
 4 man.

5 **TITLE II—MODERNIZING**  
 6 **MEDICARE BENEFITS**  
 7 **Subtitle A—Prescription Drug**  
 8 **Benefit**

9 **SEC. 201. OPTIONAL MEDICARE OUTPATIENT PRESCRIP-**  
 10 **TION MEDICINE PROGRAM UNDER TITLE**  
 11 **XVIII.**

12 (a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et  
 13 seq.) is amended—

14 (1) by redesignating section 1859 and part D  
 15 as section 1858 and part E, respectively; and

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

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

20 “ELIGIBILITY; OPTIONAL ENROLLMENT; COVERAGE

21 “SEC. 1859. (a) ELIGIBILITY.—Each individual who  
 22 is enrolled under this part is eligible to enroll in accord-  
 23 ance with this section for outpatient prescription medicine  
 24 benefits under this part.

25 “(b) OPTIONAL ENROLLMENT.—

1           “(1) IN GENERAL.—An individual may enroll  
2 under this part only in such manner and form as  
3 may be prescribed by regulations, and only during  
4 an enrollment period prescribed in or under this sub-  
5 section.

6           “(2) INITIAL ENROLLMENT PERIOD.—

7           “(A) INDIVIDUALS CURRENTLY COV-  
8 ERED.—In the case of an individual who satis-  
9 fies subsection (a) as of November 1, 2003, the  
10 initial general enrollment period shall begin on  
11 August 1, 2003, and shall end on March 1,  
12 2004.

13           “(B) INDIVIDUAL COVERED IN FUTURE.—

14 In the case of an individual who first satisfies  
15 subsection (a) on or after November 1, 2003,  
16 the individual’s initial enrollment period shall  
17 begin on the first day of the third month before  
18 the month in which such individual first satis-  
19 fies such paragraph and shall end seven months  
20 later. The Secretary shall apply rules similar to  
21 the rule described in the second sentence of sec-  
22 tion 1837(d).

23           “(3) SPECIAL ENROLLMENT PERIODS (WITHOUT  
24 PREMIUM PENALTY).—

1           “(A) EMPLOYER COVERAGE AT TIME OF  
2 INITIAL GENERAL ENROLLMENT PERIOD.—In  
3 the case of an individual who—

4           “(i) at the time the individual first  
5 satisfies subsection (a) is enrolled in a  
6 group health plan by reason of the individ-  
7 ual’s (or the individual’s spouse’s) current  
8 employment status, and

9           “(ii) has elected not to enroll (or to be  
10 deemed enrolled) under this subsection  
11 during the individual’s initial enrollment  
12 period,

13 there shall be a special enrollment period of 6  
14 months beginning with the first month that in-  
15 cludes the date of the individual’s (or individ-  
16 ual’s spouse’s) retirement from or termination  
17 of current employment status with the employer  
18 that sponsors the plan.

19           “(B) DROPPING OF RETIREE PRESCRIP-  
20 TION MEDICINE COVERAGE.—In the case of an  
21 individual who—

22           “(i) at the time the individual first  
23 satisfies subsection (a) is enrolled in a  
24 group health plan that provides outpatient  
25 prescription medicine coverage other than

1 by reason of the individual's (or the indi-  
2 vidual's spouse's) current employee; and

3 “(ii) has elected not to enroll (or to be  
4 deemed enrolled) under this subsection  
5 during the individual's initial enrollment  
6 period,

7 there shall be a special enrollment period of 6  
8 months beginning with the first month that in-  
9 cludes the date that the plan substantially ter-  
10 minates outpatient prescription medicine cov-  
11 erage and ending 6 months later.

12 “(C) LOSS OF MEDICARE+CHOICE PRE-  
13 SCRIPTION MEDICINE COVERAGE.—In the case  
14 of an individual who is enrolled under part C in  
15 a Medicare+Choice plan that provides prescrip-  
16 tion medicine benefits that are at least equiva-  
17 lent to (or greater than) the benefits made  
18 available under this part, if such enrollment is  
19 terminated because of the termination of the  
20 plan, there shall be a special enrollment period  
21 of 6 months beginning with the first month that  
22 includes the date that such plan is terminated  
23 and ending 6 months later.

1           “(D) LOSS OF MEDICAID PRESCRIPTION  
2 MEDICINE COVERAGE.—In the case of an indi-  
3 vidual who—

4                   “(i) satisfies subsection (a);

5                   “(ii) loses eligibility for prescription  
6 medicine benefits under a State plan after  
7 having been enrolled (or determined to be  
8 eligible) for such benefits under such plan;  
9 and

10                   “(iii) is not otherwise enrolled under  
11 this subsection at the time of such loss of  
12 eligibility,

13 there shall be a special enrollment period speci-  
14 fied by the Secretary beginning with the first  
15 month that includes the date that the individual  
16 loses such eligibility.

17           “(4) LATE ENROLLMENT WITH PREMIUM PEN-  
18 ALTY.—The Secretary shall permit an individual  
19 who satisfies subsection (a) to enroll other than dur-  
20 ing the initial enrollment period under paragraph (2)  
21 or a special enrollment period under paragraph (3).  
22 But, in the case of such an enrollment, the amount  
23 of the monthly premium of the individual is subject  
24 to an increase under section 1859B(a)(2).

25           “(5) INFORMATION.—

1           “(A) IN GENERAL.—The Secretary shall  
2 broadly distribute information to eligible bene-  
3 ficiaries on the benefits provided under this  
4 part. The Secretary shall periodically make  
5 available information on the cost differentials to  
6 enrollees for the use of generic medicines and  
7 other medicines.

8           “(B) TOLL-FREE HOTLINE.—The Sec-  
9 retary shall maintain a toll-free telephone hot-  
10 line (which may be a hotline already used by  
11 the Secretary under this title) for purposes of  
12 providing assistance to beneficiaries in the pro-  
13 gram under this part, including responding to  
14 questions concerning coverage, enrollment, ben-  
15 efits, grievances and appeals procedures, and  
16 other aspects of such program.

17           “(6) ENROLLEE DEFINED.—For purposes of  
18 this part, the term ‘enrollee’ means an individual en-  
19 rolled for benefits under this part.

20           “(c) COVERAGE PERIOD.—

21           “(1) IN GENERAL.—The period during which  
22 an individual is entitled to benefits under this part  
23 (in this subsection referred to as the individual’s  
24 ‘coverage period’) shall begin on such a date as the  
25 Secretary shall establish consistent with the type of

1 coverage rules described in subsections (a) and (e)  
2 of section 1838, except that in no case shall a cov-  
3 erage period begin before January 1, 2004. No pay-  
4 ments may be made under this part with respect to  
5 the expenses of an individual unless such expenses  
6 were incurred by such individual during a period  
7 which, with respect to the individual, is a coverage  
8 period.

9 “(2) TERMINATION.—The Secretary shall pro-  
10 vide for the application of provisions under this sub-  
11 section similar to the provisions in section 1838(b).

12 “BENEFITS

13 “SEC. 1859A. (a) IN GENERAL.—Subject to the suc-  
14 ceeding provisions of this section, the benefits provided to  
15 an enrollee by the program under this part shall consist  
16 of entitlement to have payment made on the individual’s  
17 behalf for covered outpatient prescription medicines.

18 “(b) COVERED OUTPATIENT MEDICINE DEFINED.—

19 “(1) IN GENERAL.—Except as provided in para-  
20 graph (2), for purposes of this part the term ‘cov-  
21 ered outpatient medicine’ means any of the following  
22 products:

23 “(A) A medicine which may be dispensed  
24 only upon prescription, and—

25 “(i) which is approved for safety and  
26 effectiveness as a prescription medicine

1 under section 505 of the Federal Food,  
2 Drug, and Cosmetic Act;

3 “(ii)(I) which was commercially used  
4 or sold in the United States before the  
5 date of enactment of the Drug Amend-  
6 ments of 1962 or which is identical, simi-  
7 lar, or related (within the meaning of sec-  
8 tion 310.6(b)(1) of title 21 of the Code of  
9 Federal Regulations) to such a medicine,  
10 and (II) which has not been the subject of  
11 a final determination by the Secretary that  
12 it is a ‘new drug’ (within the meaning of  
13 section 201(p) of the Federal Food, Drug,  
14 and Cosmetic Act) or an action brought by  
15 the Secretary under section 301, 302(a),  
16 or 304(a) of such Act to enforce section  
17 502(f) or 505(a) of such Act; or

18 “(iii)(I) which is described in section  
19 107(c)(3) of the Drug Amendments of  
20 1962 and for which the Secretary has de-  
21 termined there is a compelling justification  
22 for its medical need, or is identical, simi-  
23 lar, or related (within the meaning of sec-  
24 tion 310.6(b)(1) of title 21 of the Code of  
25 Federal Regulations) to such a medicine,

1 and (II) for which the Secretary has not  
2 issued a notice of an opportunity for a  
3 hearing under section 505(e) of the Fed-  
4 eral Food, Drug, and Cosmetic Act on a  
5 proposed order of the Secretary to with-  
6 draw approval of an application for such  
7 medicine under such section because the  
8 Secretary has determined that the medi-  
9 cine is less than effective for all conditions  
10 of use prescribed, recommended, or sug-  
11 gested in its labeling.

12 “(B) A biological product which—

13 “(i) may only be dispensed upon pre-  
14 scription;

15 “(ii) is licensed under section 351 of  
16 the Public Health Service Act; and

17 “(iii) is produced at an establishment  
18 licensed under such section to produce  
19 such product.

20 “(C) Insulin approved under appropriate  
21 Federal law, and needles, syringes, and dispos-  
22 able pumps for the administration of such insu-  
23 lin.

24 “(D) A prescribed medicine or biological  
25 product that would meet the requirements of

1           subparagraph (A) or (B) but that is available  
2           over-the-counter in addition to being available  
3           upon prescription.

4           “(E) Smoking cessation agents (as speci-  
5           fied by the Secretary)

6           “(2) EXCLUSION.—The term ‘covered out-  
7           patient medicine’ does not include any product—

8           “(A) except as provided in paragraphs  
9           (1)(D) and (1)(E), which may be distributed to  
10          individuals without a prescription;

11          “(B) when furnished as part of, or as inci-  
12          dent to, a diagnostic service or any other item  
13          or service for which payment may be made  
14          under this title;

15          “(C) that was covered under this title on  
16          the day before the date of the enactment of the  
17          Medicare Modernization and Solvency Act of  
18          2001; or

19          “(D) that is a therapeutically equivalent  
20          replacement for a product described in subpara-  
21          graph (B) or (C), as determined by the Sec-  
22          retary.

23          “(c) PAYMENT OF BENEFITS.—

24          “(1) IN GENERAL.—Subject to paragraphs (2)  
25          and (3), there shall be paid from the Federal Medi-

1 care Prescription Medicine Trust Fund, in the case  
2 of each enrollee who incurs expenses for medicines  
3 with respect to which benefits are payable under this  
4 part, amounts equal to the price for which the medi-  
5 cine is made available under this part (consistent  
6 with subsection (d) and including a reasonable dis-  
7 pensing fee). In no case shall the reimbursement for  
8 a prescribed nonformulary medicine without a re-  
9 strictive prescription be more than the lowest reim-  
10 bursement for a formulary medicine in the thera-  
11 peutic class of the prescribed medicine.

12 “(2) COST-SHARING.—

13 “(A) DEDUCTIBLE.—The amount of pay-  
14 ment under paragraph (1) for expenses in-  
15 curred in a year, beginning with 2004, shall be  
16 reduced by an annual deductible equal to \$250.

17 “(B) APPLICATION OF LIMITED COINSUR-  
18 ANCE.—The amount of payment under para-  
19 graph (1) for expenses incurred in a year shall  
20 be reduced (subject to the stop-loss limit under  
21 subparagraph (C)) by coinsurance equal to 20  
22 percent of the price or other amount described  
23 in paragraph (1) (except as the Secretary may  
24 otherwise provide under section 1859D(c)).

1           “(C) REDUCTION IN COINSURANCE FOR  
2 COSTS EXCEEDING AN AMOUNT.—

3           “(i) IN GENERAL.—Subject to clause  
4 (ii), once an enrollee has incurred aggregate  
5 cost-sharing under subparagraph (B)  
6 (including cost-sharing under part B attributable  
7 to outpatient prescription drugs  
8 or biologicals) equal to \$2,000 for expenses  
9 in a year, the coinsurance under subparagraph  
10 (B) shall be reduced from 20 percent  
11 to 5 percent.

12           “(ii) CONTINUED APPLICATION OF CO-  
13 INSURANCE FOR CERTAIN UNNECESSARILY  
14 EXPENSIVE DRUGS.—The reduction in co-  
15 insurance under clause (i) shall not apply  
16 to a prescribed formulary medicine without  
17 a restricted prescription that is more ex-  
18 pensive than the lowest cost medicine in  
19 the same therapeutic class.

20           “(D) INFLATION ADJUSTMENT.—

21           “(i) IN GENERAL.—In the case of any  
22 year beginning after 2004, each of the dol-  
23 lar amounts in subparagraphs (A) and (C)  
24 shall be increased by an amount equal to—

1                   “(I) such dollar amount, multi-  
2                   plied by

3                   “(II) the percentage change esti-  
4                   mated by the Secretary for the period  
5                   beginning with 2004 and ending with  
6                   the year involved as provided under  
7                   section 1859F.

8                   “(ii) ROUNDING.—If any dollar  
9                   amount after being increased under clause  
10                  (i) is not a multiple of \$10, such dollar  
11                  amount shall be rounded to the nearest  
12                  multiple of \$10.

13                  “(3) APPLICATION OF CATASTROPHIC LIMIT TO  
14                  PART B COST-SHARING FOR OTHER DRUGS.—In ad-  
15                  dition to payments under paragraph (1), there shall  
16                  be paid from the Federal Medicare Prescription  
17                  Medicine Trust Fund, in the case of each enrollee  
18                  who incurs out-of-pocket expenses for outpatient  
19                  prescription medicines with respect to which benefits  
20                  are payable under part B, amounts equivalent to the  
21                  amount of the reduction in cost-sharing that would  
22                  have been made under subparagraph (B) of para-  
23                  graph (2) if the payment had been made for the  
24                  drug under this part rather than under part B.

1           “(4) APPLICATION OF PRICING SYSTEM UNDER  
2           PART B.—For purposes of making payment under  
3           part B for medicines that would be covered out-  
4           patient medicines but for the exclusion under sub-  
5           paragraph (B) or (C) of subsection (b)(2), the Sec-  
6           retary may elect to apply the payment basis used for  
7           payment of covered outpatient medicines under this  
8           part instead of the payment basis otherwise used  
9           under such part, if it results in a lower cost to the  
10          program.

11          “(d) AVAILABILITY OF PRESCRIPTION MEDICINES AT  
12          REASONABLE PRICES.—In order to establish reasonable  
13          prices for covered prescription medicines under this part,  
14          the Secretary may use a competitive bidding system, con-  
15          tract with appropriate fiscal intermediaries or carriers (in  
16          this section referred to as ‘contractors’), or use such other  
17          private sector practices (including negotiations with medi-  
18          cine manufacturers, wholesalers, and pharmacies) as may  
19          be appropriate to assure adequate reimbursement in order  
20          to have the participation of sufficient numbers of phar-  
21          macies to ensure convenient access (including adequate  
22          emergency access) to covered prescription medicines. The  
23          prices established under this subsection shall not be sub-  
24          ject to administrative or judicial review.

1       “(e) AGREEMENTS WITH ANY WILLING PHAR-  
2 MACY.—

3           “(1) IN GENERAL.—The Secretary (and any  
4 contractor) shall enter into a participation agree-  
5 ment with any willing pharmacy that meets the re-  
6 quirements of this subsection and section 1859D to  
7 furnish covered prescription medicines to individuals  
8 enrolled under this part.

9           “(2) TERMS OF AGREEMENT.—An agreement  
10 under this subsection shall include the following  
11 terms and conditions:

12           “(A) LICENSING.—The pharmacy shall  
13 meet (and throughout the contract period con-  
14 tinue to meet) all applicable State and local li-  
15 censing requirements.

16           “(B) ACCESS AND QUALITY STANDARDS.—  
17 The pharmacy shall comply with such standards  
18 as the Secretary (and such a contractor) shall  
19 establish concerning the quality of, and enrolled  
20 individuals’ access to, pharmacy services under  
21 this part.

22           “(C) ADHERENCE TO ESTABLISHED  
23 PRICES.—The total charge for each medicine  
24 dispensed by the pharmacy to an enrolled indi-  
25 vidual under this part, without regard to wheth-

1 er the individual is financially responsible for  
 2 any or all of such charge, shall not exceed the  
 3 price established under subsection (d) with re-  
 4 spect to such medicine plus a reasonable dis-  
 5 pensing fee determined contractually with the  
 6 Secretary (or contractor).

7 “PREMIUMS

8 “SEC. 1859B. (a) AMOUNT OF PREMIUM.—

9 (1) IN GENERAL.—The provisions of sub-  
 10 sections (a)(1), (a)(2), (a)(3), (c), and (f) of section  
 11 1839 shall apply under this part to all enrollees in  
 12 the same manner as they apply under part B to in-  
 13 dividuals 65 years of age or older enrolled under  
 14 such part.

15 “(2) LATE ENROLLMENT PENALTY.—

16 “(A) IN GENERAL.—In the case of a late  
 17 enrollment described in section 1859A(b)(4),  
 18 subject to the succeeding provisions of this  
 19 paragraph, the Secretary shall establish proce-  
 20 dures for increasing the amount of the monthly  
 21 premium under this section applicable to such  
 22 enrollee—

23 “(i) by an amount that is equal to 10  
 24 percent of such premium for each full 12-  
 25 month period (in the same continuous pe-  
 26 riod of eligibility) in which the enrollee

1           could have been enrolled under this part  
2           but was not so enrolled; or

3           “(ii) if determined appropriate by the  
4           Secretary, by an amount that the Sec-  
5           retary determines is actuarially sound for  
6           each such period.

7           “(B) PERIODS TAKEN INTO ACCOUNT.—  
8           For purposes of calculating any 12-month pe-  
9           riod under subparagraph (A), there shall be  
10          taken into account—

11          “(i) the months which elapsed be-  
12          tween the close of the enrollee’s initial en-  
13          rollment period and the close of the enroll-  
14          ment period in which the enrollee enrolled;  
15          and

16          “(ii) in the case of an enrollee who re-  
17          enrolls under this part, the months which  
18          elapsed between the date of termination of  
19          a previous coverage period and the close of  
20          the enrollment period in which the enrollee  
21          reenrolled.

22          “(C) PERIODS NOT TAKEN INTO AC-  
23          COUNT.—

24          “(i) IN GENERAL.—For purposes of  
25          calculating any 12-month period under

1           subparagraph (A), subject to clause (ii),  
2           there shall not be taken into account  
3           months for which the enrollee can dem-  
4           onstrate that the enrollee was covered  
5           under a group health plan that provides  
6           coverage of the cost of prescription drugs  
7           whose actuarial value (as defined by the  
8           Secretary) to the enrollee equals or exceeds  
9           the actuarial value of the benefits provided  
10          to an individual enrolled in the outpatient  
11          prescription drug benefit program under  
12          this part.

13                 “(ii) APPLICATION.—This subpara-  
14                 graph shall only apply with respect to a  
15                 coverage period the enrollment for which  
16                 occurs before the end of the 60-day period  
17                 that begins on the first day of the month  
18                 which includes the date on which the plan  
19                 terminates, ceases to provide, or reduces  
20                 the value of the prescription drug coverage  
21                 under such plan to below the value of the  
22                 coverage provided under the program  
23                 under this part.

24                 “(D) PERIODS TREATED SEPARATELY.—

25                 Any increase in an enrollee’s monthly premium

1 under subparagraph (A) with respect to a par-  
2 ticular continuous period of eligibility shall not  
3 be applicable with respect to any other contin-  
4 uous period of eligibility which the enrollee may  
5 have.

6 “(E) CONTINUOUS PERIOD OF ELIGI-  
7 BILITY.—

8 “(i) IN GENERAL.—Subject to clause  
9 (ii), for purposes of this paragraph, an en-  
10 rollee’s ‘continuous period of eligibility’ is  
11 the period that begins with the first day on  
12 which the enrollee is eligible to enroll  
13 under section 1859A and ends with the en-  
14 rollee’s death.

15 “(ii) SEPARATE PERIOD.—Any period  
16 during all of which an enrollee satisfied  
17 section 1859A(a) and which terminated in  
18 or before the month preceding the month  
19 in which the beneficiary attained age 65  
20 shall be a separate ‘continuous period of  
21 eligibility’ with respect to the enrollee (and  
22 each such period which terminates shall be  
23 deemed not to have existed for purposes of  
24 subsequently applying this paragraph).



1       “(b) APPLICATION OF SMI TRUST FUND PROVI-  
2       SIONS.—The provisions of subsections (b) through (i) of  
3       section 1841 shall apply to this part and the Trust Fund  
4       in the same manner as they apply to part B and the Fed-  
5       eral Supplementary Medical Insurance Trust Fund, re-  
6       spectively.

7               “ADMINISTRATION; QUALITY ASSURANCE

8       “SEC. 1859D. (a) IN GENERAL.—The Secretary is  
9       responsible for the administration of this part and may  
10      enter into contracts with appropriate contractors (includ-  
11      ing State and local governments and agencies of such gov-  
12      ernments) on a national or regional basis to administer  
13      the program under this part in a manner similar to the  
14      administration under part B. The Secretary shall provide  
15      for only one contractor for each region, but may allow  
16      multiple specialty contractors in a region (such as a State  
17      or unit of local government serving a low-income popu-  
18      lation in an area) and may, in the case of multiple contrac-  
19      tors in a region, require them to coordinate coverage and  
20      services in that region. Such contracts shall have such  
21      terms and conditions as the Secretary shall specify and  
22      shall be for such terms (not to exceed 5 years) as the Sec-  
23      retary shall specify consistent with this part.

24      “(b) QUALITY AND FINANCIAL STANDARDS AND  
25      PROGRAMS.—In consultation with appropriate contractors  
26      with expertise in prescribing, dispensing, and the appro-

1 p r i a t e u s e o f p r e s c r i p t i o n m e d i c i n e s , t h e S e c r e t a r y s h a l l  
2 e s t a b l i s h s t a n d a r d s a n d p r o g r a m s f o r t h e a d m i n i s t r a t i o n  
3 o f t h i s p a r t t o e n s u r e a p p r o p r i a t e p r e s c r i b i n g , d i s p e n s i n g ,  
4 a n d u t i l i z a t i o n o f o u t p a t i e n t m e d i c i n e s u n d e r t h i s p a r t , t o  
5 a v o i d a d v e r s e m e d i c i n e r e a c t i o n s , a n d t o c o n t i n u a l l y r e -  
6 d u c e e r r o r s i n t h e d e l i v e r y o f m e d i c a l l y a p p r o p r i a t e c o v -  
7 e r e d b e n e f i t s . S u c h s t a n d a r d s a n d p r o g r a m s s h a l l b e a p -  
8 p l i e d t o a n y a d m i n i s t r a t i v e a g r e e m e n t s d e s c r i b e d i n s u b -  
9 s e c t i o n ( a ) t h e S e c r e t a r y e n t e r s i n t o . S u c h s t a n d a r d s a n d  
10 p r o g r a m s s h a l l i n c l u d e t h e f o l l o w i n g :

11           “(1) ON-LINE REVIEW.—A requirement for on-  
12           line prospective review available 24 hours a day and  
13           7 days a week in order to evaluate each prescription  
14           for medicine therapy problems due to duplication,  
15           interaction, or incorrect dosage or duration of ther-  
16           apy.

17           “(2) ENROLLEE GUIDELINES.—Consistent with  
18           State law, application of guidelines for counseling  
19           enrollees regarding—

20                   “(A) the proper use of prescribed covered  
21                   outpatient medicines; and

22                   “(B) interactions and contra-indications.

23           “(3) EDUCATION.—Application of methods to  
24           identify and educate providers, pharmacists, and en-  
25           rollees regarding—

1           “(A) instances or patterns concerning the  
2 unnecessary or inappropriate prescribing or dis-  
3 pensing of covered outpatient medicines;

4           “(B) instances or patterns of substandard  
5 care;

6           “(C) potential adverse reactions to covered  
7 outpatient medicines;

8           “(D) inappropriate use of antibiotics;

9           “(E) appropriate use of generic products;  
10 and

11           “(F) the importance of using covered out-  
12 patient medicines in accordance with the in-  
13 struction of prescribing providers.

14           “(4) COORDINATION.—Coordination with State  
15 prescription drug programs, contractors, pharmacies,  
16 and other relevant entities as necessary to ensure  
17 appropriate coordination of benefits with respect to  
18 enrolled individuals, including coordination of access  
19 to and payment for covered prescription medicines  
20 according to an individual’s in-service area plan pro-  
21 visions, when such individual is traveling outside the  
22 home service area, and under such other cir-  
23 cumstances as the Secretary may specify.

24           “(5) COST DATA.—

1           “(A) Requiring contracted private carriers  
2 administering a prescription medicine plan to  
3 make prescription medicine cost data available  
4 to the Secretary.

5           “(B) With respect to section 1859A(d)(1),  
6 requiring private contractors—

7                   “(i) to maintain its prescription medi-  
8 cine cost data and certify the prescription  
9 medicine cost data is current, accurate,  
10 and complete, and reflects all discounts  
11 that would affect the level of payments  
12 from the Federal Medicare Prescription  
13 Drug Trust Fund to the carrier,

14                   “(ii) to make such prescription medi-  
15 cine cost data available for review and  
16 audit by the Secretary, and

17                   “(iii) to certify that the carrier has  
18 met the requirements of subsection (c).

