

Calendar No. 138

108TH CONGRESS
1ST SESSION

S. 1

To amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 11, 2003

Mr. FRIST (for himself, Mr. GRASSLEY, and Mr. BAUCUS) introduced the following bill; which was read twice and referred to the Committee on Finance

JUNE 13, 2003

Reported by Mr. GRASSLEY, with an amendment and an amendment to the title.

[Strike out all after the enacting clause and insert the part printed in italic]

A BILL

To amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

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

1 **SECTION 1. SHORT TITLE; SENSE OF THE CONGRESS.**

2 (a) **SHORT TITLE.**—This Act may be cited as the
3 “Prescription Drug and Medicare Improvement Act of
4 2003”.

5 (b) **SENSE OF THE CONGRESS.**—It is the Sense of
6 the Congress that the Congress should enact, and the
7 President should sign, legislation to amend title XVIII of
8 the Social Security Act to make improvements in the
9 medicare program and to provide prescription drug cov-
10 erage under the medicare program.

11 **SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECU-**

12 **RITY ACT; REFERENCES TO BIPA AND SEC-**

13 **RETARY; TABLE OF CONTENTS.**

14 (a) *SHORT TITLE.*—*This Act may be cited as the “Pre-*
15 *scription Drug and Medicare Improvement Act of 2003”.*

16 (b) *AMENDMENTS TO SOCIAL SECURITY ACT.*—*Except*
17 *as otherwise specifically provided, whenever in this Act an*
18 *amendment is expressed in terms of an amendment to or*
19 *repeal of a section or other provision, the reference shall*
20 *be considered to be made to that section or other provision*
21 *of the Social Security Act.*

22 (c) *BIPA; SECRETARY.*—*In this Act:*

23 (1) *BIPA.*—*The term “BIPA” means the Medi-*
24 *care, Medicaid, and SCHIP Benefits Improvement*
25 *and Protection Act of 2000, as enacted into law by*
26 *section 1(a)(6) of Public Law 106–554.*

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

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

Sec. 1. Short title; amendments to Social Security Act; references to BIPA and Secretary; table of contents.

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

Subtitle A—Medicare Voluntary Prescription Drug Delivery Program

Sec. 101. Medicare voluntary prescription drug delivery program.

“PART D—VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

“Sec. 1860D. Definitions; treatment of references to provisions in Medicare Advantage program.

“Subpart 1—Establishment of Voluntary Prescription Drug Delivery Program

“Sec. 1860D–1. Establishment of voluntary prescription drug delivery program.

“Sec. 1860D–2. Enrollment under program.

“Sec. 1860D–3. Election of a Medicare Prescription Drug plan.

“Sec. 1860D–4. Providing information to beneficiaries.

“Sec. 1860D–5. Beneficiary protections.

“Sec. 1860D–6. Prescription drug benefits.

“Sec. 1860D–7. Requirements for entities offering Medicare Prescription Drug plans; establishment of standards.

“Subpart 2—Prescription Drug Delivery System

“Sec. 1860D–10. Establishment of service areas.

“Sec. 1860D–11. Publication of risk adjusters.

“Sec. 1860D–12. Submission of bids for proposed Medicare Prescription Drug plans.

“Sec. 1860D–13. Approval of proposed Medicare Prescription Drug plans.

“Sec. 1860D–14. Computation of monthly standard prescription drug coverage premiums.

“Sec. 1860D–15. Computation of monthly national average premium.

“Sec. 1860D–16. Payments to eligible entities.

“Sec. 1860D–17. Computation of monthly beneficiary obligation.

“Sec. 1860D–18. Collection of monthly beneficiary obligation.

“Sec. 1860D–19. Premium and cost-sharing subsidies for low-income individuals.

“Sec. 1860D–20. Reinsurance payments for expenses incurred in providing prescription drug coverage above the annual out-of-pocket threshold.

“Sec. 1860D–21. Direct subsidy for sponsor of a qualified retiree prescription drug plan for plan enrollees eligible for, but not enrolled in, this part.

“Subpart 3—Miscellaneous Provisions

“Sec. 1860D–25. Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.

“Sec. 1860D–26. Other related provisions.

Sec. 102. Study and report on permitting part B only individuals to enroll in medicare voluntary prescription drug delivery program.

Sec. 103. Rules relating to medigap policies that provide prescription drug coverage.

Sec. 104. Medicaid and other amendments related to low-income beneficiaries.

Sec. 105. Expansion of membership and duties of Medicare Payment Advisory Commission (MedPAC).

Sec. 106. Study regarding variations in spending and drug utilization.

Subtitle B—Medicare Prescription Drug Discount Card and Transitional Assistance for Low-Income Beneficiaries

Sec. 111. Medicare prescription drug discount card and transitional assistance for low-income beneficiaries.

Subtitle C—Standards for Electronic Prescribing

Sec. 121. Standards for electronic prescribing.

Subtitle D—Other Provisions

Sec. 131. Additional requirements for annual financial report and oversight on medicare program.

Sec. 132. Trustees’ report on medicare’s unfunded obligations.

TITLE II—MEDICAREADVANTAGE

Subtitle A—MedicareAdvantage Competition

Sec. 201. Eligibility, election, and enrollment.

Sec. 202. Benefits and beneficiary protections.

Sec. 203. Payments to MedicareAdvantage organizations.

Sec. 204. Submission of bids; premiums.

Sec. 205. Special rules for prescription drug benefits.

Sec. 206. Facilitating employer participation.

Sec. 207. Administration by the Center for Medicare Choices.

Sec. 208. Conforming amendments.

Sec. 209. Effective date.

Subtitle B—Preferred Provider Organizations

Sec. 211. Establishment of MedicareAdvantage preferred provider program option.