19           “(C) Requiring that all private administra-  
20 tive contractors require participating phar-  
21 macists, physicians, and manufacturers—

22                   “(i) to maintain their prescription  
23 medicine cost data,

1           “(ii) to make such prescription medi-  
2           cine cost data available for review and  
3           audit by the Secretary, and

4           “(iii) to certify that the prescription  
5           medicine cost data is current, accurate,  
6           and complete, and reflects all discounts ob-  
7           tained by the pharmacist or physician in  
8           the purchasing of covered outpatient medi-  
9           cines that were provided to the individual  
10          enrolled under the prescription medicine  
11          plan.

12          “(D) The Secretary, either directly or  
13          through a contractor, shall define, compile, and  
14          make public on the Internet in an easily com-  
15          parable form, the average manufacturer price of  
16          all medicines covered under this title.

17          “(E) Discounts referred to in subpara-  
18          graphs (B) and (C) shall include all volume dis-  
19          counts, manufacturer rebates, prompt payment  
20          discounts, free goods, in-kind services, or any  
21          other thing of financial value provided explicitly  
22          or implicitly in exchange for the purchase of a  
23          covered prescription medicine.

24          “(6) PROCEDURES TO COMPENSATE PHAR-  
25          MACISTS FOR COUNSELING.—The Secretary shall

1 publish procedures for compensating pharmacists for  
2 providing the counseling described in paragraph (2).

3 “(c) RULES RELATING TO PROVISION OF BENE-  
4 FITS.—

5 “(1) PROVISION OF BENEFITS.—

6 “(A) IN GENERAL.—In providing benefits  
7 under this part, the Secretary (directly or  
8 through contracts) shall employ mechanisms to  
9 provide benefits economically, including the use  
10 of—

11 “(i) formularies (consistent with para-  
12 graph (2));

13 “(ii) automatic generic medicine sub-  
14 stitution (unless the physician specifies  
15 otherwise, in which case a 30-day prescrip-  
16 tion may be dispensed pending a consulta-  
17 tion with the physician on whether a ge-  
18 neric substitute can be dispensed in the fu-  
19 ture);

20 “(iii) tiered copayments (which may  
21 include copayments at a rate higher than  
22 20 percent) to encourage the use of the  
23 lowest cost, on-formulary product in cases  
24 where there is no restrictive prescription  
25 (described in subparagraph (C)(i)); and

1 “(iv) therapeutic interchange.

2 “(B) CONSTRUCTION.—Nothing in this  
3 subsection shall be construed to prevent the  
4 Secretary (directly or through contracts) from  
5 using incentives (including a lower or higher  
6 beneficiary coinsurance) to encourage enrollees  
7 to select generic or other cost-effective medi-  
8 cines, so long as—

9 “(i) such incentives are designed not  
10 to result in any increase in the aggregate  
11 expenditures under the Federal Medicare  
12 Prescription Medicine Trust Fund;

13 “(ii) the average coinsurance charged  
14 to all beneficiaries by the Secretary (di-  
15 rectly or through contractors) shall seek to  
16 approximate 20 percent for on-formulary  
17 medicines;

18 “(iii) a beneficiary’s coinsurance shall  
19 be no greater than 20 percent if the pre-  
20 scription is a restrictive prescription; and

21 “(iv) the reimbursement for a pre-  
22 scribed nonformulary medicine without a  
23 restrictive prescription in no case shall be  
24 more than the lowest reimbursement for a

1           formulary medicine in the therapeutic class  
2           of the prescribed medicine.

3           “(C) RESTRICTIVE PRESCRIPTION.—For  
4           purposes of this section:

5                   “(i) WRITTEN PRESCRIPTIONS.—In  
6                   the case of a written prescription for a  
7                   medicine, it is a restrictive prescription  
8                   only if the prescription indicates, in the  
9                   writing of the physician or other qualified  
10                  person prescribing the medicine and with  
11                  an appropriate phrase (such as ‘brand  
12                  medically necessary’) recognized by the  
13                  Secretary, that a particular medicine prod-  
14                  uct must be dispensed and a brief expla-  
15                  nation of why a restrictive prescription is  
16                  necessary. Such explanation may cite lit-  
17                  erature, approved by the Food and Drug  
18                  Administration, that references adverse re-  
19                  actions of the formulary drug.

20                   “(ii) TELEPHONE PRESCRIPTIONS.—  
21                   In the case of a prescription issued by tele-  
22                   phone for a medicine, it is a restrictive  
23                   prescription only if the prescription cannot  
24                   be longer than 30 days and the physician  
25                   or other qualified person prescribing the

1 medicine (through use of such an appro-  
2 priate phrase) states that a particular  
3 medicine product must be dispensed, and  
4 the physician or other qualified person sub-  
5 mits to the pharmacy involved, within 30  
6 days after the date of the telephone pre-  
7 scription, a written confirmation from the  
8 physician or other qualified person pre-  
9 scribing the medicine and which indicates  
10 with such appropriate phrase that the par-  
11 ticular medicine product was required to  
12 have been dispensed and a brief expla-  
13 nation of why a restrictive prescription is  
14 necessary. Such explanation may cite lit-  
15 erature, approved by the Food and Drug  
16 Administration, that references adverse re-  
17 actions of the formulary drug. Such writ-  
18 ten confirmation is required to refill the  
19 prescription.

20 “(iii) REVIEW OF RESTRICTIVE PRE-  
21 SCRIPTIONS.—The advisory committee (es-  
22 tablished under paragraph (2)(A)) may de-  
23 cide to review a restrictive prescription  
24 and, if so, it may approve or disapprove  
25 such restrictive prescription and, if it dis-

1           approves, upon request of the prescribing  
2           physician or the enrollee, must provide for  
3           a review by an independent contractor of  
4           such decision within 48 hours of the time  
5           of submission of the prescription, to deter-  
6           mine whether the prescription is an eligible  
7           benefit under this part. The Secretary  
8           shall ensure that independent contractors  
9           so used are completely independent of the  
10          contractor or its advisory committee.

11           “(2) REQUIREMENTS WITH RESPECT TO  
12          FORMULARIES.—If the Secretary uses or permits the  
13          use of a formulary by a contractor to contain costs  
14          under this part, the Secretary or contractor shall—

15           “(A) use an advisory committee (or a  
16          therapeutics committee) comprised of licensed  
17          practicing physicians, pharmacists, and other  
18          health care practitioners to develop the for-  
19          mulary, except that no person (or immediate  
20          family member) who has a conflict of interest  
21          with any pharmaceutical manufacturer (such as  
22          any financial tie to a manufacturer of a covered  
23          drug) shall serve on the advisory committee;

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

4           “(C) disclose to current and prospective  
5           enrollees and to participating providers and  
6           pharmacies in the service area the nature of the  
7           formulary restrictions, including information re-  
8           garding the medicines included in the formulary  
9           and any difference in cost-sharing amounts.

10          “(3) CONSTRUCTION.—Nothing in this sub-  
11          section shall preclude the Secretary (or an admin-  
12          istering entity under a contract with the Secretary)  
13          from—

14                 “(A) educating prescribing providers, phar-  
15                 macists, and enrollees about medical and cost  
16                 benefits of formulary products;

17                 “(B) requesting prescribing providers to  
18                 consider a formulary product prior to dis-  
19                 pensing of a nonformulary medicine, as long as  
20                 such request does not unduly delay the provi-  
21                 sion of the medicine;

22                 “(C) requiring pharmacists (or contrac-  
23                 tors) to substitute a generic medicine equivalent  
24                 for a prescribed medicine, except when the pre-  
25                 scribed medicine has a restrictive prescription;

1           “(D) using mechanisms to encourage eligi-  
2           ble beneficiaries to select cost-effective medi-  
3           cines or less costly means of receiving or admin-  
4           istering medicines, including the use of thera-  
5           peutic interchange programs, disease manage-  
6           ment programs, and notification to the bene-  
7           ficiary that a more affordable generic medicine  
8           equivalent was not selected by the prescribing  
9           provider and a statement of the lost cost sav-  
10          ings to the beneficiary;

11          “(E) using a competitive bidding system  
12          for each therapeutic medicine class in order to  
13          include only the most cost-effective medicines  
14          on the formulary;

15          “(F) comparing medicine prices of OECD  
16          countries in an effort to include the most cost-  
17          effective medicines on the formulary and, in  
18          compliance with laws governing the importation  
19          and re-importation of pharmaceuticals, obtain-  
20          ing pharmaceuticals from the lowest cost source  
21          that is approved for safety by the Food and  
22          Drug Administration; and

23          “(G) establishing performance standards,  
24          or monetary bonuses or penalties, or both, if  
25          the specified performance standards are not

1 met, including the time taken to answer mem-  
2 ber and pharmacy inquiries (written or by tele-  
3 phone), the accuracy of responses, claims proc-  
4 essing accuracy, online system availability, ap-  
5 peal procedure turnaround time, system avail-  
6 ability, and the accuracy and timeliness of re-  
7 ports.

8 To encourage responsiveness to beneficiary concerns,  
9 penalties or incentive bonuses, or both, may be used  
10 based on the level of beneficiary satisfaction with  
11 their services, as measured by beneficiary satisfac-  
12 tion surveys and interviews.

13 “(4) INCENTIVES FOR COST AND UTILIZATION  
14 MANAGEMENT AND QUALITY IMPROVEMENT.—

15 “(A) IN GENERAL.—The Secretary shall  
16 include in a contract awarded under subsection  
17 (b) with a contractor such incentives for cost  
18 and utilization management and quality im-  
19 provement as the Secretary may deem appro-  
20 priate.

21 “(B) RISK CORRIDORS TIED TO PERFORM-  
22 ANCE MEASURES AND OTHER INCENTIVES.—  
23 The incentives under subparagraph (A) shall in-  
24 clude a risk corridor under which—

1           “(i) there is a 50 percent sharing of  
2           all savings (as determined based on the  
3           difference between the contract bid per  
4           beneficiary and the costs per beneficiary)  
5           greater than 5 percent; and

6           “(ii) a 50 percent sharing of all losses  
7           (as so determined) greater than 105 per-  
8           cent of the contract bid per beneficiary.

9           “(C) OTHER INCENTIVES.—Such incen-  
10          tives may also include—

11           “(i) financial incentives under which  
12           savings derived from the substitution of  
13           generic medicines in lieu of nongeneric  
14           medicines are made available to carriers,  
15           pharmacies, beneficiaries, and the Federal  
16           Medicare Prescription Medicine Trust  
17           Fund; and

18           “(ii) any other incentive that the Sec-  
19           retary deems appropriate and likely to be  
20           effective in managing costs or utilization.

21           “(D) ADJUSTMENT BASED ON ACTUARIAL  
22          RISK.—To the extent that incentives under this  
23          paragraph are established, the Secretary may  
24          include a methodology for adjusting the pay-  
25          ments made based on differences in the actu-

1           arial risk of different enrollees being served if  
2           the Secretary determines such adjustments to  
3           be necessary and appropriate.

4           “(d) CONFIDENTIALITY.—The Secretary shall ensure  
5 that the confidentiality of individually identifiable health  
6 information used under this part is protected, consistent  
7 with the Secretary’s guidelines of September 11, 1997, the  
8 Privacy Rule published in the Federal Register on Decem-  
9 ber 28, 2000, or any subsequent comprehensive and more  
10 protective set of confidentiality standards enacted into law  
11 or promulgated by the Secretary. Nothing in this sub-  
12 section shall be construed as preventing the coordination  
13 of data with a State prescription drug program so long  
14 as such program has in place confidentiality standards  
15 that are equal to or exceed the standards used by the Sec-  
16 retary.

17           “(e) PROCEDURES REGARDING DENIALS OF CARE.—  
18 The Secretary shall establish guidelines for—

19           “(1) the timely review and resolution of denials  
20 of care and grievances (including those regarding  
21 the use of formularies under subsection (c)) by en-  
22 rollees, or providers, pharmacists, and other individ-  
23 uals acting on behalf of such individual (with the in-  
24 dividual’s consent) in accordance with requirements  
25 (as established by the Secretary) that are com-

1       parable to such requirements for Medicare+Choice  
2       organizations under part C, including expedited ap-  
3       peals; and

4               “(2) providing enrollees with information re-  
5       garding such grievances and appeals procedures at  
6       the time of enrollment under this part and annually  
7       thereafter.

8       “(f) FRAUD AND ABUSE SAFEGUARDS.—The Sec-  
9       retary, through the Office of the Inspector General, is au-  
10      thorized and directed to issue regulations establishing ap-  
11      propriate safeguards to prevent fraud and abuse. Such  
12      safeguards, at a minimum, should include compliance pro-  
13      grams, certification data, and recordkeeping practices. In  
14      developing such regulations, the Secretary shall consult  
15      with the Attorney General and other law enforcement and  
16      regulatory agencies.

17       “(g) GUARANTEED ACCESS TO MEDICINES IN RURAL  
18      AND HARD-TO-SERVE AREAS.—The Secretary shall en-  
19      sure that all beneficiaries have guaranteed access to the  
20      full range of pharmaceuticals under this part, and shall  
21      give special attention to access, pharmacist counseling,  
22      and delivery in rural and hard-to-serve areas, including  
23      through the use of incentives such as bonus payments to  
24      retail pharmacists in rural areas and extra payments to

1 the benefit administrator for the cost of rapid delivery of  
2 pharmaceuticals and any other actions necessary.

3 “COMPENSATION FOR EMPLOYERS COVERING RETIREE  
4 MEDICINE COSTS

5 “SEC. 1859E. (a) IN GENERAL.—In the case of an  
6 individual who is eligible to be enrolled under this part  
7 and is a participant or beneficiary under a group health  
8 plan that provides outpatient prescription medicine cov-  
9 erage the actuarial value of which is not less than the ac-  
10 tuarial value of the coverage provided under this part, the  
11 Secretary shall make payments to such plan subject to the  
12 provisions of this section. Such payments shall be treated  
13 as payments under this part for purposes of sections  
14 1859C and 1859B(c). In applying the previous sentence  
15 with respect to section 1859B(c), the amount of the Gov-  
16 ernment contribution referred to in section 1844(a)(1)(A)  
17 is deemed to be equal to the aggregate amount of the pay-  
18 ments made under this section.

19 “(b) REQUIREMENTS.—To receive payment under  
20 this section, a group health plan shall comply with the fol-  
21 lowing requirements:

22 “(1) COMPLIANCE WITH REQUIREMENTS.—The  
23 group health plan shall comply with the require-  
24 ments of this Act and other reasonable, necessary,  
25 and related requirements that are needed to admin-  
26 ister this section, as determined by the Secretary.

1           “(2) MAINTENANCE OF CURRENT BENEFITS.—  
2           In the case of a group health plan that is in exist-  
3           ence prior to the date of the enactment of this sec-  
4           tion and that provides medicine coverage to retirees  
5           that is equal to or greater than the medicine cov-  
6           erage provided under this part, the plan shall reim-  
7           burse or otherwise arrange to compensate bene-  
8           ficiaries for the portion of such premium for at least  
9           1 year from the date that the group health plan be-  
10          gins participation under this section.

11           “(3) MAINTENANCE OF CURRENT BENEFITS  
12          UNDER CERTAIN COLLECTIVE BARGAINING AGREE-  
13          MENTS.—In the case of a group health plan that, on  
14          the date of the enactment of this section, was pro-  
15          viding medicine coverage in excess of that provided  
16          under this part to eligible beneficiaries under a col-  
17          lective bargaining agreement (other than pursuant  
18          to a labor management plan operating under the  
19          Labor-Management Relations Act, 1947 (popularly  
20          known as the Taft-Hartley Act)), the plan shall con-  
21          tinue to provide such excess coverage to such eligible  
22          beneficiaries until the later of 4 years after the date  
23          of the enactment of this section or the expiration of  
24          any contractual obligation to provide such excess  
25          coverage that existed as of such date of enactment.

1           “(4) ANNUAL ASSURANCES AND NOTICE BE-  
2           FORE TERMINATION.—The sponsor of the plan  
3           shall—

4                   “(A) annually attest, and provide such as-  
5                   surances as the Secretary may require, that the  
6                   coverage offered under the group health plan  
7                   meets the requirements of this section and will  
8                   continue to meet such requirements for the du-  
9                   ration of the sponsor’s participation in the pro-  
10                  gram under this section; and

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

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

15                           “(ii) immediately upon determining  
16                           that the actuarial value of the prescription  
17                           medicine benefit under the plan falls below  
18                           the actuarial value required under sub-  
19                           section (a).

20           “(5) BENEFICIARY INFORMATION.—The spon-  
21           sor of the plan shall report to the Secretary, for  
22           each calendar quarter for which it seeks a payment  
23           under this section, the names and social security  
24           numbers of all enrollees described in subsection (a)  
25           covered under such plan during such quarter and

1 the dates (if less than the full quarter) during which  
2 each such individual was covered.

3 “(6) AUDITS.—The sponsor or plan seeking  
4 payment under this section shall agree to maintain,  
5 and to afford the Secretary access to, such records  
6 as the Secretary may require for purposes of audits  
7 and other oversight activities necessary to ensure the  
8 adequacy of prescription medicine coverage, the ac-  
9 curacy of payments made, and such other matters as  
10 may be appropriate.

11 “(c) PAYMENT.—

12 “(1) IN GENERAL.—The sponsor of a group  
13 health plan that meets the requirements of sub-  
14 section (b) with respect to a quarter in a calendar  
15 year shall be entitled to have payment made on a  
16 quarterly basis of the amount specified in paragraph  
17 (2) for each individual described in subsection (a)  
18 who during the quarter is covered under the plan  
19 and was not enrolled in the insurance program  
20 under this part.

21 “(2) AMOUNT OF PAYMENT.—The amount of  
22 the payment for a quarter shall approximate, for  
23 each such covered individual,  $\frac{2}{3}$  of the portion of the  
24 premium under subsection (a) of section 1859B that

1 is not payable by the individual under such section  
2 for months in the quarter.

3 “PROMOTION OF PHARMACEUTICAL RESEARCH ON  
4 BREAK-THROUGH MEDICINES WHILE PROVIDING  
5 PROGRAM COST CONTAINMENT

6 “SEC. 1859F. (a) MONITORING EXPENDITURES.—  
7 The Secretary shall monitor expenditures under this part.  
8 On October 1, 2004, the Secretary shall estimate total ex-  
9 penditures under this part for 2004.

10 “(b) ESTABLISHMENT OF SUSTAINABLE GROWTH  
11 RATE.—

12 “(1) IN GENERAL.—The Secretary shall estab-  
13 lish a sustainable growth rate prescription medicine  
14 target system for expenditures under this part for  
15 each year after 2004.

16 “(2) INITIAL COMPUTATION.—Such target shall  
17 equal the amount of total expenditures estimated for  
18 2004 adjusted by the Secretary’s estimate of a sus-  
19 tainable growth rate (in this section referred to as  
20 an ‘SGR’) percentage between 2004 and 2005. Such  
21 SGR shall be estimated based on the following:

22 “(A) Reasonable changes in the cost of  
23 production or price of covered pharmaceuticals,  
24 but in no event more than the rate of increase  
25 in the consumer price index for all urban con-  
26 sumers for the period involved.

1           “(B) Population enrolled in this part, both  
2           in numbers and in average age and severity of  
3           chronic and acute illnesses.

4           “(C) Appropriate changes in utilization of  
5           pharmaceuticals, as determined by the Drug  
6           Review Board (established under subsection  
7           (c)(3)) and based on best estimates of utiliza-  
8           tion change if there were no direct-to-consumer  
9           advertising or promotions to providers.

10          “(D) Productivity index of manufacturers  
11          and distributors.

12          “(E) Percentage of products with patent  
13          and market exclusivity protection versus prod-  
14          ucts without patent protection and changes in  
15          the availability of generic substitutes.

16          “(F) Such other factors as the Secretary  
17          may determine are appropriate.

18          In no event may the sustainable growth rate exceed  
19          120 percent of the estimated per capita growth in  
20          total spending under this title.

21          “(3) COMPUTATION FOR SUBSEQUENT  
22          YEARS.—In October of 2005 and each year there-  
23          after, for purposes of setting the SGRs for the suc-  
24          ceeding year, the Secretary shall adjust each current  
25          year’s estimated expenditures by the estimated SGR

1 for the succeeding year, further adjusted for correc-  
2 tions in earlier estimates and the receipt of addi-  
3 tional data on previous years spending as follows:

4 “(A) ERROR ESTIMATES.—An adjustment  
5 (up or down) for errors in the estimate of total  
6 expenditures under this part for the previous  
7 year.

8 “(B) COSTS.—An adjustment (up or  
9 down) for corrections in the cost of production  
10 of prescriptions covered under this part between  
11 the current calendar year and the previous year.

12 “(C) TARGET.—An adjustment for any  
13 amount (over or under) that expenditures in the  
14 current year under this part are estimated to  
15 differ from the target amount set for the year.  
16 If expenditures in the current year are esti-  
17 mated to be—

18 “(i) less than the target amount, fu-  
19 ture target amounts will be adjusted down-  
20 ward; or

21 “(ii) more than the target amount,  
22 the Secretary shall notify all pharma-  
23 ceutical manufacturers with sales of phar-  
24 maceutical prescription medicine products  
25 to medicare beneficiaries under this part,

1 of a rebate requirement (except as pro-  
2 vided in this subparagraph) to be deposited  
3 in the Federal Medicare Prescription Medi-  
4 cine Trust Fund.

5 “(D) REBATE DETERMINATION.—The  
6 amount of the rebate described in subparagraph  
7 (C)(ii) may vary among manufacturers and  
8 shall be based on the manufacturer’s estimated  
9 contribution to the expenditure above the target  
10 amount, taking into consideration such factors  
11 as—

12 “(i) above average increases in the  
13 cost of the manufacturer’s product;

14 “(ii) increases in utilization due to  
15 promotion activities of the manufacturer,  
16 wholesaler, or retailer;

17 “(iii) launch prices of new drugs at  
18 the same or higher prices as similar drugs  
19 already in the marketplace (so-called ‘me  
20 too’ or ‘copy-cat’ drugs);

21 “(iv) the role of the manufacturer in  
22 delaying the entry of generic products into  
23 the market; and

24 “(v) such other actions by the manu-  
25 facturer that the Secretary may determine

1           has contributed to the failure to meet the  
2           SGR target.

3           The rebates shall be established under such  
4           subparagraph so that the total amount of the  
5           rebates is estimated to ensure that the amount  
6           the target for the current year is estimated to  
7           be exceeded is recovered in lower spending in  
8           the subsequent year; except that, no rebate  
9           shall be made in any manufacturer's product  
10          which the Food and Drug Administration has  
11          determined is a breakthrough medicine (as de-  
12          termined under subsection (c)) or an orphan  
13          medicine.

14          “(c) BREAKTHROUGH MEDICINES.—

15                 “(1) DETERMINATION.—For purposes of this  
16                 section, a medicine is a ‘breakthrough medicine’ if  
17                 the Drug Review Board (established under para-  
18                 graph (3)) determines—

19                         “(A) it is a new product that will make a  
20                         significant and major improvement by reducing  
21                         physical or mental illness, reducing mortality,  
22                         or reducing disability; and

23                         “(B) that no other product is available to  
24                         beneficiaries that achieves similar results for  
25                         the same condition at a lower cost.

1           “(2) CONDITION.—An exemption from rebates  
2           under subsection (b)(3) for a breakthrough medicine  
3           shall continue as long as the medicine is certified as  
4           a breakthrough medicine but shall be limited to 7  
5           calendar years from 2004 or 7 calendar years from  
6           the date of the initial determination under para-  
7           graph (1), whichever is later.

8           “(3) DRUG REVIEW BOARD.—The Drug Review  
9           Board under this paragraph shall consist of the  
10          Commissioner of Food and Drugs, the Directors of  
11          the National Institutes of Health, the Director of  
12          the National Science Foundation, and 10 experts in  
13          pharmaceuticals, medical research, and clinical care,  
14          selected by the Commissioner of Food and Drugs  
15          from the faculty of academic medical centers, except  
16          that no person who has (or who has an immediate  
17          family member that has) any conflict of interest with  
18          any pharmaceutical manufacturer shall serve on the  
19          Board.

20          “(d) NO REVIEW.—The Secretary’s determination of  
21          the rebate amounts under this section, and the Drug Re-  
22          view Board’s determination of what is a breakthrough  
23          drug, are not subject to administrative or judicial review.

1           “COORDINATION WITH COMPREHENSIVE STATE  
2                            PRESCRIPTION DRUG PROGRAMS

3           “SEC. 1859G. (a) IN GENERAL.—In the case of a  
4 comprehensive State-funded prescription drug program  
5 (in this section referred to as a ‘State program’) that is  
6 in existence on the date of the enactment of this part, the  
7 State shall have the option of electing to use the program  
8 as a wrap-around program to supplement and coordinate  
9 the benefits with the benefits provided under this part con-  
10 sistent with this section. In the case of a State that makes  
11 such an election, the Secretary shall require pharma-  
12 ceutical benefit managers and other contracting entities  
13 to coordinate with the State program in a manner to en-  
14 sure that the State program supplements (and does not  
15 supplant) the program under this part.

16           “(b) DEEMING.—The State program may provide  
17 that individuals who are enrolled in the State program and  
18 who are eligible to enroll in the program under this part  
19 but are not enrolled in the program under this part (or  
20 in a Medicare+Choice plan) are deemed enrolled in the  
21 program under this part.

22           “(c) COORDINATION OF BENEFITS.—The State pro-  
23 gram may coordinate benefits in a manner so that it is  
24 a payor of last resort, including payment after payment  
25 may be made under this part or under a Medicare+Choice

1 plan, including for individuals for whom the State elects  
2 to buy-in to this part or such a plan.

3       “(d) REQUIREMENT FOR EMERGENCY DIS-  
4 PENSING.—The State program may require a pharma-  
5 ceutical benefit manager to authorize dispensing of a 72-  
6 hour emergency supply of a medication for which a prior  
7 authorization is otherwise required to a person enrolled  
8 in a State program. The cost for such emergency supply  
9 shall be treated as a benefit under this part.

10       “(e) TREATMENT AS PHARMACEUTICAL BENEFIT  
11 MANAGER.—The State program may elect to treat itself  
12 as a contracting entity under this part with respect to in-  
13 dividuals enrolled (or eligible to be enrolled) under the  
14 State program. In the case of such an election, the State  
15 shall maintain its existing eligibility criteria as well as ex-  
16 isting benefit structure so long as such criteria and struc-  
17 ture provide a standard benefit equal to or greater than  
18 the benefit provided under this part.

19       “(f) CONFIDENTIALITY.—The Secretary shall waive  
20 any confidentiality requirements relating to the sharing of  
21 enrollment data between a State program and the Sec-  
22 retary in order to implement this section.”.

23       (b) CONFORMING AMENDMENTS.—(1) Part C of title  
24 XVIII of such Act is amended—

1 (A) in section 1851(a)(2)(B) (42 U.S.C.  
2 1395w-21(a)(2)(B)), by striking “1859(b)(3)” and  
3 inserting “1858(b)(3)”;

4 (B) in section 1851(a)(2)(C) (42 U.S.C.  
5 1395w-21(a)(2)(C)), by striking “1859(b)(2)” and  
6 inserting “1858(b)(2)”;

7 (C) in section 1852(a)(1) (42 U.S.C. 1395w-  
8 22(a)(1)), by striking “1859(b)(3)” and inserting  
9 “1858(b)(3)”;

10 (D) in section 1852(a)(3)(B)(ii) (42 U.S.C.  
11 1395w-22(a)(3)(B)(ii)), by striking  
12 “1859(b)(2)(B)” and inserting “1858(b)(2)(B)”;

13 (E) in section 1853(a)(1)(A) (42 U.S.C.  
14 1395w-23(a)(1)(A)), by striking “1859(e)(4)” and  
15 inserting “1858(e)(4)”;

16 (F) in section 1853(a)(3)(D) (42 U.S.C.  
17 1395w-23(a)(3)(D)), by striking “1859(e)(4)” and  
18 inserting “1858(e)(4)”.

19 (2) Section 138(b)(4) of the Internal Revenue Code  
20 of 1986 is amended by striking “1859(b)(3)” and insert-  
21 ing “1858(b)(3)”.

1 **SEC. 202. PROVISION OF MEDICARE OUTPATIENT PRE-**  
2 **SCRIPTION DRUG COVERAGE UNDER THE**  
3 **MEDICARE+CHOICE PROGRAM.**

4 (a) **REQUIRING AVAILABILITY OF AN ACTUARIALLY**  
5 **EQUIVALENT PRESCRIPTION MEDICINE BENEFIT.**—Sec-  
6 tion 1851 (42 U.S.C. 1395w–21) is amended by adding  
7 at the end the following new subsection:

8 “(j) **AVAILABILITY OF PRESCRIPTION MEDICINE**  
9 **BENEFITS.**—

10 “(1) **IN GENERAL.**—Notwithstanding any other  
11 provision of this part, each Medicare+Choice organi-  
12 zation that makes available a Medicare+Choice plan  
13 described in section 1851(a)(2)(A) shall make avail-  
14 able such a plan that offers coverage of covered out-  
15 patient medicines that is at least actuarially equiva-  
16 lent to the benefits provided under part D. Informa-  
17 tion respecting such benefits shall be made available  
18 in the same manner as information on other benefits  
19 provided under this part is made available. Nothing  
20 in this paragraph shall be construed as requiring the  
21 offering of such coverage separate from coverage  
22 that includes benefits under parts A and B.

23 “(2) **TREATMENT OF PRESCRIPTION DRUG EN-**  
24 **ROLLEES.**—In the case of a Medicare+Choice eligi-  
25 ble individual who is enrolled under part D, the ben-  
26 efits described in paragraph (1) shall be treated in

1 the same manner as benefits described in part B for  
2 purposes of coverage and payment and any reference  
3 in this part to the Federal Supplementary Medical  
4 Insurance Trust Fund shall be deemed, with respect  
5 to such benefits, to be a reference to the Federal  
6 Medicare Prescription Medicine Trust Fund.”.

7 (b) APPLICATION OF QUALITY STANDARDS.—Section  
8 1852(e)(2)(A) (42 U.S.C. 1395w–22(e)(2)(A)) is  
9 amended—

10 (1) by striking “and” at the end of clause (xi);

11 (2) by striking the period at the end of clause  
12 (xii) and inserting “, and”; and

13 (3) by adding at the end the following new  
14 clause:

15 “(xiii) comply with the standards, and  
16 apply the programs, under section  
17 1859D(b) for covered outpatient medicines  
18 under the plan.”.

19 (c) PAYMENT SEPARATE FROM PAYMENT FOR PART  
20 A AND B BENEFITS.—Section 1853 (42 U.S.C. 1395w–  
21 23) is amended—

22 (1) in subsection (a)(1)(A), by striking “and  
23 (i)” and inserting “(i), and (j)”; and

24 (2) by adding at the end the following new sub-  
25 section:

1       “(j) PAYMENT FOR PRESCRIPTION MEDICINE COV-  
2 ERAGE OPTION.—

3           “(1) IN GENERAL.—In the case of a  
4 Medicare+Choice plan that provides prescription  
5 medicine benefits described in section 1851(j)(1),  
6 the amount of payment otherwise made to the  
7 Medicare+Choice organization offering the plan  
8 shall be increased by the amount described in para-  
9 graph (2). Such payments shall be made in the same  
10 manner and time as the amount otherwise paid, but  
11 such amount shall be payable from the Federal  
12 Medicare Prescription Medicine Trust Fund.

13           “(2) AMOUNT.—The amount described in this  
14 paragraph is twice the actuarial rate computed  
15 under section 1859B(a) (based upon the provisions  
16 of section 1839(a)(1)), but subject to adjustment  
17 under paragraph (3). Such amount shall be uniform  
18 geographically and shall not vary based on the  
19 Medicare+Choice payment area involved.

20           “(3) RISK ADJUSTMENT.—The Secretary shall  
21 establish a methodology for the adjustment of the  
22 payment amount under this subsection in a manner  
23 that takes into account the relative risks for use of  
24 outpatient prescription medicines by  
25 Medicare+Choice enrollees. Such methodology shall

1 be designed in a manner so that the total payments  
2 under this title (including part D) are not changed  
3 as a result of the application of such methodology.”.

4 (d) SEPARATE APPLICATION OF ADJUSTED COMMU-  
5 NITY RATE (ACR).—Section 1854 (42 U.S.C. 1395w–24)  
6 is amended by adding at the end the following:

7 “(i) APPLICATION TO PRESCRIPTION MEDICINE COV-  
8 ERAGE.—The Secretary shall apply the previous provisions  
9 of this section (including the computation of the adjusted  
10 community rate) separately with respect to prescription  
11 medicine benefits described in section 1851(j)(1).”.

12 (e) CONFORMING AMENDMENTS.—

13 (1) Section 1851 (42 U.S.C. 1395w–21) is  
14 amended—

15 (A) in subsection (a)(1)(A), by striking  
16 “parts A and B” and inserting “parts A, B,  
17 and D”; and

18 (B) in subsection (i) by inserting “(and, if  
19 applicable, part D)” after “parts A and B”.

20 (2) Section 1852(a)(1)(A) (42 U.S.C. 1395w–  
21 22(a)(1)(A)) is amended by inserting “(and under  
22 part D to individuals also enrolled under such part)”  
23 after “parts A and B”.

24 (3) Section 1852(d)(1) (42 U.S.C. 1395w–  
25 22(d)(1)) is amended—

1 (A) by striking “and” at the end of sub-  
2 paragraph (D);

3 (B) by striking the period at the end  
4 of subparagraph (E) and inserting “;  
5 and”; and

6 (C) by adding at the end the fol-  
7 lowing:

8 “(F) the plan for part D benefits guaran-  
9 tees coverage of any specifically named pre-  
10 scription medicine for an enrollee, when pre-  
11 scribed by a physician in accordance with the  
12 provisions of such part, regardless of whether  
13 such medicine would otherwise be covered under  
14 an applicable formulary or discount arrange-  
15 ment, but only to the extent that it would be re-  
16 quired to be covered under part D.

17 In carrying out subparagraph (F), a  
18 Medicare+Choice organization has the same author-  
19 ity to establish formularies as contracting entities  
20 have under part D, but subject to an independent  
21 contractor appeal or other appeal process that would  
22 be applicable to determinations by such a con-  
23 tracting entity.”.

1           (4) Section 1854(e) (42 U.S.C. 1395w-24(e)) is  
2           amended by adding at the end the following new  
3           paragraph:

4           “(5) SPECIAL RULE FOR PART D BENEFITS.—  
5           In no event may a Medicare+Choice organization in-  
6           clude as part of a plan for part D benefits a require-  
7           ment that an enrollee pay a deductible or a coinsur-  
8           ance percentage that exceeds 20 percent, except as  
9           provided in section 1859A(c).”.

10 **SEC. 203. TRANSITIONAL ASSISTANCE FOR LOW INCOME**  
11 **BENEFICIARIES.**

12           (a) QMB COVERAGE OF PREMIUMS AND COST-SHAR-  
13           ING.—Section 1905(p)(3) (42 U.S.C. 1396d(p)(3)) is  
14           amended—

15           (1) in subparagraph (A)—

16           (A) by striking “and” at the end of clause  
17           (i),

18           (B) by adding “and” at the end of clause  
19           (ii), and

20           (C) by adding at the end the following new  
21           clause:

22           “(iii) premiums under section 1859B(a).”;

23           (2) in subparagraph (B), by inserting “and sec-  
24           tion 1859A(b)(1)(B)” after “1813”; and

1           (3) in subparagraph (C), by striking “and sec-  
2           tion 1833(b)” and inserting “, section 1833(b), and  
3           section 1859A(b)(1)(A)”.

4           (b)   EXPANDED   SLMB   ELIGIBILITY.—Section  
5   1902(a)(10)(E)   (42   U.S.C.   1396a(a)(10)(E))   is  
6   amended—

7           (1) by striking “and” at the end of clause (iii);

8           (2) by adding “and” at the end of clause (iv);

9           and

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

12                 “(v)(I) for making medical assistance  
13                 available for medicare cost sharing described in  
14                 section 1905(p)(3)(A)(iii) and medicare cost-  
15                 sharing described in section 1905(p)(3)(B) but  
16                 only insofar as it relates to benefits provided  
17                 under part D of title XVIII, subject to section  
18                 1905(p)(4), for individuals who would be quali-  
19                 fied medicare beneficiaries described in section  
20                 1905(p)(1) but for the fact that their income  
21                 exceeds 100 percent, but is less than 135 per-  
22                 cent, of the official poverty line (referred to in  
23                 such section) for a family of the size involved;  
24                 and

1           “(II) subject to section 1905(p)(4), for in-  
2           dividuals who would be qualified medicare bene-  
3           ficiaries described in section 1905(p)(1) but for  
4           the fact that their income exceeds 135 percent,  
5           but is less than 150 percent, of the official pov-  
6           erty line (referred to in such section) for a fam-  
7           ily of the size involved, for making medical as-  
8           sistance available for a portion of the medicare  
9           cost sharing described in section  
10          1905(p)(3)(A)(iii), such portion determined on  
11          a sliding scale related to income;”.

12          (c) FEDERAL FINANCING.—The second sentence of  
13          section 1905(b) (42 U.S.C. 1396d(b)) is amended by in-  
14          serting before the period at the end the following: “and  
15          with respect to amounts expended that are attributable to  
16          section 1902(a)(10)(E)(v)”.

17          (d) ALTERNATIVE ENROLLMENT METHODS.—Sec-  
18          tion 1902 (42 U.S.C. 1396a) is amended by adding at the  
19          end the following new subsection:

20          “(aa) In the process of enrolling low-income individ-  
21          uals for medicare cost-sharing under this title, the Sec-  
22          retary shall use the system provided under section 154 of  
23          the Social Security Act Amendments of 1994 for newly  
24          eligible medicare beneficiaries and shall apply a similar  
25          system for other medicare beneficiaries. Such system shall

1 use existing Federal Government databases to identify eli-  
2 gibility. Such system shall not require that beneficiaries  
3 apply for, or enroll through, State medicaid systems in  
4 order to obtain medical assistance for medicare cost-shar-  
5 ing under this title.”.

6 (e) EFFECTIVE DATE.—The amendments made by  
7 this section apply to medical assistance for premiums and  
8 cost-sharing incurred on or after January 1, 2004, with  
9 regard to whether regulations to implement such amend-  
10 ments are promulgated by such date.

11 **SEC. 204. MEDIGAP REVISIONS.**

12 (a) REQUIRED COVERAGE OF COVERED OUTPATIENT  
13 MEDICINES.—Section 1882(p)(2)(B) (42 U.S.C.  
14 1395ss(p)(2)(B)) is amended by inserting before “and” at  
15 the end the following: “including a requirement that an  
16 appropriate number of policies provide coverage of medi-  
17 cines which complements but does not duplicate the medi-  
18 cine benefits that beneficiaries are otherwise eligible for  
19 benefits under part D of this title (with the Secretary and  
20 the National Association of Insurance Commissioners de-  
21 termining the appropriate level of medicine benefits that  
22 each benefit package must provide and ensuring that poli-  
23 cies providing such coverage are affordable for bene-  
24 ficiaries and include at least a 5 percent copayment per  
25 prescription);”.

1 (b) EFFECTIVE DATE.—The amendment made by  
2 subsection (a) shall take effect on January 1, 2004.

3 (c) TRANSITION PROVISIONS.—

4 (1) IN GENERAL.—If the Secretary of Health  
5 and Human Services identifies a State as requiring  
6 a change to its statutes or regulations to conform  
7 its regulatory program to the amendments made by  
8 this section, the State regulatory program shall not  
9 be considered to be out of compliance with the re-  
10 quirements of section 1882 of the Social Security  
11 Act due solely to failure to make such change until  
12 the date specified in paragraph (4).

13 (2) NAIC STANDARDS.—If, within 9 months  
14 after the date of enactment of this Act, the National  
15 Association of Insurance Commissioners (in this  
16 subsection referred to as the “NAIC”) modifies its  
17 NAIC Model Regulation relating to section 1882 of  
18 the Social Security Act (referred to in such section  
19 as the 1991 NAIC Model Regulation, as subse-  
20 quently modified) to conform to the amendments  
21 made by this section, such revised regulation incor-  
22 porating the modifications shall be considered to be  
23 the applicable NAIC model regulation (including the  
24 revised NAIC model regulation and the 1991 NAIC  
25 Model Regulation) for the purposes of such section.

1           (3) SECRETARY STANDARDS.—If the NAIC  
2 does not make the modifications described in para-  
3 graph (2) within the period specified in such para-  
4 graph, the Secretary of Health and Human Services  
5 shall make the modifications described in such para-  
6 graph and such revised regulation incorporating the  
7 modifications shall be considered to be the appro-  
8 priate regulation for the purposes of such section.

9           (4) DATE SPECIFIED.—

10           (A) IN GENERAL.—Subject to subpara-  
11 graph (B), the date specified in this paragraph  
12 for a State is the earlier of—

13           (i) the date the State changes its stat-  
14 utes or regulations to conform its regu-  
15 latory program to the changes made by  
16 this section; or

17           (ii) 1 year after the date the NAIC or  
18 the Secretary first makes the modifications  
19 under paragraph (2) or (3), respectively.

20           (B) ADDITIONAL LEGISLATIVE ACTION RE-  
21 QUIRED.—In the case of a State which the Sec-  
22 retary identifies as—

23           (i) requiring State legislation (other  
24 than legislation appropriating funds) to

1 conform its regulatory program to the  
2 changes made in this section; but

3 (ii) having a legislature which is not  
4 scheduled to meet in 2002 in a legislative  
5 session in which such legislation may be  
6 considered;

7 the date specified in this paragraph is the first  
8 day of the first calendar quarter beginning after  
9 the close of the first legislative session of the  
10 State legislature that begins on or after Janu-  
11 ary 1, 2002. For purposes of the previous sen-  
12 tence, in the case of a State that has a 2-year  
13 legislative session, each year of such session  
14 shall be deemed to be a separate regular session  
15 of the State legislature.

16 **SEC. 205. RATE REDUCTION FOR MEDICARE ELIGIBLE FED-**  
17 **ERAL ANNUITANTS.**

18 (a) IN GENERAL.—

19 (1) The Office of Personnel Management shall,  
20 in consultation with carriers offering health benefits  
21 plans contracted pursuant to section 8902 of title 5,  
22 United States Code, reduce the rates charged medi-  
23 care eligible individuals participating in such health  
24 benefit plans, by the amount, prorated for each cov-  
25 ered medicare eligible individual, of the estimated

1 cost of medical services and supplies which, but for  
2 the amendments made by this subtitle, would have  
3 been payable by such plans.

4 (2) The reduced rates as provided under para-  
5 graph (1), shall apply as of the effective dates of the  
6 respective amendments.

7 (b) AUTHORIZATION OF AVAILABILITY OF EM-  
8 PLOYEE HEALTH BENEFITS FUND FOR RATE REDUC-  
9 TION.—Funds in the Employees Health Benefits Fund es-  
10 tablished under section 8909 of title 5, United States  
11 Code, are available without fiscal year limitation for costs  
12 incurred by the Office of Personnel Management in mak-  
13 ing rate reductions provided under this section.

14 (c) DEFINITION.—For purposes of this section, The  
15 term “medicare eligible individual” means any annuitant,  
16 survivor of an annuitant, or former spouse of an  
17 annuitant—

18 (1) who is—

19 (A) otherwise eligible for benefits under  
20 chapter 89 of title 5, United States Code; and

21 (B) enrolled for benefits under part D of  
22 title XVIII of the Social Security Act; and

23 (2) for whom benefits paid under title XVIII of  
24 the Social Security Act are the primary source of  
25 health care benefits.

1 **SEC. 206. PART B PAYMENT FOR OUTPATIENT DRUGS**  
2 **BASED ON ACTUAL ACQUISITION COST.**

3 (a) **IN GENERAL.**—Section 1842(o)(1) (42 U.S.C.  
4 1395u(o)(1)) is amended by striking “95 percent of the  
5 average wholesale price” and inserting “the actual acqui-  
6 sition cost to the physician, supplier, or other person, plus  
7 such dispensing fee as the Secretary determines is nec-  
8 essary to cover the efficient administration of the drug by  
9 the physician, supplier, or other person”.

10 (b) **EFFECTIVE DATE.**—The amendment made by  
11 subsection (a) applies to drugs provided on or after Janu-  
12 ary 1, 2002.

13 **SEC. 207. COVERAGE OF HOME INFUSION DRUG THERAPY**  
14 **SERVICES.**

15 (a) **IN GENERAL.**—Section 1832(a)(2)(A) (42 U.S.C.  
16 1395k(a)(2)(A)) is amended by inserting “and home infu-  
17 sion drug therapy services” before the semicolon.

18 (b) **HOME INFUSION DRUG THERAPY SERVICES DE-**  
19 **FINED.**—Section 1861 of such Act (42 U.S.C. 1395x), as  
20 amended by sections 102(b) and 105(b) of the Medicare,  
21 Medicaid, and SCHIP Benefits Improvement and Protec-  
22 tion Act of 2000, as enacted into law by section 1(a)(6)  
23 of Public Law 106–554, is amended by adding at the end  
24 the following new subsection:

1 “Home Infusion Drug Therapy Services

2 “(ww)(1) The term ‘home infusion drug therapy serv-  
3 ices’ means the items and services described in paragraph  
4 (2) furnished to an individual who is under the care of  
5 a physician—

6 “(A) in a setting described in paragraph  
7 (4)(A)(ii),

8 “(B) by a qualified home infusion drug therapy  
9 provider (as defined in paragraph (3)) or by others  
10 under arrangements with them made by that pro-  
11 vider, and

12 “(C) under a plan established and periodically  
13 reviewed by a physician.

14 “(2) The items and services described in this para-  
15 graph are such nursing, pharmacy, and related services  
16 (including medical supplies, intravenous fluids, delivery,  
17 and equipment) as are necessary to conduct safely and ef-  
18 fectively a drug regimen through use of a covered home  
19 infusion drug (as defined in paragraph (4)), but do not  
20 include such covered home infusion drugs.

21 “(3) The term ‘qualified home infusion drug therapy  
22 provider’ means any entity that the Secretary determines  
23 meets the following requirements (or, in the case of a  
24 home health agency or an entity with respect to which the  
25 only items and services described in paragraph (2) fur-

1 nished by the entity are enteral nutrition therapy services,  
2 meets any of the following requirements which the Sec-  
3 retary considers appropriate):

4           “(A) The entity is capable of providing or ar-  
5 ranging for the items and services described in para-  
6 graph (2) and covered home infusion drugs.

7           “(B) The entity maintains clinical records on  
8 all patients.

9           “(C) The entity adheres to written protocols  
10 and policies with respect to the provision of items  
11 and services.

12           “(D) The entity makes services available (as  
13 needed) seven days a week on a 24-hour basis.

14           “(E) The entity coordinates all service with the  
15 patient’s physician.

16           “(F) The entity conducts a quality assessment  
17 and assurance program, including drug regimen re-  
18 view and coordination of patient care.

19           “(G) The entity assures that only trained per-  
20 sonnel provide covered home infusion drugs (and any  
21 other service for which training is required to pro-  
22 vide the service safely).

23           “(H) The entity assumes responsibility for the  
24 quality of services provided by others under arrange-  
25 ments with the entity.

1           “(I) In the case of an entity in any State in  
2           which State or applicable local law provides for the  
3           licensing of entities of this nature, the entity (i) is  
4           licensed pursuant to such law, or (ii) is approved, by  
5           the agency of such State or locality responsible for  
6           licensing entities of this nature, as meeting the  
7           standards established for such licensing.

8           “(J) The entity meets such other requirements  
9           as the Secretary may determine are necessary to as-  
10          sure the safe and effective provision of home infu-  
11          sion drug therapy services and the efficient adminis-  
12          tration of the home infusion drug therapy benefit.

13          “(4)(A) The term ‘covered home infusion drug’  
14          means a covered outpatient drug dispensed to an indi-  
15          vidual that—

16               “(i) is administered intravenously,  
17               subcutaneously, or epidurally, using an access device  
18               that is inserted into the body and an infusion device  
19               to control the rate of flow of the drug (or through  
20               other means of administration determined by the  
21               Secretary);

22               “(ii) is administered—

23                       “(I) in the individual’s home,

24                       “(II) an institution used as the individual’s  
25                       home, but only if the drug is administered dur-

1           ing an inpatient day for which payment is not  
2           made to the institution under part A for inpa-  
3           tient or extended care services furnished to the  
4           individual, or

5                 “(III) in a facility other than the individ-  
6           ual’s home if the administration of the drug at  
7           the facility is determined by the Secretary to be  
8           cost-effective (in accordance with such criteria  
9           as the Secretary may establish); and

10           “(iii) with respect to a drug furnished in a  
11           home setting—

12                 “(I) is an antibiotic drug and the Sec-  
13           retary has not determined, for the specific drug  
14           or the indication to which the drug is applied,  
15           that the drug cannot generally be administered  
16           safely and effectively in such a setting, or

17                 “(II) is not an antibiotic drug and the Sec-  
18           retary has determined, for the specific drug or  
19           the indication to which the drug is applied, that  
20           the drug can generally be administered safely  
21           and effectively in such a setting.

22           “(B) Not later than January 1, 2004, (and periodi-  
23           cally thereafter), the Secretary shall publish a list of the  
24           drugs, and indications for such drugs, that are covered

1 home infusion drugs, with respect to which home infusion  
2 drug therapy may be provided under this title.”.

3 (c) PAYMENT.—

4 (1) IN GENERAL.—Section 1833 (42 U.S.C.  
5 1395l) is amended—

6 (A) in subsection (a)(2)(B), by striking “or  
7 (E)” and inserting “(E), or (F)”,

8 (B) in subsection (a)(2)(F), by striking  
9 “and” at the end,

10 (C) in subsection (a)(2)(G), by striking the  
11 semicolon and inserting “; and”,

12 (D) by inserting after subsection (a)(2)(G)  
13 the following new subparagraph:

14 “(H) with respect to home infusion drug  
15 therapy services, the amounts described in sec-  
16 tion 1834(n);”, and

17 (E) in the first sentence of subsection (b),  
18 by striking “, (3)” and inserting “and home in-  
19 fusion drug therapy services, (3)”.

20 (2) AMOUNT DESCRIBED.—Section 1834, as  
21 amended by section 223(b) of the Medicare, Med-  
22 icaid, and SCHIP Benefits Improvement and Pro-  
23 tection Act of 2000, as enacted into law by section  
24 1(a)(6) of Public Law 106–554, is amended by add-  
25 ing at the end the following new subsection:

1 “(n) HOME INFUSION DRUG THERAPY SERVICES.—

2 “(1) IN GENERAL.—With respect to home infu-  
3 sion drug therapy services, payment under this part  
4 shall be made in an amount equal to the lesser of  
5 the actual charges for such services or the fee sched-  
6 ule established under paragraph (2). Payment for  
7 drugs so infused shall be made based on actual ac-  
8 quisition costs consistent with section 1842(o) (as  
9 amended by section 206 of the Medicare Moderniza-  
10 tion and Solvency Act of 2001).

11 “(2) ESTABLISHMENT OF FEE SCHEDULE.—

12 “(A) IN GENERAL.—The Secretary shall  
13 establish by regulation before the beginning of  
14 2004 and each succeeding year a fee schedule  
15 for home infusion drug therapy services for  
16 which payment is made under this part.

17 “(B) ADJUSTMENT FOR SERVICES FUR-  
18 NISHED BY INSTITUTIONS.—The fee schedule  
19 established by the Secretary under subpara-  
20 graph (A) shall provide for adjustments in the  
21 case of home infusion drug therapy services for  
22 which payment is made under this part that are  
23 furnished by a provider of services to avoid du-  
24 plicative payments under this title for the serv-  
25 ice costs associated with such services.”.