Subtitle C—Other Managed Care Reforms

Sec. 221. Extension of reasonable cost contracts.

Sec. 222. Specialized Medicare+Choice plans for special needs beneficiaries.

Sec. 223. Payment by PACE providers for medicare and medicaid services furnished by noncontract providers.

Sec. 224. Institute of Medicine evaluation and report on health care performance measures.

Sec. 225. Expanding the work of medicare quality improvement organizations to include parts C and D.

TITLE III—CENTER FOR MEDICARE CHOICES

Sec. 301. Establishment of the Center for Medicare Choices.

Sec. 302. Miscellaneous administrative provisions.

TITLE IV—MEDICARE FEE-FOR-SERVICE IMPROVEMENTS

Subtitle A—Provisions Relating to Part A

Sec. 401. Equalizing urban and rural standardized payment amounts under the medicare inpatient hospital prospective payment system.

Sec. 402. Adjustment to the medicare inpatient hospital PPS wage index to revise the labor-related share of such index.

Sec. 403. Medicare inpatient hospital payment adjustment for low-volume hospitals.

Sec. 404. Fairness in the medicare disproportionate share hospital (DSH) adjustment for rural hospitals.

Sec. 405. Critical access hospital (CAH) improvements.

Sec. 406. Authorizing use of arrangements to provide core hospice services in certain circumstances.

Sec. 407. Services provided to hospice patients by nurse practitioners, clinical nurse specialists, and physician assistants.

Sec. 408. Authority to include costs of training of psychologists in payments to hospitals under medicare.

Sec. 409. Revision of Federal rate for hospitals in Puerto Rico.

Sec. 410. Authority regarding geriatric fellowships.

Sec. 411. Clarification of congressional intent regarding the counting of residents in a nonprovider setting and a technical amendment regarding the 3-year rolling average and the IME ratio.

Sec. 412. Limitation on charges for inpatient hospital contract health services provided to Indians by medicare participating hospitals.

Sec. 413. GAO study and report on appropriateness of payments under the prospective payment system for inpatient hospital services.

Subtitle B—Provisions Relating to Part B

Sec. 421. Establishment of floor on geographic adjustments of payments for physicians' services.

Sec. 422. Medicare incentive payment program improvements.

Sec. 423. Increase in renal dialysis composite rate.

Sec. 424. Extension of hold harmless provisions for small rural hospitals and treatment of certain sole community hospitals to limit decline in payment under the OPD PPS.

Sec. 425. Increase in payments for certain services furnished by small rural and sole community hospitals under medicare prospective payment system for hospital outpatient department services.

Sec. 426. Increase for ground ambulance services furnished in a rural area.

Sec. 427. Ensuring appropriate coverage of air ambulance services under ambulance fee schedule.

Sec. 428. Treatment of certain clinical diagnostic laboratory tests furnished by a sole community hospital.

Sec. 429. Improvement in rural health clinic reimbursement.

Sec. 430. Elimination of consolidated billing for certain services under the medicare PPS for skilled nursing facility services.

- Sec. 431. Freeze in payments for certain items of durable medical equipment and certain orthotics; establishment of quality standards and accreditation requirements for DME providers.*
- Sec. 432. Application of coinsurance and deductible for clinical diagnostic laboratory tests.*
- Sec. 433. Basing medicare payments for covered outpatient drugs on market prices.*
- Sec. 434. Indexing part B deductible to inflation.*
- Sec. 435. Revisions to reassignment provisions.*
- Sec. 436. Extension of treatment of certain physician pathology services under medicare.*
- Sec. 437. Treatment of pass-through drugs and the prospective payment system for hospital outpatient department services.*
- Sec. 438. Limitation of application of functional equivalence standard.*
- Sec. 439. Medicare coverage of routine costs associated with certain clinical trials.*
- Sec. 440. Waiver of part B late enrollment penalty for certain military retirees; special enrollment period.*
- Sec. 441. Demonstration of coverage of chiropractic services under medicare.*
- Sec. 442. Medicare health care quality demonstration programs.*
- Sec. 443. Medicare complex clinical care management payment demonstration.*
- Sec. 444. Medicare fee-for-service care coordination demonstration program.*
- Sec. 445. GAO study of geographic differences in payments for physicians' services.*

Subtitle C—Provisions Relating to Parts A and B

- Sec. 451. Increase for home health services furnished in a rural area.*
- Sec. 452. Limitation on reduction in area wage adjustment factors under the prospective payment system for home health services.*
- Sec. 453. Exception to physician referral limitation for certain transfers from specialty hospitals to general hospitals.*
- Sec. 454. Demonstration program for substitute adult day services.*

TITLE V—MEDICARE APPEALS, REGULATORY, AND CONTRACTING IMPROVEMENTS

Subtitle A—Regulatory Reform

- Sec. 501. Rules for the publication of a final regulation based on the previous publication of an interim final regulation.*
- Sec. 502. Compliance with changes in regulations and policies.*
- Sec. 503. Report on legal and regulatory inconsistencies.*

Subtitle B—Appeals Process Reform

- Sec. 511. Submission of plan for transfer of responsibility for medicare appeals.*
- Sec. 512. Expedited access to judicial review.*
- Sec. 513. Expedited review of certain provider agreement determinations.*
- Sec. 514. Revisions to medicare appeals process.*
- Sec. 515. Hearing rights related to decisions by the Secretary to deny or not renew a medicare enrollment agreement; consultation before changing provider enrollment forms.*
- Sec. 516. Appeals by providers when there is no other party available.*
- Sec. 517. Provider access to review of local coverage determinations.*

Subtitle C—Contracting Reform

Sec. 521. Increased flexibility in medicare administration.

Subtitle D—Education and Outreach Improvements

Sec. 531. Provider education and technical assistance.

Sec. 532. Access to and prompt responses from medicare contractors.