1 (d) CERTIFICATION.—Section 1835(a)(2) (42 U.S.C.  
2 1395n(a)(2)) is amended—

3 (1) by striking “and” at the end of subpara-  
4 graph (E),

5 (2) by striking the period at the end of sub-  
6 paragraph (F) and inserting “; and”, and

7 (3) by inserting after subparagraph (F) the fol-  
8 lowing:

9 “(G) in the case of home infusion drug  
10 therapy services, (i) such services are or were  
11 required because the individual needed such  
12 services for the administration of a covered  
13 home infusion drug, (ii) a plan for furnishing  
14 such services has been established and is re-  
15 viewed periodically by a physician, and (iii)  
16 such services are or were furnished while the in-  
17 dividual is or was under the care of a physi-  
18 cian.”.

19 (e) CERTIFICATION OF HOME INFUSION DRUG  
20 THERAPY PROVIDERS; INTERMEDIATE SANCTIONS FOR  
21 NONCOMPLIANCE.—

22 (1) TREATMENT AS PROVIDER OF SERVICES.—  
23 Section 1861(u) (42 U.S.C. 1395x(u)) is amended  
24 by inserting “home infusion drug therapy provider,”  
25 after “hospice program,”.

1           (2) CONSULTATION WITH STATE AGENCIES AND  
2 OTHER ORGANIZATIONS.—Section 1863 (42 U.S.C.  
3 1395z) is amended by striking “and (dd)(2)” and  
4 inserting “(dd)(2), and (ww)(3)”.

5           (3) USE OF STATE AGENCIES IN DETERMINING  
6 COMPLIANCE.—Section 1864(a) (42 U.S.C.  
7 1395aa(a)) is amended—

8           (A) in the first sentence, by striking “an  
9 agency is a hospice program” and inserting “an  
10 agency or entity is a hospice program or a  
11 home infusion drug therapy provider,”; and

12           (B) in the second sentence—

13           (i) by striking “institution or agency”  
14 and inserting “institution, agency, or enti-  
15 ty”, and

16           (ii) by striking “or hospice program”  
17 and inserting “hospice program, or home  
18 infusion drug therapy provider”.

19           (4) APPLICATION OF INTERMEDIATE SANC-  
20 TIONS.—Section 1846 (42 U.S.C. 1395w-2) is  
21 amended—

22           (A) in the heading, by adding “AND FOR  
23 QUALIFIED HOME INFUSION DRUG THERAPY  
24 PROVIDERS” at the end,

1           (B) in subsection (a), by inserting “or that  
2           a qualified home infusion drug therapy provider  
3           that is certified for participation under this title  
4           no longer substantially meets the requirements  
5           of section 1861(ww)(3)” after “under this  
6           part”, and

7           (C) in subsection (b)(2)(A)(iv), by insert-  
8           ing “or home infusion drug therapy services”  
9           after “clinical diagnostic laboratory tests”.

10       (f) USE OF REGIONAL INTERMEDIARIES IN ADMINIS-  
11       TRATION OF BENEFIT.—Section 1816 (42 U.S.C. 1395h)  
12       is amended by adding at the end the following new sub-  
13       section:

14       “(m) With respect to carrying out functions relating  
15       to payment for home infusion drug therapy services and  
16       covered home infusion drugs, the Secretary shall enter into  
17       contracts with agencies or organizations under this section  
18       to perform such functions on a regional basis.”.

19       (g) CONFORMING AMENDMENTS.—(1) Section  
20       1834(h)(4)(B) (42 U.S.C. 1395m(h)(4)(B)) is amended  
21       by striking “parenteral” and all that follows through “and  
22       does not include”.

23       (2) Section 1861(n) (42 U.S.C. 1395x(n)) is amend-  
24       ed by adding at the end the following: “Such term does  
25       not include any home infusion drug therapy services de-

1 scribed in section 1861(ww) or any covered outpatient  
2 drug used as a supply related to the furnishing of an item  
3 of durable medical equipment.”.

4 (3) Section 1861(s)(8) (42 U.S.C. 1395x(s)(8)) is  
5 amended by inserting after “dental” the following: “de-  
6 vices or enteral and parenteral nutrients, supplies, and  
7 equipment”.

8 (h) EFFECTIVE DATE.—The amendments made by  
9 this section shall apply to items and services furnished on  
10 or after January 1, 2004.

11 **SEC. 208. EXPANSION OF MEMBERSHIP OF MEDPAC TO 19.**

12 (a) IN GENERAL.—Section 1805(c) (42 U.S.C.  
13 1395b–6(c)) is amended—

14 (1) in paragraph (1), by striking “17” and in-  
15 sserting “19”; and

16 (2) in paragraph (2)(B), by inserting “experts  
17 in the area of pharmacology and prescription medi-  
18 cine benefit programs,” after “other health profes-  
19 sionals,”.

20 (b) INITIAL TERMS OF ADDITIONAL MEMBERS.—

21 (1) IN GENERAL.—For purposes of staggering  
22 the initial terms of members of the Medicare Pay-  
23 ment Advisory Commission under section 1805(c)(3)  
24 of the Social Security Act (42 U.S.C. 1395b–  
25 6(c)(3)), the initial terms of the 2 additional mem-

1       bers of the Commission provided for by the amend-  
2       ment under subsection (a)(1) are as follows:

3               (A) One member shall be appointed for 1  
4       year.

5               (B) One member shall be appointed for 2  
6       years.

7               (2) COMMENCEMENT OF TERMS.—Such terms  
8       shall begin on January 1, 2002.

9               (c) DUTY TO REVIEW SGR SYSTEM.—Section  
10       1805(b)(2) of such Act (42 U.S.C. 1395b–6(b)(2)) is  
11       amended by adding at the end the following new subpara-  
12       graph:

13               “(D) EXAMINATION OF SGR SYSTEM.—  
14       Specifically, the Commission shall review the  
15       sustainable growth rate prescription medicine  
16       target system established under section  
17       1859F(b).”.

18       **SEC. 209. GAO ONGOING STUDIES AND REPORTS ON PRO-**  
19       **GRAM; MISCELLANEOUS REPORTS.**

20               (a) ONGOING STUDY.—The Comptroller General of  
21       the United States shall conduct an ongoing study and  
22       analysis of the prescription medicine benefit program  
23       under part D of the Medicare Program under title XVIII  
24       of the Social Security Act (as added by section 201 of this  
25       subtitle), including an analysis of each of the following:

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

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

8           (3) The success of such program in reducing  
9           medication error and adverse medicine reactions and  
10          improving quality of care, and whether it is probable  
11          that the program has resulted in savings through re-  
12          duced hospitalizations and morbidity due to fewer  
13          (A) medication errors, (B) adverse medicine reac-  
14          tions, and (C) illnesses and injuries caused by medi-  
15          cations no longer foregone for financial reasons.

16          (4) Whether patient medical record confiden-  
17          tiality is being maintained and safeguarded.

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

20          (b) REPORTS.—The Comptroller General shall issue  
21          such reports on the results of the ongoing study described  
22          in subsection (a) as the Comptroller General shall deem  
23          appropriate and shall notify Congress on a timely basis  
24          of significant problems in the operation of the prescription

1 medicine program and the need for legislative adjustments  
2 and improvements.

3 (c) MISCELLANEOUS STUDIES AND REPORTS.—

4 (1) STUDY ON METHODS TO ENCOURAGE ADDI-  
5 TIONAL RESEARCH ON BREAKTHROUGH PHARMA-  
6 CEUTICALS.—

7 (A) IN GENERAL.—The Secretary of  
8 Health and Human Services shall seek the ad-  
9 vice of the Secretary of the Treasury on pos-  
10 sible tax and trade law changes to encourage  
11 increased original research on new pharma-  
12 ceutical breakthrough products designed to ad-  
13 dress disease and illness.

14 (B) REPORT.—Not later than January 1,  
15 2004, the Secretary shall submit to Congress a  
16 report on such study. The report shall include  
17 recommended methods to encourage the phar-  
18 maceutical industry to devote more resources to  
19 research and development of new covered prod-  
20 ucts than it devotes to overhead expenses.

21 (2) STUDY ON PHARMACEUTICAL SALES PRAC-  
22 TICES AND IMPACT ON COSTS AND QUALITY OF  
23 CARE.—

24 (A) IN GENERAL.—The Secretary of  
25 Health and Human Services shall conduct a

1 study on the methods used by the pharma-  
2 ceutical industry to advertise and sell to con-  
3 sumers and educate and sell to providers.

4 (B) REPORT.—Not later than January 1,  
5 2004, the Secretary shall submit to Congress a  
6 report on such study. The report shall include  
7 the estimated direct and indirect costs of the  
8 sales methods used, the quality of the informa-  
9 tion conveyed, and whether such sales efforts  
10 lead (or could lead) to inappropriate pre-  
11 scribing. Such report may include legislative  
12 and regulatory recommendations to encourage  
13 more appropriate education and prescribing  
14 practices.

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

17 (A) IN GENERAL.—The Secretary of  
18 Health and Human Services shall conduct a  
19 study on the costs of the pharmaceutical re-  
20 search and the role that the taxpayer provides  
21 in encouraging such research.

22 (B) REPORT.—Not later than January 1,  
23 2004, the Secretary shall submit to Congress a  
24 report on such study. The report shall include  
25 a description of the full range of taxpayer-as-

1           sisted programs impacting pharmaceutical re-  
2           search, including tax, trade, Government re-  
3           search, and regulatory assistance. The report  
4           may also include legislative and regulatory rec-  
5           ommendations that are designed to ensure that  
6           the taxpayer's investment in pharmaceutical re-  
7           search results in the availability of pharma-  
8           ceuticals at reasonable prices.

9           (4) REPORT ON PHARMACEUTICAL PRICES IN  
10          MAJOR FOREIGN NATIONS.—Not later than January  
11          1, 2004, the Secretary of Health and Human Serv-  
12          ices shall submit to Congress a report on the retail  
13          price of major pharmaceutical products in various  
14          developed nations, compared to prices for the same  
15          or similar products in the United States. The report  
16          shall include a description of the principal reasons  
17          for any price differences that may exist.

18          (5) STUDY ON REDUCED ERROR AND PAPER-  
19          WORK THROUGH PHYSICIAN ELECTRONIC SUBMIS-  
20          SION OF PRESCRIPTIONS.—The Secretary shall study  
21          and report within 2 years on what steps can be  
22          taken to use electronic prescribing, hand-held com-  
23          puters, and improved software resources to—

24                  (A) reduce prescription errors, the pre-  
25          scribing of inappropriate or contraindicated

1 medicines, and to make available a patient's  
2 prescription history;

3 (B) reduce paperwork;

4 (C) enable physicians to quickly and accu-  
5 rately determine whether a particular patient's  
6 medicine is on or off-formulary; and

7 (D) what the approximate cost to medicare  
8 and to patients is of various electronic and in-  
9 formation technology options available to pro-  
10 viders to improve the quality and safety of the  
11 delivery of the prescription drug benefit under  
12 this subtitle.

13 (6) STUDY ON WAYS TO REDUCE COSTS OF  
14 PHARMACEUTICALS AND FINANCE A MEDICARE PRE-  
15 SCRIPTON DRUG BENEFIT, WITHOUT REDUCING RE-  
16 SEARCH ON INNOVATIVE PHARMACEUTICALS.—The  
17 Secretary, in coordination with the Secretary of the  
18 Treasury, shall study and report on how much rev-  
19 enue could be raised for the financing of the medi-  
20 care outpatient prescription medicine program, how  
21 much medicine prices could be reduced for bene-  
22 ficiaries and for such program, and what the impact  
23 on the ability to conduct research on innovative  
24 pharmaceuticals would be if—

1 (A) tax incentives and export incentives  
2 were eliminated on the sale of United States  
3 manufactured pharmaceuticals sold to developed  
4 nations at a lower cost than offered for sale in  
5 the United States;

6 (B) tax deductions for the cost of direct to  
7 consumer advertising, gifts, and other direct  
8 lobbying of physicians (generally know as de-  
9 tailing) were denied;

10 (C) a tax at a 100 percent rate was im-  
11 posed on any income received by a pharma-  
12 ceutical company as payment for withholding a  
13 generic pharmaceutical product approved by the  
14 Food and Drug Administration from the mar-  
15 ketplace; and

16 (D) tax deductions on amounts spent on  
17 marketing and advertising in excess of research  
18 were denied.

19 SUBTITLE B—IMPROVING BENEFITS AND PREVENTIVE  
20 SERVICES

21 **SEC. 221. AUTHORITY TO PROVIDE PREVENTIVE SERVICES**

22 **UNDER PART B OF THE MEDICARE PROGRAM.**

23 (a) PREVENTIVE SERVICES BENEFIT.—Section  
24 1861(s), as amended by sections 111 and 114, is further  
25 amended—

1           (1) by striking “and” at the end of paragraph  
2           (16);

3           (2) by striking the period at the end of para-  
4           graph (17) and inserting “and”; and

5           (3) by inserting after paragraph (17) the fol-  
6           lowing new paragraph:

7           “(18) qualified preventive services, as defined in  
8           subsection (yy).”.

9           (b) DEFINITION OF PREVENTIVE SERVICES.—Sec-  
10          tion 1861 (42 U.S.C. 1395x), as amended by sections 112  
11          and 122, is further amended by adding at the end the  
12          following new subsection:

13                           “Qualified Preventive Services

14           “(yy)(1) Subject to paragraph (2), the term ‘qualified  
15          preventive services’ means items and services determined  
16          by the Secretary to be reasonable and necessary for the  
17          prevention or early detection of an illness or disability.

18           “(2) An item or service described in paragraph (1)  
19          shall be qualified as a preventive service if the Secretary  
20          determines by authoritative evidence that the provision of  
21          such item or service is cost effective. In determining if  
22          such an item or service is cost effective, the Secretary shall  
23          consider the following:

24                           “(A) Whether furnishing such an item or serv-  
25          ice for an illness or disability results in reductions

1 in estimated expenditures under the Social Security  
2 Act for the illness or disability, or avoids treatment  
3 in a more expensive setting.

4 “(B) Whether the item or service improves the  
5 health of the individual for whom the item or service  
6 is furnished.

7 “(C) In the case of an individual entitled to  
8 benefits under this title by reason of section 226(b),  
9 whether the item or service facilitates the return to  
10 work of the individual.”.

11 (c) PAYMENT FOR PREVENTIVE SERVICES.—Section  
12 1834 (42 U.S.C. 1395m) is amended by inserting after  
13 subsection (d) the following new subsection:

14 “(e) ALTERNATIVE PAYMENT FOR PREVENTIVE  
15 SERVICES.—

16 “(1) GENERAL PAYMENT RULE.—

17 “(A) QUALIFIED PREVENTIVE SERVICES.—

18 The Secretary shall establish by regulation a  
19 payment amount for qualified preventive serv-  
20 ices, as defined in section 1861(yy).

21 “(B) OTHER PREVENTIVE SERVICES.—The  
22 Secretary may establish by regulation a pay-  
23 ment amount for each type of preventive service  
24 described in subparagraphs (A) through (J) of  
25 paragraph (5).

1           “(2) PAYMENT AMOUNT.—In the case of a pre-  
2           ventive service described in paragraph (5) that may  
3           be performed as a diagnostic or therapeutic service  
4           under this title, the payment amount under this sub-  
5           section for a service performed as a preventive serv-  
6           ice shall be the same as the payment amount estab-  
7           lished under this title for such service performed as  
8           a diagnostic or therapeutic service.

9           “(3) MANNER OF PAYMENT.—In the case of a  
10          preventive service described in paragraph (6) that  
11          may be performed as a diagnostic or therapeutic  
12          service under this title, the Secretary shall apply the  
13          same method of payment under this subsection for  
14          a service performed as a preventive service as the  
15          Secretary applies under this title for such service  
16          performed as a diagnostic or therapeutic service.

17          “(4) PROHIBITION ON BALANCE BILLING.—The  
18          provisions of subparagraphs (A) and (B) of section  
19          1842(b)(18) shall apply to the furnishing of preven-  
20          tive services described in paragraph (5) for which  
21          payment is made under this subsection in the same  
22          manner as such subparagraphs apply to services fur-  
23          nished by a practitioner described in subparagraph  
24          (C) of such section.

1           “(5) PREVENTIVE SERVICES DESCRIBED.—For  
2 purposes of this subsection, the preventive services  
3 described in this paragraph are any of the following  
4 services:

5           “(A) Antigen (under section  
6 1861(s)(2)(G)).

7           “(B) Prostate cancer screening tests (as  
8 defined in section 1861(oo)).

9           “(C) Colorectal cancer screening tests (as  
10 defined in section 1861(pp)).

11           “(D) Diabetes outpatient self-management  
12 training services (as defined in section  
13 1861(qq)).

14           “(E)(i) Pneumococcal vaccine and its ad-  
15 ministration and influenza vaccine and its ad-  
16 ministration (under section 1861(s)(10)(A)).

17           “(ii) Hepatitis B vaccine and its adminis-  
18 tration (under section 1861(s)(10)(B)).

19           “(F) Screening mammography (as defined  
20 in section 1861(jj)).

21           “(G) Screening pap smear and screening  
22 pelvic exam (as defined in paragraphs (1) and  
23 (2), respectively, of section 1861(nn)).

24           “(H) Bone mass measurement (as defined  
25 in section 1861(rr)).

1                   “(I) Screening for glaucoma (as defined in  
2                   section 1861(uu).

3                   “(J) Qualified preventive services (as de-  
4                   fined in section 1861(yy)).”.

5           (d) EXCLUSION FROM COVERAGE CONFORMING  
6 AMENDMENT.—Section 1862(a)(1)(B) (42 U.S.C.  
7 1395y(a)(1)(B)) is amended by striking “section  
8 1861(s)(10)” and inserting “section 1834(e)(5)”.

9           (e) WAIVER OF DEDUCTIBLE.—Section 1833(b) (42  
10 U.S.C. 1395l(b)) is amended in clause (1) to read as fol-  
11 lows: “(1) such deductible shall not apply with respect to  
12 preventive service described in section 1834(e)(5)”.

13           (f) WAIVER OF COST-SHARING.—Section  
14 1833(a)(1)(B) (42 U.S.C. 1395l(a)(1)(B)) is amended by  
15 inserting “subject to section 1834(e),” before “the  
16 amounts paid shall be 100 percent of the reasonable  
17 charges for such items and services,”.

18           (g) ADDITIONAL CONFORMING AMENDMENTS.—(1)  
19 Section 1833(a)(2)(G) (42 U.S.C. 1395l(a)(2)(G)) is  
20 amended by inserting “subject to section 1834(e),” before  
21 “with respect to items and services”.

22           (2) Section 1834(c)(1)(C) (42 U.S.C. 1395m(c)) is  
23 amended by striking “the amount of the payment” and  
24 inserting “except as provided by the Secretary under sub-  
25 section (e), the amount of the payment”.

1       (3) Section 1834(d) (42 U.S.C. 1395m(d)) is  
2 amended—

3           (A) in paragraph (1)(A), by striking “The pay-  
4 ment amount” and inserting “Except as provided by  
5 the Secretary under subsection (e), the payment  
6 amount”; and

7           (B) in paragraphs (2)(A) and (3)(A), by strik-  
8 ing “payment under section 1848” each place it ap-  
9 pears and inserting “except as provided by the Sec-  
10 retary under subsection (e), payment under section  
11 1848”.

12       (4) Section 1848(g)(2)(C) (42 U.S.C. 1395w-  
13 4(g)(2)(C)) is amended—

14           (A) by striking “For” and inserting “(i) Sub-  
15 ject to clause (ii), for”; and

16           (B) by adding at the end the following new  
17 clause:

18                   “(ii) For physicians’ services consisting of  
19 preventive services (as described in section  
20 1834(e)(5)) furnished on or after January 1,  
21 2003, the ‘limiting charge’ shall be 100 percent  
22 of the recognized payment amount under this  
23 part for nonparticipating physicians or for non-  
24 participating suppliers or other persons.”.

1           (5) Section 1848(g)(2)(D) (42 U.S.C. 1395w-  
2 4(g)(2)(D)) is amended by striking “the fee schedule  
3 amount determined under subsection (a)” and all that fol-  
4 lows and inserting “the fee schedule amount determined  
5 under subsection (a), in the case of preventive services (as  
6 described in section 1834(e)(5)) the amount determined  
7 by the Secretary under section 1834(e), or, if payment  
8 under this part is made on a basis other than the fee  
9 schedule under this section or other than the amount es-  
10 tablished under section 1834(e) with respect to such pre-  
11 ventive services, 95 percent of the other payment basis.”.

12           (f) EFFECTIVE DATE.—The amendments made by  
13 this section shall apply to items and services furnished on  
14 or after January 1, 2004.

15 **SEC. 222. SMOKING CESSATION DEMONSTRATION.**

16           (a) IN GENERAL.—The Secretary of Health and  
17 Human Services (hereinafter in this section referred to as  
18 the “Secretary”) shall, either directly or through grants,  
19 contracts, or cooperative agreements, carry out a dem-  
20 onstration project testing a variety of smoking cessation  
21 services for medicare beneficiaries, for the purpose of iden-  
22 tifying the most successful and cost-effective approaches.

23           (b) DESIGN OF DEMONSTRATION.—

24                   (1) IN GENERAL.—The Secretary shall deter-  
25 mine the design, implementation, and evaluation of

1 the demonstration under this section, subject to the  
2 provisions of this section.

3 (2) SERVICES INCLUDED.—Services under the  
4 demonstration may include an initial patient assess-  
5 ment, counseling services, and any pharmacotherapy  
6 for smoking cessation approved by the Food and  
7 Drug Administration, and such other services as the  
8 Secretary may authorize. Services may be furnished  
9 by a person or entity that provides other services for  
10 which payment may be made under title XVIII of  
11 the Social Security Act (42 U.S.C. 1395 et seq.), as  
12 well as by health educators and other professionals  
13 in categories designated by the Secretary who meet  
14 applicable certification and licensing requirements of  
15 State and local law.

16 (3) SCOPE AND DURATION.—Demonstration  
17 projects under this section shall be conducted at a  
18 minimum of four sites and shall not exceed five  
19 years in duration.

20 (c) Notwithstanding any provision of such title XVIII  
21 or any other provision of law, in the case of smoking ces-  
22 sation items and services furnished to a medicare bene-  
23 ficiary under a demonstration conducted by the Secretary  
24 under this section by an individual or entity authorized  
25 by the Secretary to participate in such demonstration—

1           (1) such items and services shall be deemed to  
2           be health care items and services covered under the  
3           insurance programs under such title XVIII for pur-  
4           poses of payment from the Federal Health Insur-  
5           ance and Federal Supplementary Medical Insurance  
6           Trust Funds;

7           (2) persons and entities furnishing smoking ces-  
8           sation items and services under a demonstration  
9           under this section shall be entitled to be paid from  
10          such Trust Funds an amount equal to the lesser of  
11          the actual cost of such items and services or the  
12          payment amount prescribed for such items or serv-  
13          ices under a fee schedule established by the Sec-  
14          retary; and

15          (3) the Secretary shall waive all coinsurance  
16          and deductibles under such title XVIII for smoking  
17          cessation items and services furnished under such  
18          demonstration.

19          (d) WAIVER AUTHORITY.—The Secretary is author-  
20          ized to waive the requirements of such title XVIII to the  
21          extent and for the period the Secretary finds necessary  
22          to conduct the demonstration under this section.

23          (e) FUNDING.—The Secretary shall provide for the  
24          transfer from the Federal Health Insurance and Federal  
25          Supplementary Insurance Trust Fund of such funds as

1 are necessary for the costs of carrying out and evaluating  
2 the demonstration projects under this section.

3 (f) EVALUATION; REPORT TO CONGRESS; IMPLEMEN-  
4 TATION.—

5 (1) IN GENERAL.—Upon conclusion of the dem-  
6 onstration, the Secretary shall cause the demonstra-  
7 tion to be evaluated and shall submit to Congress a  
8 report on the following:

9 (A) A description of the demonstration.

10 (B) An assessment of—

11 (i) patient outcomes, including smok-  
12 ing “quit” rates;

13 (ii) the cost-effectiveness of the dem-  
14 onstration; and

15 (iii) the quality of the services fur-  
16 nished through the demonstration, includ-  
17 ing measures of beneficiary and provider  
18 satisfaction.

19 (C) Any other information that the Sec-  
20 retary determines to be appropriate.

21 (2) IMPLEMENTATION.—The Secretary may im-  
22 plement, on a permanent basis, the part or parts of  
23 the demonstration project that the Secretary deter-  
24 mines to be successful.

1 **SEC. 223. OUTREACH TO PREVENT BLINDNESS.**

2 (a) IN GENERAL.—Not later than July 1, 2003, the  
3 Secretary of Health and Human Services shall establish  
4 no fewer than 3 demonstrations of ophthalmic care out-  
5 reach in underserved communities designed to reduce the  
6 level of eye disease and to prevent blindness among medi-  
7 care beneficiaries.

8 (b) DURATION.—The duration of the demonstrations  
9 shall be for 3 years, except that the Secretary may extend  
10 or expand the demonstrations if the Secretary determines  
11 that the demonstrations have succeeded in reducing the  
12 level of blindness and eye disease in the communities serv-  
13 iced by 20 percent or more.

14 (c) COMMUNITIES TO BE SERVED.—The commu-  
15 nities to be served under the demonstrations shall be medi-  
16 cally underserved urban and rural areas (under section  
17 330 of the Public Health Service Act (42 U.S.C. 254b))  
18 with rates of preventable and treatable blindness 3 or  
19 more times the average rate of such blindness.

20 (d) PROVIDER NETWORKS.—Providers selected to  
21 participate in the demonstrations shall be a nonprofit net-  
22 work institute or group practice of ophthalmic care profes-  
23 sionals located in the areas to be served. Such profes-  
24 sionals shall include a number of minority professionals  
25 to reflect the population of the area served and shall offer

1 a substantial level (as defined by the Secretary) of uncom-  
2 pensated care to others in the community.