Sec. 533. Reliance on guidance.

Sec. 534. Medicare provider ombudsman.

Sec. 535. Beneficiary outreach demonstration programs.

Subtitle E—Review, Recovery, and Enforcement Reform

Sec. 541. Prepayment review.

Sec. 542. Recovery of overpayments.

Sec. 543. Process for correction of minor errors and omissions on claims without pursuing appeals process.

Sec. 544. Authority to waive a program exclusion.

TITLE VI—OTHER PROVISIONS

Sec. 601. Increase in medicaid DSH allotments for fiscal years 2004 and 2005.

Sec. 602. Increase in floor for treatment as an extremely low DSH State under the medicaid program for fiscal years 2004 and 2005.

Sec. 603. Increased reporting requirements to ensure the appropriateness of payment adjustments to disproportionate share hospitals under the medicaid program.

Sec. 604. Clarification of inclusion of inpatient drug prices charged to certain public hospitals in the best price exemptions for the medicaid drug rebate program.

Sec. 605. Assistance with coverage of legal immigrants under the medicaid program and SCHIP.

Sec. 606. Establishment of consumer ombudsman account.

Sec. 607. GAO study regarding impact of assets test for low-income beneficiaries.

Sec. 608. Health care infrastructure improvement.

Sec. 609. Capital infrastructure revolving loan program.

Sec. 610. Federal reimbursement of emergency health services furnished to undocumented aliens.

Sec. 611. Increase in appropriation to the health care fraud and abuse control account.

Sec. 612. Increase in civil penalties under the False Claims Act.

Sec. 613. Increase in civil monetary penalties under the Social Security Act.

Sec. 614. Extension of customs user fees.

1 **TITLE I—MEDICARE**
 2 **PRESCRIPTION DRUG BENEFIT**
 3 **Subtitle A—Medicare Voluntary**
 4 **Prescription Drug Delivery Pro-**
 5 **gram**

6 **SEC. 101. MEDICARE VOLUNTARY PRESCRIPTION DRUG DE-**
 7 **LIVERY PROGRAM.**

8 (a) *ESTABLISHMENT.*—*Title XVIII (42 U.S.C. 1395 et*
 9 *seq.) is amended by redesignating part D as part E and*
 10 *by inserting after part C the following new part:*

11 “*PART D—VOLUNTARY PRESCRIPTION DRUG DELIVERY*
 12 *PROGRAM*

13 “*DEFINITIONS; TREATMENT OF REFERENCES TO*
 14 *PROVISIONS IN MEDICAREADVANTAGE PROGRAM*

15 “*SEC. 1860D. (a) DEFINITIONS.*—*In this part:*

16 “(1) *ADMINISTRATOR.*—*The term ‘Adminis-*
 17 *trator’ means the Administrator of the Center for*
 18 *Medicare Choices as established under section 1808.*

19 “(2) *COVERED DRUG.*—

20 “(A) *IN GENERAL.*—*Except as provided in*
 21 *subparagraphs (B), (C), and (D), the term ‘cov-*
 22 *ered drug’ means—*

23 “(i) *a drug that may be dispensed only*
 24 *upon a prescription and that is described in*

1 *clause (i) or (ii) of subparagraph (A) of sec-*
 2 *tion 1927(k)(2); or*

3 *“(ii) a biological product described in*
 4 *clauses (i) through (iii) of subparagraph*
 5 *(B) of such section; or*

6 *“(iii) insulin described in subpara-*
 7 *graph (C) of such section;*

8 *and such term includes a vaccine licensed under*
 9 *section 351 of the Public Health Service Act and*
 10 *any use of a covered drug for a medically accept-*
 11 *ed indication (as defined in section 1927(k)(6)).*

12 *“(B) EXCLUSIONS.—*

13 *“(i) IN GENERAL.—The term ‘covered*
 14 *drug’ does not include drugs or classes of*
 15 *drugs, or their medical uses, which may be*
 16 *excluded from coverage or otherwise re-*
 17 *stricted under section 1927(d)(2), other than*
 18 *subparagraph (E) thereof (relating to smok-*
 19 *ing cessation agents), or under section*
 20 *1927(d)(3).*

21 *“(ii) AVOIDANCE OF DUPLICATE COV-*
 22 *ERAGE.—A drug prescribed for an indi-*
 23 *vidual that would otherwise be a covered*
 24 *drug under this part shall not be so consid-*
 25 *ered if payment for such drug is available*

under part A or B, but shall be so considered if such payment is not available under part A or B or because benefits under such parts have been exhausted.

“(C) *APPLICATION OF FORMULARY RESTRICTIONS.*—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered under a plan if the plan excludes the drug under a formulary and such exclusion is not successfully resolved under subsection (d) or (e)(2) of section 1860D–5.

“(D) *APPLICATION OF GENERAL EXCLUSION PROVISIONS.*—A Medicare Prescription Drug plan or a Medicare Advantage plan may exclude from qualified prescription drug coverage any covered drug—

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

“(ii) which are not prescribed in accordance with the plan or this part.

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860D–5(e).

1 “(3) *ELIGIBLE BENEFICIARY.*—The term ‘eligible
2 *beneficiary*’ means an individual who is entitled to,
3 or enrolled for, benefits under part A and enrolled
4 under part B (other than a dual eligible individual,
5 as defined in section 1860D–19(a)(4)(E)).

6 “(4) *ELIGIBLE ENTITY.*—The term ‘eligible enti-
7 *ty*’ means any risk-bearing entity that the Adminis-
8 trator determines to be appropriate to provide eligible
9 beneficiaries with the benefits under a Medicare Pre-
10 scription Drug plan, including—

11 “(A) a pharmaceutical benefit management
12 company;

13 “(B) a wholesale or retail pharmacist deliv-
14 ery system;

15 “(C) an insurer (including an insurer that
16 offers medicare supplemental policies under sec-
17 tion 1882);

18 “(D) any other risk-bearing entity; or

19 “(E) any combination of the entities de-
20 scribed in subparagraphs (A) through (D).