3 (e) PAYMENTS.—Payment to providers under the  
4 demonstrations shall include payment of the 20 percent  
5 copayment in cases in which the provide waives collection  
6 of the copayment from the beneficiary because of the in-  
7 come status of the beneficiary. Payment amounts shall in-  
8 clude reasonable costs (as determined by the Secretary)  
9 for follow-up pharmaceuticals, eyeglasses, lenses (contract  
10 and intraocular), specialized ophthalmic diagnostic and  
11 therapeutic equipment, and telehealth equipment, insofar  
12 as payment is not otherwise made by the beneficiary.

13 **SEC. 224. COVERAGE OF SUBSTITUTE ADULT DAY CARE**  
14 **SERVICES UNDER MEDICARE.**

15 (a) SUBSTITUTE ADULT DAY CARE SERVICES BEN-  
16 EFIT.—

17 (1) IN GENERAL.—Section 1861(m) (42 U.S.C.  
18 1395x(m)) is amended—

19 (A) in the matter preceding paragraph (1),  
20 by inserting “or paragraph (8)” after “para-  
21 graph (7)”;

22 (B) in paragraph (6), by striking “and” at  
23 the end;

24 (C) in paragraph (7), by adding “and” at  
25 the end; and

1 (D) by inserting after paragraph (7), the  
2 following new paragraph:

3 “(8) substitute adult day care services (as de-  
4 fined in subsection (zz));”.

5 (2) SUBSTITUTE ADULT DAY CARE SERVICES  
6 DEFINED.—Section 1861 (42 U.S.C. 1395x), as  
7 amended by sections 112, 122, and 221, is further  
8 amended by adding at the end the following new  
9 subsection:

10 “Substitute Adult Day Care Services; Adult Day Care  
11 Facility

12 “(zz)(1)(A) The term ‘substitute adult day care serv-  
13 ices’ means the items and services described in subpara-  
14 graph (B) furnished to an individual by an adult day care  
15 facility as a part of a plan under subsection (m) sub-  
16 stituting such services for a portion of the items and serv-  
17 ices described in subparagraph (B)(i) furnished by a home  
18 health agency under the plan, as determined by the physi-  
19 cian establishing the plan.

20 “(B) The items and services described in this sub-  
21 paragraph are the following items and services:

22 “(i) Items and services described in paragraphs  
23 (1) through (7) of subsection (m).

1           “(ii) Transportation of the individual to and  
2           from the adult day care facility in connection with  
3           any such item or service.

4           “(iii) Meals.

5           “(iv) A program of supervised activities de-  
6           signed to promote physical and mental health and  
7           furnished to the individual by the adult day care fa-  
8           cility in a group setting for a period of not fewer  
9           than four and not greater than twelve hours per day.

10          “(v) A medication management program (as de-  
11          fined in subparagraph (C)).

12          “(C) For purposes of subparagraph (B)(v), the term  
13          ‘medication management program’ means a program of  
14          education and services (that meets such criteria as the  
15          Secretary determines appropriate) to minimize—

16               “(i) unnecessary or inappropriate use of pre-  
17               scription drugs; and

18               “(ii) adverse events due to unintended prescrip-  
19               tion drug-to-drug interactions.

20          “(2)(A) Except as provided in subparagraph (B), the  
21          term ‘adult day care facility’ means a public agency or  
22          private organization, or a subdivision of such an agency  
23          or organization, that—

24               “(i) is engaged in providing skilled nursing  
25               services and other therapeutic services;

1           “(ii) meets such standards established by the  
2           Secretary to assure quality of care and such other  
3           requirements as the Secretary finds necessary in the  
4           interest of the health and safety of individuals who  
5           are furnished services in the facility;

6           “(iii) provides the items and services described  
7           in paragraph (1)(B); and

8           “(iv) meets the requirements of paragraphs (2)  
9           through (8) of subsection (o).

10          “(B) The Secretary may waive the requirement of a  
11         surety bond under paragraph (7) of subsection (o) in the  
12         case of an agency or organization that provides a com-  
13         parable surety bond under State law.

14          “(C) For purposes of payment for home health serv-  
15         ices consisting of substitute adult day care services fur-  
16         nished under this title, any reference to a home health  
17         agency is deemed to be a reference to an adult day care  
18         facility.”.

19                 (3) CONFORMING AMENDMENTS.—Sections  
20         1814(a)(2)(C) and 1835(a)(2)(A)(i) (42 U.S.C.  
21         1395f(a)(2)(C) and 42 U.S.C. 1395f(a)(2)(C)) are  
22         each amended by striking “section 1861(m)(7)” and  
23         inserting “paragraph (7) or (8) of section 1861(m)”.

24                 (b) PAYMENT FOR SUBSTITUTE ADULT DAY CARE  
25         SERVICES UNDER THE HOME HEALTH PROSPECTIVE

1 PAYMENT SYSTEM.—Section 1895 (42 U.S.C. 1395fff),  
2 as amended by section 504(a) of the Medicare, Medicaid,  
3 and SCHIP Benefits Improvement and Protection Act of  
4 2000 (as enacted into law by section 1(a)(6) of Public Law  
5 106–554), is amended—

6 (1) in the first sentence of paragraph (b)(1), by  
7 inserting after “home health services” the following:  
8 “or home health services consisting of substitute  
9 adult day care services.”; and

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

12 “(f) LIMITATION ON PAYMENT FOR SUBSTITUTE  
13 ADULT DAY CARE SERVICES.—

14 “(1) GENERAL LIMITATION.—With respect to  
15 home health services consisting of substitute adult  
16 day care services, no payment may be made under  
17 this section for home health services consisting of  
18 substitute adult day care services described in  
19 clauses (ii) through (v) of section 1861(zz)(1)(B).

20 “(2) LIMITATION ON BALANCE BILLING.—An  
21 adult day care facility shall accept as payment in full  
22 for substitute adult day care services (including  
23 those services described in clauses (ii) through (v) of  
24 section 1861(zz)(1)(B)) furnished by the facility to  
25 an individual entitled to benefits under this title the

1 amount of payment provided under this section for  
2 home health services consisting of substitute adult  
3 day care services.”.

4 (c) EFFECTIVE DATE.—The amendments made by  
5 this section shall apply to items and services furnished on  
6 or after January 1, 2003.

7 **Subtitle C—Rationalizing Pay-**  
8 **ments and Cost Sharing and**  
9 **Medigap**

10 **SEC. 231. EXTENSION OF BUY-DOWN OF COPAYMENT ON**  
11 **HOSPITAL OUTPATIENT SERVICES.**

12 Section 1833(t)(8)(C)(ii) (42 U.S.C.  
13 1395l(t)(8)(C)(ii)), as amended by section 111(a) of the  
14 Medicare, Medicaid, and SCHIP Benefits Improvement  
15 and Protection Act of 2000, as enacted into law by section  
16 1(a)(6) of Public Law 106–554, is amended by striking  
17 subclause (V) and inserting the following:

18 “(V) For procedures performed  
19 in 2006, 40 percent.

20 “(VI) For procedures performed  
21 in 2007, 35 percent.

22 “(VII) For procedures performed  
23 in 2008, 30 percent.

24 “(VIII) For procedures per-  
25 formed in 2009, 25 percent; and.

1                                   “(IX) For procedures performed  
2                                   in 2010 and thereafter, 20 percent.”.

3 **SEC. 232. INDEXING DEDUCTIBLE TO INFLATION.**

4           Section 1833(b) (42 U.S.C. 1395l(b)) is amended by  
5 inserting after “1991 and subsequent years” the following:  
6 “, adjusted annually, effective January 1 of each year be-  
7 ginning in 2004, by a percentage increase or decrease  
8 equal to the percentage increase or decrease in the con-  
9 sumer price index for all urban consumers (U.S. city aver-  
10 age) for the 12-month period ending with June of the pre-  
11 vious year, rounded to the nearest dollar”.

12 **SEC. 233. MEDICARE DIRECT SUPPLEMENTAL INSURANCE**  
13 **OPTION.**

14           (a) IN GENERAL.—Title XVIII is amended by insert-  
15 ing after section 1882 the following new section:

16           “MEDICARE DIRECT SUPPLEMENTAL INSURANCE OPTION  
17           “SEC. 1882A. (a) IN GENERAL.—The Secretary shall  
18 provide for the offering under this section of a voluntary  
19 program to supplement the benefits provided to individ-  
20 uals under parts A and B of this title.

21           “(b) ELIGIBILITY; ENROLLMENT.—The Secretary  
22 shall provide procedures for the enrollment under the pro-  
23 gram under this section of individuals who are entitled to  
24 benefits under part A and enrolled under part B, but who  
25 are not enrolled in Medicare+Choice plan under part C  
26 (or in a plan under section 1876). Such procedures shall

1 be similar in timing and manner to the procedures by  
2 which individuals are permitted to enroll in  
3 Medicare+Choice plans under part C, except that the Sec-  
4 retary shall provide for an initial enrollment period during  
5 2001 that permits benefits to be first made available  
6 under the program for months beginning with January  
7 2003.

8 “(c) BENEFITS.—

9 “(1) IN GENERAL.—Subject to paragraph (2),  
10 the benefits provided under the program under this  
11 section shall consist of payment of the cost of  
12 deductibles, copayments, and other cost-sharing  
13 amounts (including amounts attributable to and per-  
14 mitted as balance billing) otherwise imposed or per-  
15 mitted under this title, subject to an annual deduct-  
16 ible of \$500.

17 “(2) NOMINAL COPAYMENT.—

18 “(A) IN GENERAL.—With respect to each  
19 part B service furnished to an enrollee under  
20 this section during 2003, the enrollee shall pay  
21 a nominal copayment of \$5.

22 “(B) OUTYEARS.—For 2004 and each sub-  
23 sequent year, the amount of nominal copayment  
24 applicable for each part B service under this  
25 paragraph is equal to the amount of copayment

1 for the previous year adjusted by a percentage  
2 increase or decrease equal to the percentage in-  
3 crease or decrease in the Consumer Price Index  
4 for All Urban Consumers (United States city  
5 average). Any amount determined under this  
6 subparagraph that is not a multiple of \$1 shall  
7 be rounded to the nearest multiple of \$1.

8 “(C) COUNTING NOMINAL COPAYMENTS  
9 TOWARD THE ANNUAL DEDUCTIBLE.—A nomi-  
10 nal copayment payable by an enrollee under this  
11 paragraph in a year shall count toward the an-  
12 nual deductible applicable under paragraph (1)  
13 for that year.

14 “(3) ADMINISTRATION.—The Secretary shall  
15 coordinate payment of benefits under this part with  
16 those under parts A and B and may, for such pur-  
17 pose, enter into appropriate arrangements with  
18 qualified entities (which may include fiscal inter-  
19 mediaries and carriers).

20 “(d) PREMIUMS.—

21 “(1) ACTUARIAL COST.—The Secretary shall,  
22 during September of each year beginning with 2002,  
23 determine a monthly actuarial rate for all enrollees  
24 under this section, which rate shall be applicable for  
25 months in the succeeding calendar year. Such actu-

1       arial rate shall be the amount the Secretary esti-  
2       mates to be necessary so that the aggregate amount  
3       for such calendar year with respect to those enrollees  
4       will equal the total amount which the Secretary esti-  
5       mates will be payable under this section for benefits  
6       accrued (including services performed and related  
7       administrative costs incurred) in such calendar year  
8       under the program under this section. In calculating  
9       the monthly actuarial rate, the Secretary shall make  
10      adjustments to take into account errors in esti-  
11      mations under this paragraph for previous years and  
12      shall include an appropriate amount for a contin-  
13      gency margin.

14           “(2) PREMIUM.—The monthly premium of each  
15      individual enrolled under this section for a month in  
16      a year shall be the monthly actuarial rate deter-  
17      mined under paragraph (1) for months in such year.  
18      Such premium shall not vary among enrollees based  
19      upon the age, place of residence, or any other fac-  
20      tors.

21           “(3) COLLECTION.—The Secretary shall pro-  
22      vide for the collection of premiums for enrollees  
23      under this part in the same manner as premiums  
24      under part B are collected under section 1840, ex-  
25      cept that any reference in such section to the Fed-

1       eral Supplementary Medical Insurance Trust Fund  
2       shall be deemed a reference to an account (to be  
3       known as the “Direct Medicare Supplemental Insur-  
4       ance Account”) to be established in the Treasury by  
5       the Secretary to carry out the program under this  
6       section. Amounts in such account may be invested  
7       and draw interest in the same manner as such Trust  
8       Fund under section 1840(c).

9               “(4) USE OF FUNDS.—Premium amounts de-  
10       posited into the account established under paragraph  
11       (3) shall be available without regard to appropria-  
12       tions to the Secretary to make payment for benefits  
13       and administrative costs incurred in carrying out  
14       this section.”.

15       (b) EFFECTIVE DATE.—The amendment made by  
16       subsection (a) shall take effect on the date of the enact-  
17       ment of this Act and shall apply to benefits for months  
18       beginning with January 2003.

19       **Subtitle D—Improved Assistance to**  
20       **Low-Income Beneficiaries**

21       **SEC. 241. INCREASE IN SLMB ELIGIBILITY TO 135 PERCENT**  
22       **OF POVERTY; PRESUMPTIVE ENROLLMENT.**

23       (a) INCREASE IN SLMB ELIGIBILITY TO 135 PER-  
24       CENT OF POVERTY.—Section 1902(a)(10)(E)(iii) (42  
25       U.S.C. 1396a(a)(10)(E)(iii)) is amended by striking “120

1 percent in 1995 and years thereafter” and inserting “120  
2 percent in 1995 through 2003 and 135 percent in 2004  
3 and years thereafter”.

4 (b) PRESUMPTIVE ENROLLMENT.—Title XVIII is  
5 amended by inserting after section 1806 the following new  
6 section:

7 “VOLUNTARY PROVISION OF INFORMATION TO ESTABLISH  
8 PRESUMPTIVE ELIGIBILITY; APPLICATION OF PRE-  
9 SUMPTIVE ELIGIBILITY

10 “SEC. 1807. (a) At the time an individual first ap-  
11 plies for old-age and survivors insurance benefit payments  
12 or disability insurance benefit payments under title II, the  
13 Commissioner of Social Security shall ask the individual  
14 to voluntarily disclose and attest to information on ex-  
15 pected annual income and assets. If, on the basis of such  
16 attestation, the Commissioner determines that the indi-  
17 vidual qualifies for medical assistance for medicare cost-  
18 sharing under title XIX (either as a qualified medicare  
19 beneficiary, special low-income medicare beneficiary, or  
20 otherwise), the Commissioner—

21 “(1) shall transmit, to the State agency respon-  
22 sible for administration of such title in the State in  
23 which the individual resides, a certification of such  
24 eligibility; and



1 “PROMOTING PROVISION OF MEDICARE COST-SHARING  
2 ASSISTANCE UNDER MEDICAID PROGRAM FOR IDEN-  
3 TIFIED LOW-INCOME MEDICARE BENEFICIARIES

4 “SEC. 1150A. (a) REQUIREMENT FOR DATA  
5 MATCH.—

6 “(1) REQUESTING MATCHING INFORMATION.—

7 The Commissioner of Social Security shall, not less  
8 often than annually beginning with 2002, transmit  
9 to the Secretary of the Treasury a list of the names  
10 and taxpayer identification numbers (TIN) of medi-  
11 care beneficiaries (as defined in section 6103(l)(18)  
12 of the Internal Revenue Code of 1986) and request  
13 that such Secretary disclose to the Secretary of  
14 Health and Human Services the information de-  
15 scribed in subparagraph (A) of such section.

16 “(2) SPECIFICATION OF INCOME LEVELS.—The  
17 Secretary shall specify—

18 “(A) the items that will be included in de-  
19 termination of income for purposes of applying  
20 this section and section 6103(l)(18)(A)(i) of the  
21 Internal Revenue Code of 1986; and

22 “(B) the levels of such income (based upon  
23 a percentage of the Federal poverty guidelines)  
24 that individuals may have and qualify for med-  
25 ical assistance under section 1902(a)(10)(E)(i)

1 of the Social Security Act (relating to assist-  
2 ance for medicare cost-sharing benefits under  
3 the Medicaid program).

4 “(b) NOTICE TO INDIVIDUALS IDENTIFIED.—

5 “(1) INITIAL ELIGIBILITY.—The Secretary  
6 promptly shall provide for an appropriate notice to  
7 each individual identified under subsection (a) who  
8 is described in section 6103(l)(18)(A)(i), of the fol-  
9 lowing:

10 “(A) Subject to subparagraph (B), the in-  
11 dividual is deemed eligible for some form of  
12 medical assistance for some medicare cost-shar-  
13 ing under clause (i) or (iii) of section  
14 1902(a)(10)(E), depending on the individual’s  
15 level of income.

16 “(B) By accepting such assistance the in-  
17 dividual is obligated to notify the Secretary if  
18 the individual is not eligible for such assistance  
19 due to—

20 “(i) the individual having tax-exempt  
21 income;

22 “(ii) the individual having countable  
23 assets in excess of the maximum permis-  
24 sible assets, if the individual resides in a

1 State that imposes an asset test for such  
2 eligibility; or

3 “(iii) the individual otherwise is not  
4 eligible for such assistance.

5 “(C) If the individual accepts such assist-  
6 ance notwithstanding that the individual is not  
7 eligible, the individual is liable to the State for  
8 the amount of medical assistance provided (with  
9 interest).

10 “(2) CONTINUED ELIGIBILITY.—The Secretary  
11 shall provide for an appropriate notice to each indi-  
12 vidual identified under subsection (a) who is de-  
13 scribed in section 6103(l)(18)(A)(ii), of the fol-  
14 lowing: ‘Unless the individual declines coverage or  
15 indicates otherwise, the individual will be enrolled  
16 for the appropriate assistance with medicare cost-  
17 sharing under the State plan operated under title  
18 XIX for the State in which the individual resides.’

19 “(c) NOTICE TO STATE.—In the case of an individual  
20 who is identified under this section and resides in a State,  
21 the Secretary shall provide for appropriate notice to the  
22 State of the individual’s eligibility or termination of eligi-  
23 bility (as the case may be) for medical assistance under  
24 clause (i) or (iii) of section 1902(a)(10)(E), as the case  
25 may be.”

1 (b) CONFORMING AMENDMENT TO MEDICAID PRO-  
2 GRAM.—Section 1902 (42 U.S.C. 1396a), as amended by  
3 section 702(b) of the Medicare, Medicaid, and SCHIP  
4 Benefits Improvement and Protection Act of 2000, as en-  
5 acted into law by section 1(a)(6) of Public Law 106–554,  
6 is amended by adding at the end the following:

7 “(cc) A State shall treat an individual who is identi-  
8 fied under section 1150A(b) as being eligible for medical  
9 assistance under clause (i) or (ii) of subsection (a)(10)(E)  
10 as being so eligible, until the Secretary notifies the State  
11 otherwise, with respect to medical assistance for items and  
12 services furnished on or after the date of the notice.”.

13 (c) AUTHORIZATION OF DISCLOSURE.—Section  
14 6103(l) of the Internal Revenue Code of 1986 (relating  
15 to disclosure of returns and return information for pur-  
16 poses other than tax administration) is amended by add-  
17 ing at the end the following new paragraph:

18 “(18) DISCLOSURE OF CERTAIN INFORMATION  
19 IN ORDER TO QUALIFY FOR MEDICARE COST-SHAR-  
20 ING ASSISTANCE.—

21 “(A) IN GENERAL.—The Secretary shall,  
22 upon written request from the Commissioner of  
23 Social Security, disclose to the Secretary of  
24 Health and Human Services, whether with re-  
25 spect to any medicare beneficiary (as defined in

1 paragraph (12)(E)(i)) identified by the  
2 Commissioner—

3 “(i) there has not been filed an in-  
4 come tax return for the most recent period  
5 for which the Secretary has information; or  
6 there has been such a return filed and the  
7 amount of the gross income (or the sum of  
8 such elements of gross income as the Sec-  
9 retary of Health and Human Services may  
10 specify) is below such level (or levels) as  
11 such Secretary may specify to carry out  
12 section 1150A(b) of the Social Security  
13 Act, treating the number of dependents as  
14 the size of the family involved; and

15 “(ii) whether, for such an individual  
16 who qualified for medicare cost-sharing as-  
17 sistance described in section 1150A at any  
18 time in the previous year, the individual is  
19 still described in clause (i).

20 “(B) DISCLOSURE BY HEALTH CARE FI-  
21 NANCING ADMINISTRATION.—With respect to  
22 information disclosed under subparagraph (A),  
23 the Administrator of the Health Care Financing  
24 Administration may disclose to the appropriate  
25 officials of a State responsible for administra-

1           tion of a State plan under title XIX of the So-  
2           cial Security Act the name, address, and TIN  
3           of the preliminary eligibility determination.

4           “(C) SPECIAL RULES.—

5           “(i) RESTRICTIONS ON DISCLO-  
6           SURE.—Information may be disclosed  
7           under this paragraph only for purposes of,  
8           and to the extent necessary in, determining  
9           the extent to which an individual bene-  
10          ficiary is entitled to medical assistance  
11          under a State plan under title XIX of the  
12          Social Security Act for some or all medi-  
13          care cost-sharing.

14          “(ii) TIMELY RESPONSES TO RE-  
15          QUESTS.—Any request made under sub-  
16          paragraph (A) shall be complied with as  
17          soon as possible but in no event later than  
18          60 days after the date the request was  
19          made.”.

1     **Subtitle E—Medicare Early Access**  
2                     **and Tax Credits**

3     **PART I—ACCESS TO MEDICARE BENEFITS FOR**  
4                     **INDIVIDUALS 62-TO-65 YEARS OF AGE**

5     **SEC. 251. ACCESS TO MEDICARE BENEFITS FOR INDIVID-**  
6                     **UALS 62-TO-65 YEARS OF AGE.**

7             (a) IN GENERAL.—Title XVIII, as amended by sec-  
8     tion 201, is amended—

9                     (1) by redesignating part E as part F; and

10                    (2) by inserting after part D the following new  
11     part:

12             “PART E—PURCHASE OF MEDICARE BENEFITS BY  
13     CERTAIN INDIVIDUALS AGE 62-TO-65 YEARS OF AGE  
14     **“SEC. 1860. PROGRAM BENEFITS; ELIGIBILITY.**

15             “(a) ENTITLEMENT TO MEDICARE BENEFITS FOR  
16     ENROLLED INDIVIDUALS.—

17                     “(1) IN GENERAL.—An individual enrolled  
18     under this part is entitled to the same benefits  
19     under this title as an individual entitled to benefits  
20     under part A and enrolled under part B.

21                     “(2) DEFINITIONS.—For purposes of this part:

22                             “(A) FEDERAL OR STATE COBRA CONTINU-  
23     ATION PROVISION.—The term ‘Federal or State  
24     COBRA continuation provision’ has the mean-  
25     ing given the term ‘COBRA continuation provi-

1           sion’ in section 2791(d)(4) of the Public Health  
2           Service Act and includes a comparable State  
3           program, as determined by the Secretary.

4           “(B) FEDERAL HEALTH INSURANCE PRO-  
5           GRAM DEFINED.—The term ‘Federal health in-  
6           surance program’ means any of the following:

7                   “(i) MEDICARE.—Part A or part B of  
8                   this title (other than by reason of this  
9                   part).

10                   “(ii) MEDICAID.—A State plan under  
11                   title XIX.

12                   “(iii) FEHBP.—The Federal employ-  
13                   ees health benefit program under chapter  
14                   89 of title 5, United States Code.

15                   “(iv) TRICARE.—The TRICARE  
16                   program (as defined in section 1072(7) of  
17                   title 10, United States Code).

18                   “(v) ACTIVE DUTY MILITARY.—Health  
19                   benefits under title 10, United States  
20                   Code, to an individual as a member of the  
21                   uniformed services of the United States.

22           “(C) GROUP HEALTH PLAN.—The term  
23           ‘group health plan’ has the meaning given such  
24           term in section 2791(a)(1) of the Public Health  
25           Service Act.

1       “(b) ELIGIBILITY OF INDIVIDUALS AGE 62-TO-65  
2 YEARS OF AGE.—

3           “(1) IN GENERAL.—Subject to paragraph (2),  
4 an individual who meets the following requirements  
5 with respect to a month is eligible to enroll under  
6 this part with respect to such month:

7           “(A) AGE.—As of the last day of the  
8 month, the individual has attained 62 years of  
9 age, but has not attained 65 years of age.

10          “(B) MEDICARE ELIGIBILITY (BUT FOR  
11 AGE).—The individual would be eligible for ben-  
12 efits under part A or part B for the month if  
13 the individual were 65 years of age.

14          “(C) NOT ELIGIBLE FOR COVERAGE  
15 UNDER GROUP HEALTH PLANS OR FEDERAL  
16 HEALTH INSURANCE PROGRAMS.—The indi-  
17 vidual is not eligible for benefits or coverage  
18 under a Federal health insurance program (as  
19 defined in subsection (a)(2)(B)) or under a  
20 group health plan (other than such eligibility  
21 merely through a Federal or State COBRA con-  
22 tinuation provision) as of the last day of the  
23 month involved.

24          “(2) LIMITATION ON ELIGIBILITY IF TERMI-  
25 NATED ENROLLMENT.—If an individual described in

1 paragraph (1) enrolls under this part and coverage  
2 of the individual is terminated under section  
3 1860A(d) (other than because of age), the individual  
4 is not again eligible to enroll under this subsection  
5 unless the following requirements are met:

6 “(A) NEW COVERAGE UNDER GROUP  
7 HEALTH PLAN OR FEDERAL HEALTH INSUR-  
8 ANCE PROGRAM.—After the date of termination  
9 of coverage under such section, the individual  
10 obtains coverage under a group health plan or  
11 under a Federal health insurance program.