21 “(5) *INITIAL COVERAGE LIMIT.*—The term ‘ini-
22 tial coverage limit’ means the limit as established
23 under section 1860D–6(c)(3), or, in the case of cov-
24 erage that is not standard prescription drug coverage,

1 *the comparable limit (if any) established under the*
 2 *coverage.*

3 “(6) *MEDICAREADVANTAGE ORGANIZATION;*
 4 *MEDICAREADVANTAGE PLAN.—The terms*
 5 *‘MedicareAdvantage organization’ and*
 6 *‘MedicareAdvantage plan’ have the meanings given*
 7 *such terms in subsections (a)(1) and (b)(1), respec-*
 8 *tively, of section 1859 (relating to definitions relating*
 9 *to MedicareAdvantage organizations).*

10 “(7) *MEDICARE PRESCRIPTION DRUG PLAN.—*
 11 *The term ‘Medicare Prescription Drug plan’ means*
 12 *prescription drug coverage that is offered under a pol-*
 13 *icy, contract, or plan—*

14 “(A) *that has been approved under section*
 15 *1860D–13; and*

16 “(B) *by an eligible entity pursuant to, and*
 17 *in accordance with, a contract between the Ad-*
 18 *ministrator and the entity under section 1860D–*
 19 *7(b).*

20 “(8) *PRESCRIPTION DRUG ACCOUNT.—The term*
 21 *‘Prescription Drug Account’ means the Prescription*
 22 *Drug Account (as established under section 1860D–*
 23 *25) in the Federal Supplementary Medical Insurance*
 24 *Trust Fund under section 1841.*

1 “(9) *QUALIFIED PRESCRIPTION DRUG COV-*
 2 *ERAGE.*—*The term ‘qualified prescription drug cov-*
 3 *erage’ means the coverage described in section 1860D–*
 4 *6(a)(1).*

5 “(10) *STANDARD PRESCRIPTION DRUG COV-*
 6 *ERAGE.*—*The term ‘standard prescription drug cov-*
 7 *erage’ means the coverage described in section 1860D–*
 8 *6(c).*

9 “(b) *APPLICATION OF MEDICAREADVANTAGE PROVI-*
 10 *SIONS UNDER THIS PART.*—*For purposes of applying pro-*
 11 *visions of part C under this part with respect to a Medicare*
 12 *Prescription Drug plan and an eligible entity, unless other-*
 13 *wise provided in this part such provisions shall be applied*
 14 *as if—*

15 “(1) *any reference to a MedicareAdvantage plan*
 16 *included a reference to a Medicare Prescription Drug*
 17 *plan;*

18 “(2) *any reference to a provider-sponsored orga-*
 19 *nization included a reference to an eligible entity;*

20 “(3) *any reference to a contract under section*
 21 *1857 included a reference to a contract under section*
 22 *1860D–7(b); and*

23 “(4) *any reference to part C included a reference*
 24 *to this part.*

1 *“Subpart 1—Establishment of Voluntary Prescription*
 2 *Drug Delivery Program*

3 *“ESTABLISHMENT OF VOLUNTARY PRESCRIPTION DRUG*
 4 *DELIVERY PROGRAM*

5 *“SEC. 1860D–1. (a) PROVISION OF BENEFIT.—*

6 *“(1) IN GENERAL.—The Administrator shall pro-*
 7 *vide for and administer a voluntary prescription*
 8 *drug delivery program under which each eligible bene-*
 9 *ficiary enrolled under this part shall be provided with*
 10 *access to qualified prescription drug coverage as fol-*
 11 *lows:*

12 *“(A) MEDICAREADVANTAGE ENROLLEES RE-*
 13 *CEIVE COVERAGE THROUGH*
 14 *MEDICAREADVANTAGE PLAN.—*

15 *“(i) IN GENERAL.—Except as provided*
 16 *in clause (ii), an eligible beneficiary who is*
 17 *enrolled under this part and enrolled in a*
 18 *MedicareAdvantage plan offered by a*
 19 *MedicareAdvantage organization shall re-*
 20 *ceive coverage of benefits under this part*
 21 *through such plan.*

22 *“(ii) EXCEPTION FOR ENROLLEES IN*
 23 *MEDICAREADVANTAGE MSA PLANS.—An eli-*
 24 *gible beneficiary who is enrolled under this*
 25 *part and enrolled in an MSA plan under*

1 *part C shall receive coverage of benefits*
 2 *under this part through enrollment in a*
 3 *Medicare Prescription Drug plan that is of-*
 4 *fered in the geographic area in which the*
 5 *beneficiary resides. For purposes of this*
 6 *part, the term ‘MSA plan’ has the meaning*
 7 *given such term in section 1859(b)(3).*

8 “(iii) *EXCEPTION FOR ENROLLEES IN*
 9 *MEDICAREADVANTAGE PRIVATE FEE-FOR-*
 10 *SERVICE PLANS.—An eligible beneficiary*
 11 *who is enrolled under this part and enrolled*
 12 *in a private fee-for-service plan under part*
 13 *C shall—*

14 “(i) *receive benefits under this*
 15 *part through such plan if the plan pro-*
 16 *vides qualified prescription drug cov-*
 17 *erage; and*

18 “(ii) *if the plan does not provide*
 19 *qualified prescription drug coverage,*
 20 *receive coverage of benefits under this*
 21 *part through enrollment in a Medicare*
 22 *Prescription Drug plan that is offered*
 23 *in the geographic area in which the*
 24 *beneficiary resides. For purposes of*
 25 *this part, the term ‘private fee-for-serv-*

1 ice plan’ has the meaning given such
2 term in section 1859(b)(2).