12 “(B) SUBSEQUENT LOSS OF NEW COV-  
13 ERAGE.—The individual subsequently loses eli-  
14 gibility for the coverage described in subpara-  
15 graph (A) and exhausts any eligibility the indi-  
16 vidual may subsequently have for coverage  
17 under a Federal or State COBRA continuation  
18 provision.

19 “(3) CHANGE IN HEALTH PLAN ELIGIBILITY  
20 DOES NOT AFFECT COVERAGE.—In the case of an  
21 individual who is eligible for and enrolls under this  
22 part under this subsection, the individual’s continued  
23 entitlement to benefits under this part shall not be  
24 affected by the individual’s subsequent eligibility for

1 benefits or coverage described in paragraph (1)(C),  
2 or entitlement to such benefits or coverage.

3 **“SEC. 1860A. ENROLLMENT PROCESS; COVERAGE.**

4 “(a) IN GENERAL.—An individual may enroll in the  
5 program established under this part only in such manner  
6 and form as may be prescribed by regulations, and only  
7 during an enrollment period prescribed by the Secretary  
8 consistent with the provisions of this section. Such regula-  
9 tions shall provide a process under which—

10 “(1) individuals eligible to enroll as of a month  
11 are permitted to pre-enroll during a prior month  
12 within an enrollment period described in subsection  
13 (b); and

14 “(2) each individual seeking to enroll under sec-  
15 tion 1860(b) is notified, before enrolling, of the de-  
16 ferred monthly premium amount the individual will  
17 be liable for under section 1860C(b) upon attaining  
18 65 years of age as determined under section  
19 1860B(c)(3).

20 “(b) ENROLLMENT PERIODS.—

21 “(1) INDIVIDUALS 62-TO-65 YEARS OF AGE.—In  
22 the case of individuals eligible to enroll under this  
23 part under section 1860(b)—

24 “(A) INITIAL ENROLLMENT PERIOD.—If  
25 the individual is eligible to enroll under such

1 section for January 2002, the enrollment period  
2 shall begin on November 1, 2001, and shall end  
3 on February 28, 2002. Any such enrollment be-  
4 fore January 1, 2002, is conditioned upon com-  
5 pliance with the conditions of eligibility for Jan-  
6 uary 2002.

7 “(B) SUBSEQUENT PERIODS.—If the indi-  
8 vidual is eligible to enroll under such section for  
9 a month after January 2002, the enrollment pe-  
10 riod shall begin on the first day of the second  
11 month before the month in which the individual  
12 first is eligible to so enroll and shall end four  
13 months later. Any such enrollment before the  
14 first day of the third month of such enrollment  
15 period is conditioned upon compliance with the  
16 conditions of eligibility for such third month.

17 “(2) AUTHORITY TO CORRECT FOR GOVERN-  
18 MENT ERRORS.—The provisions of section 1837(h)  
19 apply with respect to enrollment under this part in  
20 the same manner as they apply to enrollment under  
21 part B.

22 “(c) DATE COVERAGE BEGINS.—

23 “(1) IN GENERAL.—The period during which  
24 an individual is entitled to benefits under this part

1 shall begin as follows, but in no case earlier than  
2 January 1, 2002:

3 “(A) In the case of an individual who en-  
4 rolls (including pre-enrolls) before the month in  
5 which the individual satisfies eligibility for en-  
6 rollment under section 1860, the first day of  
7 such month of eligibility.

8 “(B) In the case of an individual who en-  
9 rolls during or after the month in which the in-  
10 dividual first satisfies eligibility for enrollment  
11 under such section, the first day of the fol-  
12 lowing month.

13 “(2) AUTHORITY TO PROVIDE FOR PARTIAL  
14 MONTHS OF COVERAGE.—Under regulations, the  
15 Secretary may, in the Secretary’s discretion, provide  
16 for coverage periods that include portions of a  
17 month in order to avoid lapses of coverage.

18 “(3) LIMITATION ON PAYMENTS.—No payments  
19 may be made under this title with respect to the ex-  
20 penses of an individual enrolled under this part un-  
21 less such expenses were incurred by such individual  
22 during a period which, with respect to the individual,  
23 is a coverage period under this section.

24 “(d) TERMINATION OF COVERAGE.—

1           “(1) IN GENERAL.—An individual’s coverage  
2 period under this part shall continue until the indi-  
3 vidual’s enrollment has been terminated at the ear-  
4 liest of the following:

5           “(A) GENERAL PROVISIONS.—

6           “(i) NOTICE.—The individual files no-  
7 tice (in a form and manner prescribed by  
8 the Secretary) that the individual no  
9 longer wishes to participate in the insur-  
10 ance program under this part.

11           “(ii) NONPAYMENT OF PREMIUMS.—

12 The individual fails to make payment of  
13 premiums required for enrollment under  
14 this part.

15           “(iii) MEDICARE ELIGIBILITY.—The

16 individual becomes entitled to benefits  
17 under part A or enrolled under part B  
18 (other than by reason of this part).

19           “(B) TERMINATION BASED ON AGE.—The  
20 individual attains 65 years of age.

21           “(2) EFFECTIVE DATE OF TERMINATION.—

22           “(A) NOTICE.—The termination of a cov-  
23 erage period under paragraph (1)(A)(i) shall  
24 take effect at the close of the month following  
25 for which the notice is filed.

1           “(B) NONPAYMENT OF PREMIUM.—The  
2           termination of a coverage period under para-  
3           graph (1)(A)(ii) shall take effect on a date de-  
4           termined under regulations, which may be de-  
5           termined so as to provide a grace period in  
6           which overdue premiums may be paid and cov-  
7           erage continued. The grace period determined  
8           under the preceding sentence shall not exceed  
9           60 days; except that it may be extended for an  
10          additional 30 days in any case where the Sec-  
11          retary determines that there was good cause for  
12          failure to pay the overdue premiums within  
13          such 60-day period.

14          “(C) AGE OR MEDICARE ELIGIBILITY.—  
15          The termination of a coverage period under  
16          paragraph (1)(A)(iii) or (1)(B) shall take effect  
17          as of the first day of the month in which the  
18          individual attains 65 years of age or becomes  
19          entitled to benefits under part A or enrolled for  
20          benefits under part B (other than by reason of  
21          this part).

22   **“SEC. 1860B. PREMIUMS.**

23          “(a) AMOUNT OF MONTHLY PREMIUMS.—

24                  “(1) BASE MONTHLY PREMIUMS.—The Sec-  
25          retary shall, during September of each year (begin-

1       ning with 1998), determine the following premium  
2       rates which shall apply with respect to coverage pro-  
3       vided under this title for any month in the suc-  
4       ceeding year:

5               “(A) BASE MONTHLY PREMIUM FOR INDI-  
6               VIDUALS 62 YEARS OF AGE OR OLDER.—A base  
7               monthly premium for individuals 62 years of  
8               age or older, equal to  $\frac{1}{12}$  of the base annual  
9               premium rate computed under subsection (b)  
10              for each premium area.

11             “(2) DEFERRED MONTHLY PREMIUMS FOR IN-  
12             DIVIDUALS 62 YEARS OF AGE OR OLDER.—The Sec-  
13             retary shall, during September of each year (begin-  
14             ning with 2001), determine under subsection (c) the  
15             amount of deferred monthly premiums that shall  
16             apply with respect to individuals who first obtain  
17             coverage under this part under section 1860(b) in  
18             the succeeding year.

19             “(3) ESTABLISHMENT OF PREMIUM AREAS.—  
20             For purposes of this part, the term ‘premium area’  
21             means such an area as the Secretary shall specify to  
22             carry out this part. The Secretary from time to time  
23             may change the boundaries of such premium areas.  
24             The Secretary shall seek to minimize the number of  
25             such areas specified under this paragraph.

1       “(b) BASE ANNUAL PREMIUM FOR INDIVIDUALS 62  
2 YEARS OF AGE OR OLDER.—

3           “(1) NATIONAL, PER CAPITA AVERAGE.—The  
4 Secretary shall estimate the average, annual per  
5 capita amount that would be payable under this title  
6 with respect to individuals residing in the United  
7 States who meet the requirement of section  
8 1860(b)(1)(A) as if all such individuals were eligible  
9 for (and enrolled) under this title during the entire  
10 year (and assuming that section 1862(b)(2)(A)(i)  
11 did not apply).

12           “(2) GEOGRAPHIC ADJUSTMENT.—The Sec-  
13 retary shall adjust the amount determined under  
14 paragraph (1) for each premium area (specified  
15 under subsection (a)(3)) in order to take into ac-  
16 count such factors as the Secretary deems appro-  
17 priate and shall limit the maximum premium under  
18 this paragraph in a premium area to assure partici-  
19 pation in all areas throughout the United States.

20           “(3) BASE ANNUAL PREMIUM.—The base an-  
21 nual premium under this subsection for months in a  
22 year for individuals 62 years of age or older residing  
23 in a premium area is equal to the average, annual  
24 per capita amount estimated under paragraph (1)

1 for the year, adjusted for such area under paragraph  
2 (2).

3 “(c) DEFERRED PREMIUM RATE FOR INDIVIDUALS  
4 62 YEARS OF AGE OR OLDER.—The deferred premium  
5 rate for individuals with a group of individuals who obtain  
6 coverage under section 1860(b) in a year shall be com-  
7 puted by the Secretary as follows:

8 “(1) ESTIMATION OF NATIONAL, PER CAPITA  
9 ANNUAL AVERAGE EXPENDITURES FOR ENROLL-  
10 MENT GROUP.—The Secretary shall estimate the av-  
11 erage, per capita annual amount that will be paid  
12 under this part for individuals in such group during  
13 the period of enrollment under section 1860(b). In  
14 making such estimate for coverage beginning in a  
15 year before 2005, the Secretary may base such esti-  
16 mate on the average, per capita amount that would  
17 be payable if the program had been in operation over  
18 a previous period of at least 4 years.

19 “(2) DIFFERENCE BETWEEN ESTIMATED EX-  
20 PENDITURES AND ESTIMATED PREMIUMS.—Based  
21 on the characteristics of individuals in such group,  
22 the Secretary shall estimate during the period of  
23 coverage of the group under this part under section  
24 1860(b) the amount by which—

1           “(A) the amount estimated under para-  
2 graph (1); exceeds

3           “(B) the average, annual per capita  
4 amount of premiums that will be payable for  
5 months during the year under section 1860C(a)  
6 for individuals in such group (including pre-  
7 miums that would be payable if there were no  
8 terminations in enrollment under clause (i) or  
9 (ii) of section 1860A(d)(1)(A)).

10           “(3) ACTUARIAL COMPUTATION OF DEFERRED  
11 MONTHLY PREMIUM RATES.—The Secretary shall  
12 determine deferred monthly premium rates for indi-  
13 viduals in such group in a manner so that—

14           “(A) the estimated actuarial value of such  
15 premiums payable under section 1860C(b), is  
16 equal to

17           “(B) the estimated actuarial present value  
18 of the differences described in paragraph (2).

19 Such rate shall be computed for each individual in  
20 the group in a manner so that the rate is based on  
21 the number of months between the first month of  
22 coverage based on enrollment under section 1860(b)  
23 and the month in which the individual attains 65  
24 years of age.

1           “(4) DETERMINANTS OF ACTUARIAL PRESENT  
2           VALUES.—The actuarial present values described in  
3           paragraph (3) shall reflect—

4                   “(A) the estimated probabilities of survival  
5                   at ages 62 through 84 for individuals enrolled  
6                   during the year; and

7                   “(B) the estimated effective average inter-  
8                   est rates that would be earned on investments  
9                   held in the trust funds under this title during  
10                  the period in question.

11 **“SEC. 1860C. PAYMENT OF PREMIUMS.**

12           “(a) PAYMENT OF BASE MONTHLY PREMIUM.—

13                   “(1) IN GENERAL.—The Secretary shall provide  
14                   for payment and collection of the base monthly pre-  
15                   mium, determined under section 1860B(a)(1) for the  
16                   age (and age cohort, if applicable) of the individual  
17                   involved and the premium area in which the indi-  
18                   vidual principally resides, in the same manner as for  
19                   payment of monthly premiums under section 1840,  
20                   except that, for purposes of applying this section,  
21                   any reference in such section to the Federal Supple-  
22                   mentary Medical Insurance Trust Fund is deemed a  
23                   reference to the Trust Fund established under sec-  
24                   tion 1860D.

1           “(2) PERIOD OF PAYMENT.—In the case of an  
2 individual who participates in the program estab-  
3 lished by this title, the base monthly premium shall  
4 be payable for the period commencing with the first  
5 month of the individual’s coverage period and ending  
6 with the month in which the individual’s coverage  
7 under this title terminates.

8           “(b) PAYMENT OF DEFERRED PREMIUM FOR INDI-  
9 VIDUALS COVERED AFTER ATTAINING AGE 62.—

10           “(1) RATE OF PAYMENT.—

11           “(A) IN GENERAL.—In the case of an indi-  
12 vidual who is covered under this part for a  
13 month pursuant to an enrollment under section  
14 1860(b), subject to subparagraph (B), the indi-  
15 vidual is liable for payment of a deferred pre-  
16 mium in each month during the period de-  
17 scribed in paragraph (2) in an amount equal to  
18 the full deferred monthly premium rate deter-  
19 mined for the individual under section  
20 1860B(c).

21           “(B) SPECIAL RULES FOR THOSE WHO  
22 DISENROLL EARLY.—

23           “(i) IN GENERAL.—If such an individ-  
24 ual’s enrollment under such section is ter-  
25 minated under clause (i) or (ii) of section

1 1860A(d)(1)(A), subject to clause (ii), the  
2 amount of the deferred premium otherwise  
3 established under this paragraph shall be  
4 pro-rated to reflect the number of months  
5 of coverage under this part under such en-  
6 rollment compared to the maximum num-  
7 ber of months of coverage that the indi-  
8 vidual would have had if the enrollment  
9 were not so terminated.

10 “(ii) ROUNDING TO 12-MONTH MIN-  
11 IMUM COVERAGE PERIODS.—In applying  
12 clause (i), the number of months of cov-  
13 erage (if not a multiple of 12) shall be  
14 rounded to the next highest multiple of 12  
15 months, except that in no case shall this  
16 clause result in a number of months of  
17 coverage exceeding the maximum number  
18 of months of coverage that the individual  
19 would have had if the enrollment were not  
20 so terminated.

21 “(2) PERIOD OF PAYMENT.—The period de-  
22 scribed in this paragraph for an individual is the pe-  
23 riod beginning with the first month in which the in-  
24 dividual has attained 65 years of age and ending

1 with the month before the month in which the indi-  
2 vidual attains 85 years of age.

3 “(3) COLLECTION.—In the case of an individual  
4 who is liable for a premium under this subsection,  
5 the amount of the premium shall be collected in the  
6 same manner as the premium for enrollment under  
7 such part is collected under section 1840, except  
8 that any reference in such section to the Federal  
9 Supplementary Medical Insurance Trust Fund is  
10 deemed to be a reference to the Medicare Early Ac-  
11 cess Trust Fund established under section 1860D.

12 “(c) APPLICATION OF CERTAIN PROVISIONS.—The  
13 provisions of section 1840 (other than subsection (h))  
14 shall apply to premiums collected under this section in the  
15 same manner as they apply to premiums collected under  
16 part B, except that any reference in such section to the  
17 Federal Supplementary Medical Insurance Trust Fund is  
18 deemed a reference to the Trust Fund established under  
19 section 1860D.

20 **“SEC. 1860D. MEDICARE EARLY ACCESS TRUST FUND.**

21 “(a) ESTABLISHMENT OF TRUST FUND.—

22 “(1) IN GENERAL.—There is hereby created on  
23 the books of the Treasury of the United States a  
24 trust fund to be known as the ‘Medicare Early Ac-  
25 cess Trust Fund’ (in this section referred to as the

1 ‘Trust Fund’). The Trust Fund shall consist of such  
2 gifts and bequests as may be made as provided in  
3 section 201(i)(1) and such amounts as may be de-  
4 posited in, or appropriated to, such fund as provided  
5 in this title.

6 “(2) PREMIUMS.—Premiums collected under  
7 section 1860B shall be transferred to the Trust  
8 Fund.

9 “(b) INCORPORATION OF PROVISIONS.—

10 “(1) IN GENERAL.—Subject to paragraph (2),  
11 subsections (b) through (i) of section 1841 shall  
12 apply with respect to the Trust Fund and this title  
13 in the same manner as they apply with respect to  
14 the Federal Supplementary Medical Insurance Trust  
15 Fund and part B, respectively.

16 “(2) MISCELLANEOUS REFERENCES.—In apply-  
17 ing provisions of section 1841 under paragraph  
18 (1)—

19 “(A) any reference in such section to ‘this  
20 part’ is construed to refer to this part E;

21 “(B) any reference in section 1841(h) to  
22 section 1840(d) and in section 1841(i) to sec-  
23 tions 1840(b)(1) and 1842(g) are deemed ref-  
24 erences to comparable authority exercised under  
25 this part; and

1           “(C) payments may be made under section  
2           1841(g) to the Trust Funds under sections  
3           1817 and 1841 as reimbursement to such funds  
4           for payments they made for benefits provided  
5           under this part.

6   **“SEC. 1860E. OVERSIGHT AND ACCOUNTABILITY.**

7           “(a) THROUGH ANNUAL REPORTS OF TRUSTEES.—  
8   The Board of Trustees of the Medicare Early Access  
9   Trust Fund under section 1860D(b)(1) shall report on an  
10   annual basis to Congress concerning the status of the  
11   Trust Fund and the need for adjustments in the program  
12   under this part to maintain financial solvency of the pro-  
13   gram under this part.

14          “(b) PERIODIC GAO REPORTS.—The Comptroller  
15   General of the United States shall periodically submit to  
16   Congress reports on the adequacy of the financing of cov-  
17   erage provided under this part. The Comptroller General  
18   shall include in such report such recommendations for ad-  
19   justments in such financing and coverage as the Comp-  
20   troller General deems appropriate in order to maintain fi-  
21   nancial solvency of the program under this part.

22   **“SEC. 1860F. ADMINISTRATION AND MISCELLANEOUS.**

23          “(a) TREATMENT FOR PURPOSES OF TITLE.—Ex-  
24   cept as otherwise provided in this part—

1           “(1) individuals enrolled under this part shall  
2           be treated for purposes of this title as though the in-  
3           dividual were entitled to benefits under part A and  
4           enrolled under part B; and

5           “(2) benefits described in section 1860 shall be  
6           payable under this title to such individuals in the  
7           same manner as if such individuals were so entitled  
8           and enrolled.

9           “(b) NOT TREATED AS MEDICARE PROGRAM FOR  
10          PURPOSES OF MEDICAID PROGRAM.—For purposes of ap-  
11          plying title XIX (including the provision of medicare cost-  
12          sharing assistance under such title), an individual who is  
13          enrolled under this part shall not be treated as being enti-  
14          tled to benefits under this title.

15          “(c) NOT TREATED AS MEDICARE PROGRAM FOR  
16          PURPOSES OF COBRA CONTINUATION PROVISIONS.—In  
17          applying a COBRA continuation provision (as defined in  
18          section 2791(d)(4) of the Public Health Service Act), any  
19          reference to an entitlement to benefits under this title  
20          shall not be construed to include entitlement to benefits  
21          under this title pursuant to the operation of this part.”.

22          (b) CONFORMING AMENDMENTS TO SOCIAL SECUR-  
23          ITY ACT PROVISIONS.—

24                  (1) Section 201(i)(1) of the Social Security Act  
25                  (42 U.S.C. 401(i)(1)) is amended by striking “or the

1 Federal Supplementary Medical Insurance Trust  
2 Fund” and inserting “the Federal Supplementary  
3 Medical Insurance Trust Fund, and the Medicare  
4 Early Access Trust Fund”.

5 (2) Section 201(g)(1)(A) of such Act (42  
6 U.S.C. 401(g)(1)(A)) is amended by striking “and  
7 the Federal Supplementary Medical Insurance Trust  
8 Fund established by title XVIII” and inserting  
9 “, the Federal Supplementary Medical Insurance  
10 Trust Fund, and the Medicare Early Access Trust  
11 Fund established by title XVIII”.

12 (3) Section 1820(i) of such Act (42 U.S.C.  
13 1395i-4(i)) is amended by striking “part D” and in-  
14 serting “part F”.

15 (4) Section 1853(c) of such Act (42 U.S.C.  
16 1395w-23(c)) is amended—

17 (A) in paragraph (1), by striking “or (7)”  
18 and inserting “, (7), or (8)”, and

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

20 “(8) ADJUSTMENT FOR EARLY ACCESS.—In ap-  
21 plying this subsection with respect to individuals en-  
22 titled to benefits under part E, the Secretary shall  
23 provide for an appropriate adjustment in the  
24 Medicare+Choice capitation rate as may be appro-  
25 priate to reflect differences between the population

1 served under such part and the population under  
2 parts A and B.”.

3 (c) OTHER CONFORMING AMENDMENTS.—

4 (2)(A) Section 602(2)(D)(ii) of the Employee  
5 Retirement Income Security Act of 1974 (29 U.S.C.  
6 1162(2)) is amended by inserting “(not including an  
7 individual who is so entitled pursuant to enrollment  
8 under section 1860A)” after “Social Security Act”.

9 (B) Section 2202(2)(D)(ii) of the Public Health  
10 Service Act (42 U.S.C. 300bb–2(2)(D)(ii)) is amend-  
11 ed by inserting “(not including an individual who is  
12 so entitled pursuant to enrollment under section  
13 1860A)” after “Social Security Act”.

14 (C) Section 4980B(f)(2)(B)(i)(V) of the Inter-  
15 nal Revenue Code of 1986 is amended by inserting  
16 “(not including an individual who is so entitled pur-  
17 suant to enrollment under section 1860A)” after  
18 “Social Security Act”.

19 **PART II—ACCESS TO MEDICARE BENEFITS FOR**  
20 **DISPLACED WORKERS 55-TO-62 YEARS OF AGE**  
21 **SEC. 252. ACCESS TO MEDICARE BENEFITS FOR DISPLACED**  
22 **WORKERS 55-TO-62 YEARS OF AGE.**

23 (a) ELIGIBILITY.—Section 1860, as inserted by sec-  
24 tion 251(a)(2), is amended by adding at the end the fol-  
25 lowing new subsection:

1 “(c) DISPLACED WORKERS AND SPOUSES.—

2 “(1) DISPLACED WORKERS.—Subject to para-  
3 graph (3), an individual who meets the following re-  
4 quirements with respect to a month is eligible to en-  
5 roll under this part with respect to such month:

6 “(A) AGE.—As of the last day of the  
7 month, the individual has attained 55 years of  
8 age, but has not attained 62 years of age.

9 “(B) MEDICARE ELIGIBILITY (BUT FOR  
10 AGE).—The individual would be eligible for ben-  
11 efits under part A or part B for the month if  
12 the individual were 65 years of age.

13 “(C) LOSS OF EMPLOYMENT-BASED COV-  
14 ERAGE.—

15 “(i) ELIGIBLE FOR UNEMPLOYMENT  
16 COMPENSATION.—The individual meets the  
17 requirements relating to period of covered  
18 employment and conditions of separation  
19 from employment to be eligible for unem-  
20 ployment compensation (as defined in sec-  
21 tion 85(b) of the Internal Revenue Code of  
22 1986), based on a separation from employ-  
23 ment occurring on or after July 1, 2001.  
24 The previous sentence shall not be con-

1           strued as requiring the individual to be re-  
2           ceiving such unemployment compensation.

3           “(ii) LOSS OF EMPLOYMENT-BASED  
4           COVERAGE.—Immediately before the time  
5           of such separation of employment, the indi-  
6           vidual was covered under a group health  
7           plan on the basis of such employment, and,  
8           because of such loss, is no longer eligible  
9           for coverage under such plan (including  
10          such eligibility based on the application of  
11          a Federal or State COBRA continuation  
12          provision) as of the last day of the month  
13          involved.

14          “(iii) PREVIOUS CREDITABLE COV-  
15          ERAGE FOR AT LEAST 1 YEAR.—As of the  
16          date on which the individual loses coverage  
17          described in clause (ii), the aggregate of  
18          the periods of creditable coverage (as de-  
19          termined under section 2701(c) of the  
20          Public Health Service Act) is 12 months or  
21          longer.

22          “(D) EXHAUSTION OF AVAILABLE COBRA  
23          CONTINUATION BENEFITS.—

1           “(i) IN GENERAL.—In the case of an  
2 individual described in clause (ii) for a  
3 month described in clause (iii)—

4                   “(I) the individual (or spouse)  
5 elected coverage described in clause  
6 (ii); and

7                   “(II) the individual (or spouse)  
8 has continued such coverage for all  
9 months described in clause (iii) in  
10 which the individual (or spouse) is eli-  
11 gible for such coverage.

12           “(ii) INDIVIDUALS TO WHOM COBRA  
13 CONTINUATION COVERAGE MADE AVAIL-  
14 ABLE.—An individual described in this  
15 clause is an individual—

16                   “(I) who was offered coverage  
17 under a Federal or State COBRA  
18 continuation provision at the time of  
19 loss of coverage eligibility described in  
20 subparagraph (C)(ii); or

21                   “(II) whose spouse was offered  
22 such coverage in a manner that per-  
23 mitted coverage of the individual at  
24 such time.

1           “(iii) MONTHS OF POSSIBLE COBRA  
2           CONTINUATION COVERAGE.—A month de-  
3           scribed in this clause is a month for which  
4           an individual described in clause (ii) could  
5           have had coverage described in such clause  
6           as of the last day of the month if the indi-  
7           vidual (or the spouse of the individual, as  
8           the case may be) had elected such coverage  
9           on a timely basis.

10           “(E) NOT ELIGIBLE FOR COVERAGE  
11           UNDER FEDERAL HEALTH INSURANCE PRO-  
12           GRAM OR GROUP HEALTH PLANS.—The indi-  
13           vidual is not eligible for benefits or coverage  
14           under a Federal health insurance program or  
15           under a group health plan (whether on the  
16           basis of the individual’s employment or employ-  
17           ment of the individual’s spouse) as of the last  
18           day of the month involved.