3 “(B) *FEE-FOR-SERVICE ENROLLEES RE-*
4 *CEIVE COVERAGE THROUGH A MEDICARE PRE-*
5 *SCRIPTION DRUG PLAN.*—An eligible beneficiary
6 who is enrolled under this part but is not en-
7 rolled in a MedicareAdvantage plan (except for
8 an MSA plan or a private fee-for-service plan
9 that does not provide qualified prescription drug
10 coverage) shall receive coverage of benefits under
11 this part through enrollment in a Medicare Pre-
12 scription Drug plan that is offered in the geo-
13 graphic area in which the beneficiary resides.

14 “(2) *VOLUNTARY NATURE OF PROGRAM.*—Noth-
15 ing in this part shall be construed as requiring an el-
16 igible beneficiary to enroll in the program under this
17 part.

18 “(3) *SCOPE OF BENEFITS.*—Pursuant to section
19 1860D–6(b)(3)(C), the program established under this
20 part shall provide for coverage of all therapeutic cat-
21 egories and classes of covered drugs (although not nec-
22 essarily for all drugs within such categories and class-
23 es).

24 “(4) *PROGRAM TO BEGIN IN 2006.*—The Adminis-
25 trator shall establish the program under this part in

1 *a manner so that benefits are first provided beginning*
 2 *on January 1, 2006.*

3 “(b) *ACCESS TO ALTERNATIVE PRESCRIPTION DRUG*
 4 *COVERAGE.—In the case of an eligible beneficiary who has*
 5 *creditable prescription drug coverage (as defined in section*
 6 *1860D–2(b)(1)(F)), such beneficiary—*

7 *“(1) may continue to receive such coverage and*
 8 *not enroll under this part; and*

9 *“(2) pursuant to section 1860D–2(b)(1)(C), is*
 10 *permitted to subsequently enroll under this part with-*
 11 *out any penalty and obtain access to qualified pre-*
 12 *scription drug coverage in the manner described in*
 13 *subsection (a) if the beneficiary involuntarily loses*
 14 *such coverage.*

15 “(c) *FINANCING.—The costs of providing benefits*
 16 *under this part shall be payable from the Prescription Drug*
 17 *Account.*

18 “*ENROLLMENT UNDER PROGRAM*

19 “*SEC. 1860D–2. (a) ESTABLISHMENT OF ENROLL-*
 20 *MENT PROCESS.—*

21 *“(1) PROCESS SIMILAR TO PART B ENROLL-*
 22 *MENT.—The Administrator shall establish a process*
 23 *through which an eligible beneficiary (including an*
 24 *eligible beneficiary enrolled in a MedicareAdvantage*
 25 *plan offered by a MedicareAdvantage organization)*
 26 *may make an election to enroll under this part. Such*

1 *process shall be similar to the process for enrollment*
 2 *in part B under section 1837, including the deeming*
 3 *provisions of such section.*

4 “(2) *CONDITION OF ENROLLMENT.*—*An eligible*
 5 *beneficiary must be enrolled under this part in order*
 6 *to be eligible to receive access to qualified prescription*
 7 *drug coverage.*

8 “(b) *SPECIAL ENROLLMENT PROCEDURES.*—

9 “(1) *LATE ENROLLMENT PENALTY.*—

10 “(A) *INCREASE IN MONTHLY BENEFICIARY*
 11 *OBLIGATION.*—*Subject to the succeeding provi-*
 12 *sions of this paragraph, in the case of an eligible*
 13 *beneficiary whose coverage period under this*
 14 *part began pursuant to an enrollment after the*
 15 *beneficiary’s initial enrollment period under*
 16 *part B (determined pursuant to section 1837(d))*
 17 *and not pursuant to the open enrollment period*
 18 *described in paragraph (2), the Administrator*
 19 *shall establish procedures for increasing the*
 20 *amount of the monthly beneficiary obligation*
 21 *under section 1860D–17 applicable to such bene-*
 22 *ficiary by an amount that the Administrator de-*
 23 *termines is actuarially sound for each full 12-*
 24 *month period (in the same continuous period of*
 25 *eligibility) in which the eligible beneficiary could*

1 *have been enrolled under this part but was not*
 2 *so enrolled.*

3 “(B) *PERIODS TAKEN INTO ACCOUNT.—For*
 4 *purposes of calculating any 12-month period*
 5 *under subparagraph (A), there shall be taken*
 6 *into account—*

7 “(i) *the months which elapsed between*
 8 *the close of the eligible beneficiary’s initial*
 9 *enrollment period and the close of the en-*
 10 *rollment period in which the beneficiary en-*
 11 *rolled; and*

12 “(ii) *in the case of an eligible bene-*
 13 *ficiary who reenrolls under this part, the*
 14 *months which elapsed between the date of*
 15 *termination of a previous coverage period*
 16 *and the close of the enrollment period in*
 17 *which the beneficiary reenrolled.*

18 “(C) *PERIODS NOT TAKEN INTO ACCOUNT.—*

19 “(i) *IN GENERAL.—For purposes of*
 20 *calculating any 12-month period under sub-*
 21 *paragraph (A), subject to clause (ii), there*
 22 *shall not be taken into account months for*
 23 *which the eligible beneficiary can dem-*
 24 *onstrate that the beneficiary had creditable*

1 *prescription drug coverage (as defined in*
2 *subparagraph (F)).*

3 “(ii) *BENEFICIARY MUST INVOLUN-*
4 *TARILY LOSE COVERAGE.—Clause (i) shall*
5 *only apply with respect to coverage—*

6 “(I) *in the case of coverage de-*
7 *scribed in clause (ii) of subparagraph*
8 *(F), if the plan terminates, ceases to*
9 *provide, or reduces the value of the pre-*
10 *scription drug coverage under such*
11 *plan to below the actuarial value of*
12 *standard prescription drug coverage*
13 *(as determined under section 1860D–*
14 *6(f));*

15 “(II) *in the case of coverage de-*
16 *scribed in clause (i), (iii), or (iv) of*
17 *subparagraph (F), if the beneficiary is*
18 *involuntarily disenrolled or becomes*
19 *ineligible for such coverage; or*

20 “(III) *in the case of a beneficiary*
21 *with coverage described in clause (v) of*
22 *subparagraph (F), if the issuer of the*
23 *policy terminates coverage under the*
24 *policy.*

1 “(D) *PERIODS TREATED SEPARATELY.*—

2 *Any increase in an eligible beneficiary’s monthly*
 3 *beneficiary obligation under subparagraph (A)*
 4 *with respect to a particular continuous period of*
 5 *eligibility shall not be applicable with respect to*
 6 *any other continuous period of eligibility which*
 7 *the beneficiary may have.*

8 “(E) *CONTINUOUS PERIOD OF ELIGI-*
 9 *BILITY.*—

10 “(i) *IN GENERAL.*—Subject to clause
 11 *(ii), for purposes of this paragraph, an eli-*
 12 *gible beneficiary’s ‘continuous period of eli-*
 13 *gibility’ is the period that begins with the*
 14 *first day on which the beneficiary is eligible*
 15 *to enroll under section 1836 and ends with*
 16 *the beneficiary’s death.*

17 “(ii) *SEPARATE PERIOD.*—Any period
 18 *during all of which an eligible beneficiary*
 19 *satisfied paragraph (1) of section 1836 and*
 20 *which terminated in or before the month*
 21 *preceding the month in which the bene-*
 22 *ficiary attained age 65 shall be a separate*
 23 *‘continuous period of eligibility’ with re-*
 24 *spect to the beneficiary (and each such pe-*
 25 *riod which terminates shall be deemed not*

1 to have existed for purposes of subsequently
2 applying this paragraph).

3 “(F) *CREDITABLE PRESCRIPTION DRUG*
4 *COVERAGE DEFINED.*—Subject to subparagraph
5 (G), for purposes of this part, the term ‘cred-
6 itable prescription drug coverage’ means any of
7 the following:

8 “(i) *DRUG-ONLY COVERAGE UNDER*
9 *MEDICAID.*—Coverage of covered outpatient
10 drugs (as defined in section 1927) under
11 title XIX or a waiver under 1115 that is
12 provided to an individual who is not a dual
13 eligible individual (as defined in section
14 1860D–19(a)(4)(E)).

15 “(ii) *PRESCRIPTION DRUG COVERAGE*
16 *UNDER A GROUP HEALTH PLAN.*—Any out-
17 patient prescription drug coverage under a
18 group health plan, including a health bene-
19 fits plan under chapter 89 of title 5, United
20 States Code (commonly known as the Fed-
21 eral employees health benefits program),
22 and a qualified retiree prescription drug
23 plan (as defined in section 1860D–
24 20(e)(4)).

1 “(iii) *STATE PHARMACEUTICAL AS-*
 2 *SISTANCE PROGRAM.*—Coverage of prescrip-
 3 *tion drugs under a State pharmaceutical*
 4 *assistance program.*

5 “(iv) *VETERANS’ COVERAGE OF PRE-*
 6 *SCRIPTION DRUGS.*—Coverage of prescrip-
 7 *tion drugs for veterans, and survivors and*
 8 *dependents of veterans, under chapter 17 of*
 9 *title 38, United States Code.*

10 “(v) *PRESCRIPTION DRUG COVERAGE*
 11 *UNDER MEDIGAP POLICIES.*—Coverage
 12 *under a medicare supplemental policy*
 13 *under section 1882 that provides benefits for*
 14 *prescription drugs (whether or not such cov-*
 15 *erage conforms to the standards for pack-*
 16 *ages of benefits under section 1882(p)(1)).*

17 “(G) *REQUIREMENT FOR CREDITABLE COV-*
 18 *ERAGE.*—Coverage described in clauses (i)
 19 *through (v) of subparagraph (F) shall not be*
 20 *considered to be creditable coverage under this*
 21 *part unless the coverage provides coverage of the*
 22 *cost of prescription drugs the actuarial value of*
 23 *which (as defined by the Administrator) to the*
 24 *beneficiary equals or exceeds the actuarial value*

1 *of standard prescription drug coverage (as deter-*
 2 *mined under section 1860D–6(f)).*

3 “(H) *DISCLOSURE.*—

4 “(i) *IN GENERAL.*—*Each entity that*
 5 *offers coverage of the type described in*
 6 *clause (ii) (iii), (iv), or (v) of subparagraph*
 7 *(F) shall provide for disclosure, consistent*
 8 *with standards established by the Adminis-*
 9 *trator, of whether the coverage provides cov-*
 10 *erage of the cost of prescription drugs the*
 11 *actuarial value of which (as defined by the*
 12 *Administrator) to the beneficiary equals or*
 13 *exceeds the actuarial value of standard pre-*
 14 *scription drug coverage (as determined*
 15 *under section 1860D–6(f)).*

16 “(ii) *WAIVER OF LIMITATIONS.*—*An*
 17 *individual may apply to the Administrator*
 18 *to waive the application of subparagraph*
 19 *(G) if the individual establishes that the in-*
 20 *dividual was not adequately informed that*
 21 *the coverage the beneficiary was enrolled in*
 22 *did not provide the level of benefits required*
 23 *in order for the coverage to be considered*
 24 *creditable coverage under subparagraph (F).*