19           “(2) SPOUSE OF DISPLACED WORKER.—Subject  
20           to paragraph (3), an individual who meets the fol-  
21           lowing requirements with respect to a month is eligi-  
22           ble to enroll under this part with respect to such  
23           month:

1           “(A) AGE.—As of the last day of the  
2           month, the individual has not attained 62 years  
3           of age.

4           “(B) MARRIED TO DISPLACED WORKER.—  
5           The individual is the spouse of an individual at  
6           the time the individual enrolls under this part  
7           under paragraph (1) and loses coverage de-  
8           scribed in paragraph (1)(C)(ii) because the in-  
9           dividual’s spouse lost such coverage.

10           “(C) MEDICARE ELIGIBILITY (BUT FOR  
11           AGE); EXHAUSTION OF ANY COBRA CONTINU-  
12           ATION COVERAGE; AND NOT ELIGIBLE FOR COV-  
13           ERAGE UNDER FEDERAL HEALTH INSURANCE  
14           PROGRAM OR GROUP HEALTH PLAN.—The indi-  
15           vidual meets the requirements of subparagraphs  
16           (B), (D), and (E) of paragraph (1).

17           “(3) CHANGE IN HEALTH PLAN ELIGIBILITY  
18           AFFECTS CONTINUED ELIGIBILITY.—For provision  
19           that terminates enrollment under this section in the  
20           case of an individual who becomes eligible for cov-  
21           erage under a group health plan or under a Federal  
22           health insurance program, see section  
23           1860A(d)(1)(C).

24           “(4) REENROLLMENT PERMITTED.—Nothing in  
25           this subsection shall be construed as preventing an

1 individual who, after enrolling under this subsection,  
2 terminates such enrollment from subsequently re-  
3 enrolling under this subsection if the individual is el-  
4 ible to enroll under this subsection at that time.”.

5 (b) ENROLLMENT.—Section 1860A, as so inserted, is  
6 amended—

7 (1) in subsection (a), by striking “and” at the  
8 end of paragraph (1), by striking the period at the  
9 end of paragraph (2) and inserting “; and”, and by  
10 adding at the end the following new paragraph:

11 “(3) individuals whose coverage under this part  
12 would terminate because of subsection (d)(1)(B)(ii)  
13 are provided notice and an opportunity to continue  
14 enrollment in accordance with section  
15 1860E(c)(1).”;

16 (2) in subsection (b), by inserting after Not-  
17 withstanding any other provision of law, (1) the fol-  
18 lowing:

19 “(2) DISPLACED WORKERS AND SPOUSES.—In  
20 the case of individuals eligible to enroll under this  
21 part under section 1860(c), the following rules  
22 apply:

23 “(A) INITIAL ENROLLMENT PERIOD.—If  
24 the individual is first eligible to enroll under  
25 such section for January 2002, the enrollment

1 period shall begin on November 1, 2001, and  
2 shall end on February 28, 2002. Any such en-  
3 rollment before January 1, 2002, is conditioned  
4 upon compliance with the conditions of eligi-  
5 bility for January 2002.

6 “(B) SUBSEQUENT PERIODS.—If the indi-  
7 vidual is eligible to enroll under such section for  
8 a month after January 2002, the enrollment pe-  
9 riod based on such eligibility shall begin on the  
10 first day of the second month before the month  
11 in which the individual first is eligible to so en-  
12 roll (or reenroll) and shall end four months  
13 later.”;

14 (3) in subsection (d)(1), by amending subpara-  
15 graph (B) to read as follows:

16 “(B) TERMINATION BASED ON AGE.—

17 “(i) AT AGE 65.—Subject to clause  
18 (ii), the individual attains 65 years of age.

19 “(ii) AT AGE 62 FOR DISPLACED  
20 WORKERS AND SPOUSES.—In the case of  
21 an individual enrolled under this part pur-  
22 suant to section 1860(c), subject to sub-  
23 section (a)(1), the individual attains 62  
24 years of age.”;

1           (4) in subsection (d)(1), by adding at the end  
2 the following new subparagraph:

3           “(C) OBTAINING ACCESS TO EMPLOYMENT-  
4           BASED COVERAGE OR FEDERAL HEALTH INSUR-  
5           ANCE PROGRAM FOR INDIVIDUALS UNDER 62  
6           YEARS OF AGE.—In the case of an individual  
7           who has not attained 62 years of age, the indi-  
8           vidual is covered (or eligible for coverage) as a  
9           participant or beneficiary under a group health  
10          plan or under a Federal health insurance pro-  
11          gram.”;

12          (5) in subsection (d)(2), by amending subpara-  
13          graph (C) to read as follows:

14               “(C) AGE OR MEDICARE ELIGIBILITY.—

15               “(i) IN GENERAL.—The termination  
16               of a coverage period under paragraph  
17               (1)(A)(iii) or (1)(B)(i) shall take effect as  
18               of the first day of the month in which the  
19               individual attains 65 years of age or be-  
20               comes entitled to benefits under part A or  
21               enrolled for benefits under part B.

22               “(ii) DISPLACED WORKERS.—The ter-  
23               mination of a coverage period under para-  
24               graph (1)(B)(ii) shall take effect as of the  
25               first day of the month in which the indi-

1           vidual attains 62 years of age, unless the  
2           individual has enrolled under this part pur-  
3           suant to section 1860(b) and section  
4           1860E(e)(1).”; and

5           (6) in subsection (d)(2), by adding at the end  
6           the following new subparagraph:

7           “(D) ACCESS TO COVERAGE.—The termi-  
8           nation of a coverage period under paragraph  
9           (1)(C) shall take effect on the date on which  
10          the individual is eligible to begin a period of  
11          creditable coverage (as defined in section  
12          2701(c) of the Public Health Service Act)  
13          under a group health plan or under a Federal  
14          health insurance program.”.

15          (c) PREMIUMS.—Section 1860B, as so inserted, is  
16          amended—

17          (1) in subsection (a)(1), by adding at the end  
18          the following:

19          “(B) BASE MONTHLY PREMIUM FOR INDI-  
20          VIDUALS UNDER 62 YEARS OF AGE.—A base  
21          monthly premium for individuals under 62  
22          years of age, equal to  $\frac{1}{12}$  of the base annual  
23          premium rate computed under subsection (d)(3)  
24          for each premium area and age cohort.”; and

1           (2) by adding at the end the following new sub-  
2 section:

3           “(d) BASE MONTHLY PREMIUM FOR INDIVIDUALS  
4 UNDER 62 YEARS OF AGE.—

5           “(1) NATIONAL, PER CAPITA AVERAGE FOR AGE  
6 GROUPS.—

7           “(A) ESTIMATE OF AMOUNT.—The Sec-  
8 retary shall estimate the average, annual per  
9 capita amount that would be payable under this  
10 title with respect to individuals residing in the  
11 United States who meet the requirement of sec-  
12 tion 1860(c)(1)(A) within each of the age co-  
13 horts established under subparagraph (B) as if  
14 all such individuals within such cohort were eli-  
15 gible for (and enrolled) under this title during  
16 the entire year (and assuming that section  
17 1862(b)(2)(A)(i) did not apply).

18           “(B) AGE COHORTS.—For purposes of  
19 subparagraph (A), the Secretary shall establish  
20 separate age cohorts in 5 year age increments  
21 for individuals who have not attained 60 years  
22 of ages and a separate cohort for individuals  
23 who have attained 60 years of age.

24           “(2) GEOGRAPHIC ADJUSTMENT.—The Sec-  
25 retary shall adjust the amount determined under

1 paragraph (1)(A) for each premium area (specified  
2 under subsection (a)(3)) in the same manner and to  
3 the same extent as the Secretary provides for adjust-  
4 ments under subsection (b)(2).

5 “(3) BASE ANNUAL PREMIUM.—The base an-  
6 nual premium under this subsection for months in a  
7 year for individuals in an age cohort under para-  
8 graph (1)(B) in a premium area is equal to 165 per-  
9 cent of the average, annual per capita amount esti-  
10 mated under paragraph (1) for the age cohort and  
11 year, adjusted for such area under paragraph (2).

12 “(4) PRO-RATION OF PREMIUMS TO REFLECT  
13 COVERAGE DURING A PART OF A MONTH.—If the  
14 Secretary provides for coverage of portions of a  
15 month under section 1860A(c)(2), the Secretary  
16 shall pro-rate the premiums attributable to such cov-  
17 erage under this section to reflect the portion of the  
18 month so covered.”.

19 (d) ADMINISTRATIVE PROVISIONS.—Section 1860F,  
20 as so inserted, is amended by adding at the end the fol-  
21 lowing:

22 “(d) ADDITIONAL ADMINISTRATIVE PROVISIONS.—

23 “(1) PROCESS FOR CONTINUED ENROLLMENT  
24 OF DISPLACED WORKERS WHO ATTAIN 62 YEARS OF  
25 AGE.—The Secretary shall provide a process for the

1 continuation of enrollment of individuals whose en-  
2 rollment under section 1860(c) would be terminated  
3 upon attaining 62 years of age. Under such process  
4 such individuals shall be provided appropriate and  
5 timely notice before the date of such termination  
6 and of the requirement to enroll under this part pur-  
7 suant to section 1860(b) in order to continue entitle-  
8 ment to benefits under this title after attaining 62  
9 years of age.

10 “(2) ARRANGEMENTS WITH STATES FOR DE-  
11 TERMINATIONS RELATING TO UNEMPLOYMENT COM-  
12 PENSATION ELIGIBILITY.—The Secretary may pro-  
13 vide for appropriate arrangements with States for  
14 the determination of whether individuals in the State  
15 meet or would meet the requirements of section  
16 1860(e)(1)(C)(i).”.

17 (e) CONFORMING AMENDMENT TO HEADING TO  
18 PART.—The heading of part E of title XVIII, as so in-  
19 serted, is amended by striking “62” and inserting “55”.



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

3 “(D) SPECIAL RULE FOR QUALIFYING RE-  
4 TIREES AND DEPENDENTS.—In the case of a  
5 qualifying event described in section 603(7), the  
6 term ‘qualified beneficiary’ means a qualified  
7 retiree and any other individual who, on the day  
8 before such qualifying event, is a beneficiary  
9 under the plan on the basis of the individual’s  
10 relationship to such qualified retiree.”; and

11 (B) by adding at the end the following new  
12 paragraphs:

13 “(6) QUALIFIED RETIREE.—The term ‘qualified  
14 retiree’ means, with respect to a qualifying event de-  
15 scribed in section 603(7), a covered employee who,  
16 at the time of the event—

17 “(A) has attained 55 years of age; and

18 “(B) was receiving group health coverage  
19 under the plan by reason of the retirement of  
20 the covered employee.

21 “(7) SUBSTANTIAL REDUCTION.—The term  
22 ‘substantial reduction’—

23 “(A) means, as determined under regula-  
24 tions of the Secretary and with respect to a  
25 qualified beneficiary, a reduction in the average

1           actuarial value of benefits under the plan  
2           (through reduction or elimination of benefits,  
3           an increase in premiums, deductibles, copay-  
4           ments, and coinsurance, or any combination  
5           thereof), since the date of commencement of  
6           coverage of the beneficiary by reason of the re-  
7           irement of the covered employee (or, if later,  
8           January 6, 2001), in an amount equal to at  
9           least 50 percent of the total average actuarial  
10          value of the benefits under the plan as of such  
11          date (taking into account an appropriate ad-  
12          justment to permit comparison of values over  
13          time); and

14                 “(B) includes an increase in premiums re-  
15                 quired to an amount that exceeds the premium  
16                 level described in the fourth sentence of section  
17                 602(3).”.

18          (b) DURATION OF COVERAGE THROUGH AGE 65.—  
19          Section 602(2)(A) of such Act (29 U.S.C. 1162(2)(A)) is  
20          amended—

21                 (1) in clause (ii), by inserting “or 603(7)” after  
22                 “603(6)”;

23                 (2) in clause (iv), by striking “or 603(6)” and  
24                 inserting “, 603(6), or 603(7)”;

25                 (3) by redesignating clause (iv) as clause (vi);

1           (4) by redesignating clause (v) as clause (iv)  
2           and by moving such clause to immediately follow  
3           clause (iii); and

4           (5) by inserting after such clause (iv) the fol-  
5           lowing new clause:

6                           “(v) SPECIAL RULE FOR CERTAIN DE-  
7                           PENDENTS IN CASE OF TERMINATION OR  
8                           SUBSTANTIAL REDUCTION OF RETIREE  
9                           HEALTH COVERAGE.—In the case of a  
10                          qualifying event described in section  
11                          603(7), in the case of a qualified bene-  
12                          ficiary described in section 607(3)(D) who  
13                          is not the qualified retiree or spouse of  
14                          such retiree, the later of—

15   “(I) the date that is 36 months  
16   after the earlier of the date the quali-  
17   fied retiree becomes entitled to bene-  
18   fits under title XVIII of the Social Se-  
19   curity Act, or the date of the death of  
20   the qualified retiree; or

21   “(II) the date that is 36 months  
22   after the date of the qualifying  
23   event.”.

24           (c) TYPE OF COVERAGE IN CASE OF TERMINATION  
25           OR SUBSTANTIAL REDUCTION OF RETIREE HEALTH COV-

1 ERAGE.—Section 602(1) of such Act (29 U.S.C. 1162(1))  
2 is amended—

3 (1) by striking “The coverage” and inserting  
4 the following:

5 “(A) IN GENERAL.—Except as provided in  
6 subparagraph (B), the coverage”; and

7 (2) by adding at the end the following:

8 “(B) CERTAIN RETIREES.—In the case of  
9 a qualifying event described in section 603(7),  
10 in applying the first sentence of subparagraph  
11 (A) and the fourth sentence of paragraph (3),  
12 the coverage offered that is the most prevalent  
13 coverage option (as determined under regula-  
14 tions of the Secretary) continued under the  
15 group health plan (or, if none, under the most  
16 prevalent other plan offered by the same plan  
17 sponsor) shall be treated as the coverage de-  
18 scribed in such sentence, or (at the option of  
19 the plan and qualified beneficiary) such other  
20 coverage option as may be offered and elected  
21 by the qualified beneficiary involved.”.

22 (d) INCREASED LEVEL OF PREMIUMS PERMITTED.—  
23 Section 602(3) of such Act (29 U.S.C. 1162(3)) is amend-  
24 ed by adding at the end the following new sentence: “In  
25 the case of an individual provided continuation coverage

1 by reason of a qualifying event described in section  
2 603(7), any reference in subparagraph (A) of this para-  
3 graph to ‘102 percent of the applicable premium’ is  
4 deemed a reference to ‘125 percent of the applicable pre-  
5 mium for employed individuals (and their dependents, if  
6 applicable) for the coverage option referred to in para-  
7 graph (1)(B)’.”.

8 (e) NOTICE.—Section 606(a) of such Act (29 U.S.C.  
9 1166) is amended—

10 (1) in paragraph (4)(A), by striking “or (6)”  
11 and inserting “(6), or (7)”; and

12 (2) by adding at the end the following:

13 “The notice under paragraph (4) in the case of a quali-  
14 fying event described in section 603(7) shall be provided  
15 at least 90 days before the date of the qualifying event.”.

16 (f) EFFECTIVE DATES.—

17 (1) IN GENERAL.—The amendments made by  
18 this section (other than subsection (e)(2)) shall  
19 apply to qualifying events occurring on or after Jan-  
20 uary 6, 2001. In the case of a qualifying event oc-  
21 ccurring on or after such date and before the date of  
22 the enactment of this Act, such event shall be  
23 deemed (for purposes of such amendments) to have  
24 occurred on the date of the enactment of this Act.

1           (2) ADVANCE NOTICE OF TERMINATIONS AND  
2 REDUCTIONS.—The amendment made by subsection  
3 (e)(2) shall apply to qualifying events occurring  
4 after the date of the enactment of this Act, except  
5 that in no case shall notice be required under such  
6 amendment before such date.

7           **Subpart B—Amendments to the Public Health**

8                           **Service Act**

9           **SEC. 254. COBRA CONTINUATION BENEFITS FOR CERTAIN**  
10                           **RETIRED WORKERS WHO LOSE RETIREE**  
11                           **HEALTH COVERAGE.**

12           (a) ESTABLISHMENT OF NEW QUALIFYING  
13 EVENT.—

14           (1) IN GENERAL.—Section 2203 of the Public  
15 Health Service Act (42 U.S.C. 300bb–3) is amended  
16 by inserting after paragraph (5) the following new  
17 paragraph:

18                   “(6) The termination or substantial reduction  
19 in benefits (as defined in section 2208(6)) of group  
20 health plan coverage as a result of plan changes or  
21 termination in the case of a covered employee who  
22 is a qualified retiree.”.

23           (2) QUALIFIED RETIREE; QUALIFIED BENE-  
24 FICIARY; AND SUBSTANTIAL REDUCTION DE-

1 FINED.—Section 2208 of such Act (42 U.S.C.  
2 300bb–8) is amended—

3 (A) in paragraph (3)—

4 (i) in subparagraph (A), by inserting  
5 “except as otherwise provided in this para-  
6 graph,” after “means,”; and

7 (ii) by adding at the end the following  
8 new subparagraph:

9 “(C) SPECIAL RULE FOR QUALIFYING RE-  
10 TIREES AND DEPENDENTS.—In the case of a  
11 qualifying event described in section 2203(6),  
12 the term ‘qualified beneficiary’ means a quali-  
13 fied retiree and any other individual who, on  
14 the day before such qualifying event, is a bene-  
15 ficiary under the plan on the basis of the indi-  
16 vidual’s relationship to such qualified retiree.”;  
17 and

18 (B) by adding at the end the following new  
19 paragraphs:

20 “(5) QUALIFIED RETIREE.—The term ‘qualified  
21 retiree’ means, with respect to a qualifying event de-  
22 scribed in section 2203(6), a covered employee who,  
23 at the time of the event—

24 “(A) has attained 55 years of age; and

1           “(B) was receiving group health coverage  
2           under the plan by reason of the retirement of  
3           the covered employee.

4           “(6) SUBSTANTIAL REDUCTION.—The term  
5           ‘substantial reduction’—

6           “(A) means, as determined under regula-  
7           tions of the Secretary of Labor and with respect  
8           to a qualified beneficiary, a reduction in the av-  
9           erage actuarial value of benefits under the plan  
10          (through reduction or elimination of benefits,  
11          an increase in premiums, deductibles, copay-  
12          ments, and coinsurance, or any combination  
13          thereof), since the date of commencement of  
14          coverage of the beneficiary by reason of the re-  
15          irement of the covered employee (or, if later,  
16          January 6, 2001), in an amount equal to at  
17          least 50 percent of the total average actuarial  
18          value of the benefits under the plan as of such  
19          date (taking into account an appropriate ad-  
20          justment to permit comparison of values over  
21          time); and

22          “(B) includes an increase in premiums re-  
23          quired to an amount that exceeds the premium  
24          level described in the fourth sentence of section  
25          2202(3).”.

1 (b) DURATION OF COVERAGE THROUGH AGE 65.—  
2 Section 2202(2)(A) of such Act (42 U.S.C. 300bb—  
3 2(2)(A)) is amended—

4 (1) by redesignating clause (iii) as clause (iv);  
5 and

6 (2) by inserting after clause (ii) the following  
7 new clause:

8 “(iii) SPECIAL RULE FOR CERTAIN  
9 DEPENDENTS IN CASE OF TERMINATION  
10 OR SUBSTANTIAL REDUCTION OF RETIREE  
11 HEALTH COVERAGE.—In the case of a  
12 qualifying event described in section  
13 2203(6), in the case of a qualified bene-  
14 ficiary described in section 2208(3)(C) who  
15 is not the qualified retiree or spouse of  
16 such retiree, the later of—

17 “(I) the date that is 36 months  
18 after the earlier of the date the quali-  
19 fied retiree becomes entitled to bene-  
20 fits under title XVIII of the Social Se-  
21 curity Act, or the date of the death of  
22 the qualified retiree; or

23 “(II) the date that is 36 months  
24 after the date of the qualifying  
25 event.”.

1           (c) TYPE OF COVERAGE IN CASE OF TERMINATION  
2 OR SUBSTANTIAL REDUCTION OF RETIREE HEALTH COV-  
3 ERAGE.—Section 2202(1) of such Act (42 U.S.C. 300bb-  
4 2(1)) is amended—

5           (1) by striking “The coverage” and inserting  
6 the following:

7           “(A) IN GENERAL.—Except as provided in  
8 subparagraph (B), the coverage”; and

9           (2) by adding at the end the following:

10           “(B) CERTAIN RETIREES.—In the case of  
11 a qualifying event described in section 2203(6),  
12 in applying the first sentence of subparagraph  
13 (A) and the fourth sentence of paragraph (3),  
14 the coverage offered that is the most prevalent  
15 coverage option (as determined under regula-  
16 tions of the Secretary of Labor) continued  
17 under the group health plan (or, if none, under  
18 the most prevalent other plan offered by the  
19 same plan sponsor) shall be treated as the cov-  
20 erage described in such sentence, or (at the op-  
21 tion of the plan and qualified beneficiary) such  
22 other coverage option as may be offered and  
23 elected by the qualified beneficiary involved.”.

24           (d) INCREASED LEVEL OF PREMIUMS PERMITTED.—  
25 Section 2202(3) of such Act (42 U.S.C. 300bb-2(3)) is

1 amended by adding at the end the following new sentence:  
2 “In the case of an individual provided continuation cov-  
3 erage by reason of a qualifying event described in section  
4 2203(6), any reference in subparagraph (A) of this para-  
5 graph to ‘102 percent of the applicable premium’ is  
6 deemed a reference to ‘125 percent of the applicable pre-  
7 mium for employed individuals (and their dependents, if  
8 applicable) for the coverage option referred to in para-  
9 graph (1)(B)’.”.

10 (e) NOTICE.—Section 2206(a) of such Act (42 U.S.C.  
11 300bb–6(a)) is amended—

12 (1) in paragraph (4)(A), by striking “or (4)”  
13 and inserting “(4), or (6)”; and

14 (2) by adding at the end the following:  
15 “The notice under paragraph (4) in the case of a quali-  
16 fying event described in section 2203(6) shall be provided  
17 at least 90 days before the date of the qualifying event.”.

18 (f) EFFECTIVE DATES.—

19 (1) IN GENERAL.—The amendments made by  
20 this section (other than subsection (e)(2)) shall  
21 apply to qualifying events occurring on or after Jan-  
22 uary 6, 2001. In the case of a qualifying event oc-  
23 ccurring on or after such date and before the date of  
24 the enactment of this Act, such event shall be

1 deemed (for purposes of such amendments) to have  
2 occurred on the date of the enactment of this Act.

3 (2) ADVANCE NOTICE OF TERMINATIONS AND  
4 REDUCTIONS.—The amendment made by subsection  
5 (e)(2) shall apply to qualifying events occurring  
6 after the date of the enactment of this Act, except  
7 that in no case shall notice be required under such  
8 amendment before such date.

9 **Subpart C—Amendments to the Internal Revenue**

10 **Code of 1986**

11 **SEC. 255. COBRA CONTINUATION BENEFITS FOR CERTAIN**  
12 **RETIRED WORKERS WHO LOSE RETIREE**  
13 **HEALTH COVERAGE.**

14 (a) ESTABLISHMENT OF NEW QUALIFYING  
15 EVENT.—

16 (1) IN GENERAL.—Section 4980B(f)(3) of the  
17 Internal Revenue Code of 1986 is amended by in-  
18 serting after subparagraph (F) the following new  
19 subparagraph:

20 “(G) The termination or substantial reduc-  
21 tion in benefits (as defined in subsection (g)(6))  
22 of group health plan coverage as a result of  
23 plan changes or termination in the case of a  
24 covered employee who is a qualified retiree.”.

1           (2) QUALIFIED RETIREE; QUALIFIED BENE-  
2           FICLARY; AND SUBSTANTIAL REDUCTION DE-  
3           FINED.—Section 4980B(g) of such Code is  
4           amended—

5                   (A) in paragraph (1)—

6                           (i) in subparagraph (A), by inserting  
7                           “except as otherwise provided in this para-  
8                           graph,” after “means,”; and

9                           (ii) by adding at the end the following  
10                          new subparagraph:

11                          “(E) SPECIAL RULE FOR QUALIFYING RE-  
12                          TIREES AND DEPENDENTS.—In the case of a  
13                          qualifying event described in subsection  
14                          (f)(3)(G), the term ‘qualified beneficiary’ means  
15                          a qualified retiree and any other individual who,  
16                          on the day before such qualifying event, is a  
17                          beneficiary under the plan on the basis of the  
18                          individual’s relationship to such qualified re-  
19                          tiree.”; and

20                          (B) by adding at the end the following new  
21                          paragraphs:

22                          “(5) QUALIFIED RETIREE.—The term ‘qualified  
23                          retiree’ means, with respect to a qualifying event de-  
24                          scribed in subsection (f)(3)(G), a covered employee  
25                          who, at the time of the event—

1           “(A) has attained 55 years of age; and

2           “(B) was receiving group health coverage  
3 under the plan by reason of the retirement of  
4 the covered employee.

5           “(6) SUBSTANTIAL REDUCTION.—The term  
6 ‘substantial reduction’—

7           “(A) means, as determined under regula-  
8 tions of the Secretary of Labor and with respect  
9 to a qualified beneficiary, a reduction in the av-  
10 erage actuarial value of benefits under the plan  
11 (through reduction or elimination of benefits,  
12 an increase in premiums, deductibles, copay-  
13 ments, and coinsurance, or any combination  
14 thereof), since the date of commencement of  
15 coverage of the beneficiary by reason of the re-  
16 tirement of the covered employee (or, if later,  
17 January 6, 2001), in an amount equal to at  
18 least 50 percent of the total average actuarial  
19 value of the benefits under the plan as of such  
20 date (taking into account an appropriate ad-  
21 justment to permit comparison of values over  
22 time); and

23           “(B) includes an increase in premiums re-  
24 quired to an amount that exceeds the premium

1 level described in the fourth sentence of sub-  
2 section (f)(2)(C).”.