25 “(2) *INITIAL ELECTION PERIODS.*—

1 “(A) *OPEN ENROLLMENT PERIOD FOR CUR-*
 2 *RENT BENEFICIARIES IN WHICH LATE ENROLL-*
 3 *MENT PROCEDURES DO NOT APPLY.*—*In the case*
 4 *of an individual who is an eligible beneficiary as*
 5 *of November 1, 2005, there shall be an open en-*
 6 *rollment period of 6 months beginning on that*
 7 *date under which such beneficiary may enroll*
 8 *under this part without the application of the*
 9 *late enrollment procedures established under*
 10 *paragraph (1)(A).*

11 “(B) *INDIVIDUAL COVERED IN FUTURE.*—*In*
 12 *the case of an individual who becomes an eligible*
 13 *beneficiary after such date, there shall be an ini-*
 14 *tial election period which is the same as the ini-*
 15 *tial enrollment period under section 1837(d).*

16 “(3) *SPECIAL ENROLLMENT PERIOD FOR BENE-*
 17 *FICIARIES WHO INVOLUNTARILY LOSE CREDITABLE*
 18 *PRESCRIPTION DRUG COVERAGE.*—

19 “(A) *ESTABLISHMENT.*—*The Administrator*
 20 *shall establish a special open enrollment period*
 21 *(as described in subparagraph (B)) for an eligi-*
 22 *ble beneficiary that loses creditable prescription*
 23 *drug coverage.*

24 “(B) *SPECIAL OPEN ENROLLMENT PE-*
 25 *RIOD.*—*The special open enrollment period de-*

scribed in this subparagraph is the 63-day period that begins on—

“(i) in the case of a beneficiary with coverage described in clause (ii) of paragraph (1)(F), the later of the date on which the plan terminates, ceases to provide, or substantially reduces (as defined by the Administrator) the value of the prescription drug coverage under such plan or the date the beneficiary is provided with notice of such termination or reduction;

“(ii) in the case of a beneficiary with coverage described in clause (i), (iii), or (iv) of paragraph (1)(F), the later of the date on which the beneficiary is involuntarily disenrolled or becomes ineligible for such coverage or the date the beneficiary is provided with notice of such loss of eligibility; or

“(iii) in the case of a beneficiary with coverage described in clause (v) of paragraph (1)(F), the latter of the date on which the issuer of the policy terminates coverage under the policy or the date the beneficiary is provided with notice of such termination.

1 “(c) *PERIOD OF COVERAGE.*—

2 “(1) *IN GENERAL.*—*Except as provided in para-*
 3 *graph (2) and subject to paragraph (3), an eligible*
 4 *beneficiary’s coverage under the program under this*
 5 *part shall be effective for the period provided in sec-*
 6 *tion 1838, as if that section applied to the program*
 7 *under this part.*

8 “(2) *OPEN AND SPECIAL ENROLLMENT.*—

9 “(A) *OPEN ENROLLMENT.*—*An eligible bene-*
 10 *ficiary who enrolls under the program under this*
 11 *part pursuant to subsection (b)(2) shall be enti-*
 12 *tled to the benefits under this part beginning on*
 13 *January 1, 2006.*

14 “(B) *SPECIAL ENROLLMENT.*—*Subject to*
 15 *paragraph (3), an eligible beneficiary who en-*
 16 *rolls under the program under this part pursu-*
 17 *ant to subsection (b)(3) shall be entitled to the*
 18 *benefits under this part beginning on the first*
 19 *day of the month following the month in which*
 20 *such enrollment occurs.*

21 “(3) *LIMITATION.*—*Coverage under this part*
 22 *shall not begin prior to January 1, 2006.*

23 “(d) *TERMINATION.*—

1 “(1) *IN GENERAL.*—*The causes of termination*
 2 *specified in section 1838 shall apply to this part in*
 3 *the same manner as such causes apply to part B.*

4 “(2) *COVERAGE TERMINATED BY TERMINATION*
 5 *OF COVERAGE UNDER PART A OR B.*—

6 “(A) *IN GENERAL.*—*In addition to the*
 7 *causes of termination specified in paragraph (1),*
 8 *the Administrator shall terminate an individ-*
 9 *ual’s coverage under this part if the individual*
 10 *is no longer enrolled in both parts A and B.*

11 “(B) *EFFECTIVE DATE.*—*The termination*
 12 *described in subparagraph (A) shall be effective*
 13 *on the effective date of termination of coverage*
 14 *under part A or (if earlier) under part B.*

15 “(3) *PROCEDURES REGARDING TERMINATION OF*
 16 *A BENEFICIARY UNDER A PLAN.*—*The Administrator*
 17 *shall establish procedures for determining the status of*
 18 *an eligible beneficiary’s enrollment under this part if*
 19 *the beneficiary’s enrollment in a Medicare Prescrip-*
 20 *tion Drug plan offered by an eligible entity under*
 21 *this part is terminated by the entity for cause (pursu-*
 22 *ant to procedures established by the Administrator*
 23 *under section 1860D–3(a)(1)).*

24 “*ELECTION OF A MEDICARE PRESCRIPTION DRUG PLAN*

25 “*SEC. 1860D–3. (a) IN GENERAL.*—

26 “(1) *PROCESS.*—

1 “(A) *ELECTION.*—

2 “(i) *IN GENERAL.*—*The Administrator*
 3 *shall establish a process through which an*
 4 *eligible beneficiary who is enrolled under*
 5 *this part but not enrolled in a*
 6 *MedicareAdvantage plan (except for an*
 7 *MSA plan or a private fee-for-service plan*
 8 *that does not provide qualified prescription*
 9 *drug coverage) offered by a*
 10 *MedicareAdvantage organization—*