3 (b) DURATION OF COVERAGE THROUGH AGE 65.—

4 Section 4980B(f)(2)(B)(i) of such Code is amended—

5 (1) in subclause (II), by inserting “or (3)(G)”  
6 after “(3)(F)”;

7 (2) in subclause (IV), by striking “or (3)(F)”  
8 and inserting “, (3)(F), or (3)(G)”;

9 (3) by redesignating subclause (IV) as sub-  
10 clause (VI);

11 (4) by redesignating subclause (V) as subclause  
12 (IV) and by moving such clause to immediately fol-  
13 low subclause (III); and

14 (5) by inserting after such subclause (IV) the  
15 following new subclause:

16 “(V) SPECIAL RULE FOR CER-  
17 TAIN DEPENDENTS IN CASE OF TER-  
18 MINATION OR SUBSTANTIAL REDUC-  
19 TION OF RETIREE HEALTH COV-  
20 ERAGE.—In the case of a qualifying  
21 event described in paragraph (3)(G),  
22 in the case of a qualified beneficiary  
23 described in subsection (g)(1)(E) who  
24 is not the qualified retiree or spouse  
25 of such retiree, the later of—

1                   “(a) the date that is 36  
2 months after the earlier of the  
3 date the qualified retiree becomes  
4 entitled to benefits under title  
5 XVIII of the Social Security Act,  
6 or the date of the death of the  
7 qualified retiree; or

8                   “(b) the date that is 36  
9 months after the date of the  
10 qualifying event.”.

11           (c) TYPE OF COVERAGE IN CASE OF TERMINATION  
12 OR SUBSTANTIAL REDUCTION OF RETIREE HEALTH COV-  
13 ERAGE.—Section 4980B(f)(2)(A) of such Code is  
14 amended—

15           (1) by striking “The coverage” and inserting  
16 the following:

17                   “(i) IN GENERAL.—Except as pro-  
18 vided in clause (ii), the coverage”; and

19           (2) by adding at the end the following:

20                   “(ii) CERTAIN RETIREES.—In the  
21 case of a qualifying event described in  
22 paragraph (3)(G), in applying the first  
23 sentence of clause (i) and the fourth sen-  
24 tence of subparagraph (C), the coverage  
25 offered that is the most prevalent coverage

1 option (as determined under regulations of  
2 the Secretary of Labor) continued under  
3 the group health plan (or, if none, under  
4 the most prevalent other plan offered by  
5 the same plan sponsor) shall be treated as  
6 the coverage described in such sentence, or  
7 (at the option of the plan and qualified  
8 beneficiary) such other coverage option as  
9 may be offered and elected by the qualified  
10 beneficiary involved.”.

11 (d) INCREASED LEVEL OF PREMIUMS PERMITTED.—  
12 Section 4980B(f)(2)(C) of such Code is amended by add-  
13 ing at the end the following new sentence: “In the case  
14 of an individual provided continuation coverage by reason  
15 of a qualifying event described in paragraph (3)(G), any  
16 reference in clause (i) of this subparagraph to ‘102 per-  
17 cent of the applicable premium’ is deemed a reference to  
18 ‘125 percent of the applicable premium for employed indi-  
19 viduals (and their dependents, if applicable) for the cov-  
20 erage option referred to in subparagraph (A)(ii)’.”.

21 (e) NOTICE.—Section 4980B(f)(6) of such Code is  
22 amended—

23 (1) in subparagraph (D)(i), by striking “or  
24 (F)” and inserting “(F), or (G)”; and

25 (2) by adding at the end the following:

1 “The notice under subparagraph (D)(i) in the case of a  
2 qualifying event described in paragraph (3)(G) shall be  
3 provided at least 90 days before the date of the qualifying  
4 event.”.

5 (f) EFFECTIVE DATES.—

6 (1) IN GENERAL.—The amendments made by  
7 this section (other than subsection (e)(2)) shall  
8 apply to qualifying events occurring on or after Jan-  
9 uary 6, 2001. In the case of a qualifying event oc-  
10 ccurring on or after such date and before the date of  
11 the enactment of this Act, such event shall be  
12 deemed (for purposes of such amendments) to have  
13 occurred on the date of the enactment of this Act.

14 (2) ADVANCE NOTICE OF TERMINATIONS AND  
15 REDUCTIONS.—The amendment made by subsection  
16 (e)(2) shall apply to qualifying events occurring  
17 after the date of the enactment of this Act, except  
18 that in no case shall notice be required under such  
19 amendment before such date.

1 **PART IV—50 PERCENT CREDIT AGAINST INCOME**  
 2 **TAX FOR MEDICARE BUY-IN PREMIUMS AND**  
 3 **FOR CERTAIN COBRA CONTINUATION COV-**  
 4 **ERAGE PREMIUMS**

5 **SEC. 256. 50 PERCENT CREDIT FOR MEDICARE BUY-IN PRE-**  
 6 **MIUMS AND FOR CERTAIN COBRA CONTINU-**  
 7 **ATION COVERAGE PREMIUMS.**

8 (a) IN GENERAL.—Subpart A of part IV of sub-  
 9 chapter A of chapter 1 of the Internal Revenue Code of  
 10 1986 (relating to nonrefundable personal credits) is  
 11 amended by inserting after section 25A the following new  
 12 section:

13 **“SEC. 25B. MEDICARE BUY-IN PREMIUMS AND CERTAIN**  
 14 **COBRA CONTINUATION COVERAGE PRE-**  
 15 **MIUMS.**

16 “(a) IN GENERAL.—In the case of an individual,  
 17 there shall be allowed as a credit against the tax imposed  
 18 by this chapter for the taxable year an amount equal to  
 19 50 percent of the amount paid during such year as—

20 “(1) qualified continuation health coverage pre-  
 21 miums, and

22 “(2) medicare buy-in coverage premiums.

23 “(b) DEFINITIONS.—For purposes of this section—

24 “(1) QUALIFIED CONTINUATION HEALTH COV-  
 25 ERAGE PREMIUMS.—The term ‘qualified continu-  
 26 ation health coverage premiums’ means, for any pe-



1 **TITLE III—PROTECTING AND EX-**  
2 **TENDING MEDICARE SOL-**  
3 **VENCY**

4 **Subtitle A—Dedication of 20 Per-**  
5 **cent of Projected Budget Sur-**  
6 **plus to Medicare**

7 **SEC. 301. TRANSFERS TO EXTEND MEDICARE SOLVENCY.**

8 Section 1817 (42 U.S.C. 1395i) is amended by add-  
9 ing at the end the following new subsection:

10 “(l) Additional Appropriation to Federal Hospital In-  
11 surance Trust Fund.—

12 “(1) FINDINGS.—The Congress finds as fol-  
13 lows:

14 “(A) The number of individuals eligible for  
15 benefits under the medicare program will ap-  
16 proximately double (from about 40,000,000 to  
17 80,000,000) between 2000 and 2030.

18 “(B) It is expected that there will be major  
19 new high technology services available to medi-  
20 care beneficiaries that may be priced accord-  
21 ingly.

22 “(C) It is essential that additional re-  
23 sources be made available to finance the medi-  
24 care program in the future.

1           “(2) AMOUNT OF ADDITIONAL APPROPRIA-  
2           TION.—In addition to any other amounts appro-  
3           priated to the Trust Fund, there is hereby appro-  
4           priated to the Trust Fund, out of any moneys in the  
5           Treasury not otherwise appropriated, 20 percent of  
6           the on-budget surplus, as estimated by the Congres-  
7           sional Budget Office in January 2001 (adjusted to  
8           exclude surpluses in the Federal Hospital Insurance  
9           Trust Fund), as follows:

10                   “(A)     for     fiscal     year     2002,

11                   \$21,200,000,000;

12                   “(B)     for     fiscal     year     2003,

13                   \$26,400,000,000;

14                   “(C)     for     fiscal     year     2004,

15                   \$31,000,000,000;

16                   “(D)     for     fiscal     year     2005,

17                   \$34,400,000,000;

18                   “(E)     for     fiscal     year     2006,

19                   \$44,600,000,000;

20                   “(F)     for     fiscal     year     2007,

21                   \$55,000,000,000;

22                   “(G)     for     fiscal     year     2008,

23                   \$63,600,000,000;

24                   “(H)     for     fiscal     year     2009,

25                   \$75,600,000,000;

1 “(I) for fiscal year 2010, \$89,400,000,000;

2 “(J) for fiscal year 2011,  
3 \$104,800,000,000; and

4 “(K) for any subsequent fiscal year  
5 through fiscal year 2015, 20 percent of any  
6 such adjusted on-budget surplus.

7 “(3) TRANSFER OF FUNDS.—The amounts ap-  
8 propriated for each fiscal year by paragraph (2)  
9 shall be transferred from the general fund in the  
10 Treasury to the Trust Fund in equal monthly in-  
11 stallments on the first business day of each month.”.

12 **SEC. 302. MEDICARE SOLVENCY DEBT REDUCTION RE-**  
13 **SERVE.**

14 (a) IN GENERAL.—The transfers under section  
15 1817(l) of the Social Security Act shall be known as the  
16 Medicare Solvency Debt Reduction Reserve.

17 (b) POINTS OF ORDER TO PROTECT RESERVE.—

18 (1) Section 301 of the Congressional Budget  
19 Act of 1974 is amended by adding at the end the  
20 following:

21 “(j) POINT OF ORDER TO PROTECT MEDICARE SOL-  
22 VENCY DEBT REDUCTION RESERVE.—It shall not be in  
23 order in the House of Representatives or the Senate to  
24 consider any concurrent resolution on the budget (or  
25 amendment, motion, or conference report on the resolu-

1 tion) that would allocate any amount of, or assume a re-  
2 duction in the Medicare Solvency Debt Reduction Re-  
3 serve.”.

4 (2) Section 311(a) of the Congressional Budget  
5 Act of 1974 is amended by adding at the end the  
6 following:

7 “(4) ENFORCEMENT OF MEDICARE SOLVENCY  
8 RESERVE.—It shall not be in order in the House of  
9 Representatives or the Senate to consider any bill,  
10 joint resolution, amendment, motion, or conference  
11 report that would cause a decrease in the level of the  
12 Medicare Solvency Debt Reduction Reserve.”.

13 (c) SUPER MAJORITY REQUIREMENT.—

14 (1) Section 904(c)(2) of the Congressional  
15 Budget Act of 1974 is amended by inserting  
16 “301(j),” after “301(i),”.

17 (2) Section 904(d)(3) of the Congressional  
18 Budget Act of 1974 is amended by inserting  
19 “301(j),” after “301(i),”.

20 **SEC. 303. PROTECTION OF MEDICARE SOLVENCY DEBT RE-**  
21 **DUCTION RESERVE.**

22 (a) REDUCTION OF MEDICARE SOLVENCY TRANS-  
23 FERS NOT TO BE COUNTED AS PAY-AS-YOU-GO OFF-  
24 SET.—Any provision of legislation that would reduce, re-  
25 peal, or reverse the transfers to the Hospital Insurance

1 Trust Fund under section 1817(l) of the Social Security  
2 Act shall not be counted on the pay-as-you-go scorecard  
3 and shall not be included in any pay-as-you-go estimates  
4 made by the Congressional Budget Office or the Office  
5 of Management and Budget under section 252 of the Bal-  
6 anced Budget and Emergency Deficit Control Act of 1985.

7 (b) CONFORMING CHANGE.—Section 252 of the Bal-  
8 anced Budget and Emergency Deficit Control Act of 1985  
9 is amended, in paragraph (4) of subsection (d), by—

- 10 (1) striking “and” after subparagraph (A),
- 11 (2) striking the period after the subparagraph
- 12 (B) and inserting “; and”, and
- 13 (3) adding the following:

14 “(C) provisions that reduce, repeal, or re-  
15 verse transfers under section 1817(l) of the So-  
16 cial Security Act.”.

17 (c) MEDICARE SOLVENCY TRANSFERS REDUCE ON-  
18 BUDGET SURPLUS.—The transfers under section 1817(l)  
19 of the Social Security Act, known as the “Medicare Sol-  
20 vency Debt Reduction Reserve”, shall be treated for pur-  
21 poses of the President’s budget under title 31, United  
22 States Code, the Balanced Budget and Emergency Deficit  
23 Control Act of 1985, and the Congressional Budget Act  
24 of 1974 as reductions to the on-budget surplus (or in-  
25 creases in the on-budget deficit).

## 1     **Subtitle B—Additional Revenues**

### 2     **SEC. 311. INCREASED FEDERAL EXCISE TAXES ON TO-** 3                   **BACCO PRODUCTS.**

4           (a) IN GENERAL.—Section 5701 of the Internal Rev-  
5     enue Code of 1986 (relating to rate of tax on tobacco  
6     products) is amended to read as follows:

#### 7     **“SEC. 5701. RATE OF TAX.**

8           “(a) CIGARS.—On cigars, manufactured in or im-  
9     ported into the United States, there shall be imposed the  
10    following taxes:

11           “(1) SMALL CIGARS.—On cigars, weighing not  
12           more than 3 pounds per thousand, \$4.406 per thou-  
13           sand.

14           “(2) LARGE CIGARS.—On cigars weighing more  
15           than 3 pounds per thousand, a tax equal to 49.99  
16           percent of the price for which sold but not more  
17           than \$98.75 per thousand.

18    Cigars not exempt from tax under this chapter which are  
19    removed but not intended for sale shall be taxed at the  
20    same rate as similar cigars removed for sale.

21           “(b) CIGARETTES.—On cigarettes, manufactured in  
22    or imported into the United States, there shall be imposed  
23    the following taxes:

1           “(1) SMALL CIGARETTES.—On cigarettes,  
2           weighing not more than 3 pounds per thousand,  
3           \$47.00 per thousand.

4           “(2) LARGE CIGARETTES.—On cigarettes,  
5           weighing more than 3 pounds per thousand, \$98.70  
6           per thousand.

7 Cigarettes described in paragraph (2), if more than 6½  
8 inches in length, shall be taxable at the rate under para-  
9 graph (1) by treating each 2¾ inches (or fraction thereof)  
10 of the length of each as 1 cigarette.

11          “(c) CIGARETTE PAPERS.—On cigarette papers,  
12 manufactured in or imported into the United States, there  
13 shall be imposed a tax of 2.9 cents for each 50 papers  
14 or fractional part thereof; except that cigarette papers  
15 which measure more than 6½ inches in length shall be  
16 taxable at the rate prescribed by treating each 2¾ inches  
17 (or fraction thereof) of the length of each as 1 cigarette  
18 paper.

19          “(d) CIGARETTE TUBES.—On cigarette tubes, manu-  
20 factured in or imported into the United States, there shall  
21 be imposed a tax of 5.9 cents for each 50 tubes or frac-  
22 tional part thereof; except that cigarette tubes which  
23 measure more than 6½ inches in length shall be taxable  
24 at the rate prescribed by treating each 2¾ inches (or frac-  
25 tion thereof) of the length of each as 1 cigarette tube.

1 “(e) SMOKELESS TOBACCO.—

2 “(1) SNUFF.—On snuff, manufactured in or  
3 imported into the United States, there shall be im-  
4 posed a tax of \$1.41 per pound (and a proportionate  
5 tax at the like rate on all fractional parts of a  
6 pound).

7 “(2) CHEWING TOBACCO.—On chewing tobacco,  
8 manufactured in or imported into the United States,  
9 there shall be imposed a tax of 47 cents (and a pro-  
10 portionate tax at the like rate on all fractional parts  
11 of a pound).

12 “(f) PIPE TOBACCO.—On pipe tobacco, manufac-  
13 tured in or imported into the United States, there shall  
14 be imposed a tax of \$2.64 per pound (and a proportionate  
15 tax at the like rate on all fractional parts of a pound).

16 “(g) ROLL-YOUR-OWN TOBACCO.—On roll-your-own  
17 tobacco, manufactured in or imported into the United  
18 States, there shall be imposed a tax \$2.64 per pound (and  
19 a proportionate tax at the like rate on all fractional parts  
20 of a pound).

21 “(h) IMPORTED TOBACCO PRODUCTS AND CIGA-  
22 RETTE PAPERS AND TUBES.—The taxes imposed by this  
23 section on tobacco products and cigarette papers and  
24 tubes imported into the United States shall be in addition

1 to any import duties imposed on such articles, unless such  
2 import duties are imposed in lieu of internal revenue tax.”.

3 (b) EFFECTIVE DATE.—The amendments made by  
4 this section shall take effect on January 1, 2002.

5 (c) FLOOR STOCKS TAXES.—

6 (1) IMPOSITION OF TAX.—On tobacco products  
7 and cigarette papers and tubes manufactured in or  
8 imported into the United States which are removed  
9 before January 1, 2002, and held on such date for  
10 sale by any person, there is hereby imposed a tax in  
11 an amount equal to the excess of—

12 (A) the tax which would be imposed under  
13 section 5701 of the Internal Revenue Code of  
14 1986 on the article if the article had been re-  
15 moved on such date, over

16 (B) the prior tax (if any) imposed under  
17 section 5701 of such Code on such article.

18 (2) AUTHORITY TO EXEMPT CIGARETTES HELD  
19 IN VENDING MACHINES.—To the extent provided in  
20 regulations prescribed by the Secretary, no tax shall  
21 be imposed by paragraph (1) on cigarettes held for  
22 retail sale on January 1, 2002, by any person in any  
23 vending machine. If the Secretary provides such a  
24 benefit with respect to any person, the Secretary

1       may reduce the \$500 amount in paragraph (3) with  
2       respect to such person.

3               (3) CREDIT AGAINST TAX.—Each person shall  
4       be allowed as a credit against the taxes imposed by  
5       paragraph (1) an amount equal to \$500. Such credit  
6       shall not exceed the amount of taxes imposed by  
7       paragraph (1) for which such person is liable.

8               (4) LIABILITY FOR TAX AND METHOD OF PAY-  
9       MENT.—

10              (A) LIABILITY FOR TAX.—A person hold-  
11       ing cigarettes on January 1, 2002, to which any  
12       tax imposed by paragraph (1) applies shall be  
13       liable for such tax.

14              (B) METHOD OF PAYMENT.—The tax im-  
15       posed by paragraph (1) shall be paid in such  
16       manner as the Secretary shall prescribe by reg-  
17       ulations.

18              (C) TIME FOR PAYMENT.—The tax im-  
19       posed by paragraph (1) shall be paid on or be-  
20       fore April 1, 2000.

21              (5) ARTICLES IN FOREIGN TRADE ZONES.—  
22       Notwithstanding the Act of June 18, 1934 (48 Stat.  
23       998, 19 U.S.C. 81a) and any other provision of law,  
24       any article which is located in a foreign trade zone

1 on January 1, 2002, shall be subject to the tax im-  
2 posed by paragraph (1) if—

3 (A) internal revenue taxes have been deter-  
4 mined, or customs duties liquidated, with re-  
5 spect to such article before such date pursuant  
6 to a request made under the 1st proviso of sec-  
7 tion 3(a) of such Act, or

8 (B) such article is held on such date under  
9 the supervision of a customs officer pursuant to  
10 the 2d proviso of such section 3(a).

11 (6) DEFINITIONS.—For purposes of this  
12 subsection—

13 (A) IN GENERAL.—Terms used in this sub-  
14 section which are also used in section 5702 of  
15 the Internal Revenue Code of 1986 shall have  
16 the respective meanings such terms have in  
17 such section, as amended by this Act.

18 (B) SECRETARY.—The term “Secretary”  
19 means the Secretary of the Treasury or the  
20 Secretary’s delegate.

21 (7) CONTROLLED GROUPS.—Rules similar to  
22 the rules of section 5061(e)(3) of such Code shall  
23 apply for purposes of this subsection.

24 (8) OTHER LAWS APPLICABLE.—All provisions  
25 of law, including penalties, applicable with respect to

1 the taxes imposed by section 5701 of such Code  
2 shall, insofar as applicable and not inconsistent with  
3 the provisions of this subsection, apply to the floor  
4 stocks taxes imposed by paragraph (1), to the same  
5 extent as if such taxes were imposed by such section  
6 5701. The Secretary may treat any person who bore  
7 the ultimate burden of the tax imposed by para-  
8 graph (1) as the person to whom a credit or refund  
9 under such provisions may be allowed or made.

10 **SEC. 312. TOBACCO SETTLEMENT DEPOSIT.**

11 Amounts that are recovered by the United States in  
12 the civil action brought on September 22, 1999, under the  
13 Racketeer Influenced and Corrupt Organizations Act  
14 (RICO) in the United States District Court for the Dis-  
15 trict of Columbia against the industry engaged in the pro-  
16 duction and sale of tobacco products and persons engaged  
17 in public relations and lobbying for such industry and that  
18 are attributable to the expenditures of the Department of  
19 Health and Human Services for tobacco-related illnesses  
20 shall be deposited in the Federal Hospital Insurance Trust  
21 Fund established under section 1817 of the Social Secu-  
22 rity Act (42 U.S.C. 1395i).

1 **SEC. 313. EXCESS PROFITS FROM MEDICARE TAX.**

2 (a) IN GENERAL.—Subchapter A of chapter 1 of the  
3 Internal Revenue Code of 1986 is amended by adding at  
4 the end the following new part:

5 **“PART VIII—EXCESS PROFITS OF**  
6 **PHARMACEUTICAL COMPANIES**

“Sec. 59B. Imposition of tax.

7 **“SEC. 59B. IMPOSITION OF TAX.**

8 “(a) IN GENERAL.—In the case of any person who  
9 manufactures or produces any article reimbursed under  
10 part D of title XVIII of the Social Security Act, there is  
11 hereby imposed (in addition to any other tax imposed by  
12 this title) a tax equal to 50 percent of the excess profit  
13 on the sale of such article by such person.

14 “(b) EXCESS PROFIT.—For purposes of subsection  
15 (a), the term ‘excess profit’ means, with respect to an arti-  
16 cle, the amount by which the costs associated with the sale  
17 of such article (including gifts, other than samples of the  
18 article, provided to physicians) exceeds twice the research  
19 and development costs properly allocable to such article.”

20 (b) CLERICAL AMENDMENT.—The table of parts for  
21 subchapter A of chapter 1 of such Code is amended by  
22 adding at the end the following new item:

“Part VIII. Excess profits of pharmaceutical companies.”

1 (c) EFFECTIVE DATE.—The amendments made by  
 2 this section shall take effect on January 1, 2004.

3 **SEC. 314. MEDICARE PART B PERCENT SUBSIDY INCLUDED**  
 4 **IN GROSS INCOME.**

5 (a) IN GENERAL.—Part II of subchapter B of chap-  
 6 ter 1 of the Internal Revenue Code of 1986 (relating to  
 7 items specifically included in gross income) is amended by  
 8 adding at the end the following new section:

9 **“SEC. 91. MEDICARE PART B SUBSIDY.**

10 “(a) IN GENERAL.—Gross income includes the appli-  
 11 cable percentage of the Medicare part B subsidy with re-  
 12 spect to premiums under part B of title XVIII of the So-  
 13 cial Security Act which are paid by the taxpayer during  
 14 the taxable year.

15 “(b) APPLICABLE PERCENTAGE.—For purposes of  
 16 this section, the applicable percentage for any taxable year  
 17 is the applicable percentage determined under the fol-  
 18 lowing table for the calendar year in which such taxable  
 19 year begins.

| <b>Calendar year</b>     | <b>Applicable<br/>percentage</b> |
|--------------------------|----------------------------------|
| 2005 .....               | 10                               |
| 2006 .....               | 20                               |
| 2007 .....               | 30                               |
| 2008 .....               | 40                               |
| 2009 .....               | 50                               |
| 2010 .....               | 60                               |
| 2011 .....               | 70                               |
| 2012 .....               | 80                               |
| 2014 .....               | 90                               |
| 2015 or thereafter ..... | 100.”                            |

1 (b) CLERICAL AMENDMENT.—The table of sections  
 2 for part II of subchapter B of chapter 1 of such Code  
 3 is amended by adding at the end the following new item:

“Sec. 91. Medicare part B subsidy.”

4 (c) EFFECTIVE DATE.—The amendments made by  
 5 this section shall apply with respect to taxable years begin-  
 6 ning after December 31, 2004.

7 **SEC. 315. DEDICATION OF FEDERAL ESTATE AND GIFT TAX**  
 8 **RECEIPTS, TOBACCO TAX RECEIPTS AND**  
 9 **OTHER REVENUES TO MEDICARE.**

10 (a) TRANSFER TO FEDERAL HOSPITAL INSURANCE  
 11 TRUST FUND.—Section 1817(a) (42 U.S.C. 1395i(a)) is  
 12 amended—

13 (1) by striking “and” at the end of paragraph  
 14 (1), and

15 (2) by striking the period at the end of para-  
 16 graph (2) and inserting a semicolon, and

17 (3) by inserting after paragraph (2) the fol-  
 18 lowing new paragraphs:

19 “(3) the taxes imposed by subtitle B of the In-  
 20 ternal Revenue Code of 1986 (relating to estate and  
 21 gift taxes) reported to the Secretary of the Treasury  
 22 or his delegate on tax returns under subtitle F of  
 23 such Code;

24 “(4) the taxes imposed by chapter 52 of such  
 25 Code (relating to cigars, cigarettes, smokeless to-

1       bacco, pipe tobacco, and cigarette papers and tubes)  
2       as so reported;

3             “(5) the taxes imposed by section 59B of such  
4       Code (relating to excess profits of pharmaceutical  
5       companies) as so reported; and

6             “(6) the increase in tax liabilities under chapter  
7       1 of such Code which is attributable to section 91  
8       of such Code (relating to medicare part B subsidy).”

9       (b) EFFECTIVE DATE.—The amendments made by  
10      this section apply to taxes imposed after the date of the  
11      enactment of this Act.

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