11 “(I) *shall make an election to en-*
 12 *roll in any Medicare Prescription*
 13 *Drug plan that is offered by an eligible*
 14 *entity and that serves the geographic*
 15 *area in which the beneficiary resides;*
 16 *and*

17 “(II) *may make an annual elec-*
 18 *tion to change the election under this*
 19 *clause.*

20 “(ii) *CLARIFICATION REGARDING EN-*
 21 *ROLLMENT.*—*The process established under*
 22 *clause (i) shall include, in the case of an el-*
 23 *igible beneficiary who is enrolled under this*
 24 *part but who has failed to make an election*
 25 *of a Medicare Prescription Drug plan in an*

1 *area, for the enrollment in any Medicare*
 2 *Prescription Drug plan that has been des-*
 3 *ignated by the Administrator in the area.*
 4 *The Administrator shall establish a process*
 5 *for designating a plan or plans in order to*
 6 *carry out the preceding sentence.*

7 *“(B) REQUIREMENTS FOR PROCESS.—In es-*
 8 *tablishing the process under subparagraph (A),*
 9 *the Administrator shall—*

10 *“(i) use rules similar to the rules for*
 11 *enrollment, disenrollment, and termination*
 12 *of enrollment with a MedicareAdvantage*
 13 *plan under section 1851, including—*

14 *“(I) the establishment of special*
 15 *election periods under subsection (e)(4)*
 16 *of such section; and*

17 *“(II) the application of the guar-*
 18 *anteed issue and renewal provisions of*
 19 *section 1851(g) (other than clause (i)*
 20 *and the second sentence of clause (ii) of*
 21 *paragraph (3)(C), relating to default*
 22 *enrollment); and*

23 *“(ii) coordinate enrollments,*
 24 *disenrollments, and terminations of enroll-*
 25 *ment under part C with enrollments,*

1 *disenrollments, and terminations of enroll-*
 2 *ment under this part.*

3 “(2) *FIRST ENROLLMENT PERIOD FOR PLAN EN-*
 4 *ROLLMENT.—The process developed under paragraph*
 5 *(1) shall ensure that eligible beneficiaries who enroll*
 6 *under this part during the open enrollment period*
 7 *under section 1860D–2(b)(2) are permitted to elect an*
 8 *eligible entity prior to January 1, 2006, in order to*
 9 *ensure that coverage under this part is effective as of*
 10 *such date.*

11 “(b) *ENROLLMENT IN A MEDICAREADVANTAGE*
 12 *PLAN.—*

13 “(1) *IN GENERAL.—An eligible beneficiary who*
 14 *is enrolled under this part and enrolled in a*
 15 *MedicareAdvantage plan (except for an MSA plan or*
 16 *a private fee-for-service plan that does not provide*
 17 *qualified prescription drug coverage) offered by a*
 18 *MedicareAdvantage organization shall receive access*
 19 *to such coverage under this part through such plan.*

20 “(2) *RULES.—Enrollment in a*
 21 *MedicareAdvantage plan is subject to the rules for en-*
 22 *rollment in such plan under section 1851.*

23 “*PROVIDING INFORMATION TO BENEFICIARIES*

24 “*SEC. 1860D–4. (a) ACTIVITIES.—*

25 “(1) *IN GENERAL.—The Administrator shall con-*
 26 *duct activities that are designed to broadly dissemi-*

1 *nate information to eligible beneficiaries (and pro-*
 2 *spective eligible beneficiaries) regarding the coverage*
 3 *provided under this part.*

4 “(2) *SPECIAL RULE FOR FIRST ENROLLMENT*
 5 *UNDER THE PROGRAM.—The activities described in*
 6 *paragraph (1) shall ensure that eligible beneficiaries*
 7 *are provided with such information at least 30 days*
 8 *prior to the first enrollment period described in sec-*
 9 *tion 1860D–3(a)(2).*

10 “(b) *REQUIREMENTS.—*

11 “(1) *IN GENERAL.—The activities described in*
 12 *subsection (a) shall—*

13 “(A) *be similar to the activities performed*
 14 *by the Administrator under section 1851(d);*

15 “(B) *be coordinated with the activities per-*
 16 *formed by—*

17 “(i) *the Administrator under such sec-*
 18 *tion; and*

19 “(ii) *the Secretary under section 1804;*
 20 *and*

21 “(C) *provide for the dissemination of infor-*
 22 *mation comparing the plans offered by eligible*
 23 *entities under this part that are available to eli-*
 24 *gible beneficiaries residing in an area.*

1 “(2) *COMPARATIVE INFORMATION.—The com-*
 2 *parative information described in paragraph (1)(C)*
 3 *shall include a comparison of the following:*

4 “(A) *BENEFITS.—The benefits provided*
 5 *under the plan and the formularies and griev-*
 6 *ance and appeals processes under the plan.*

7 “(B) *MONTHLY BENEFICIARY OBLIGA-*
 8 *TION.—The monthly beneficiary obligation under*
 9 *the plan.*

10 “(C) *QUALITY AND PERFORMANCE.—The*
 11 *quality and performance of the eligible entity of-*
 12 *fering the plan.*

13 “(D) *BENEFICIARY COST-SHARING.—The*
 14 *cost-sharing required of eligible beneficiaries*
 15 *under the plan.*

16 “(E) *CONSUMER SATISFACTION SURVEYS.—*
 17 *The results of consumer satisfaction surveys re-*
 18 *garding the plan and the eligible entity offering*
 19 *such plan (conducted pursuant to section*
 20 *1860D–5(h).*

21 “(F) *ADDITIONAL INFORMATION.—Such ad-*
 22 *ditional information as the Administrator may*
 23 *prescribe.*

24 “*BENEFICIARY PROTECTIONS*

25 “*SEC. 1860D–5. (a) DISSEMINATION OF INFORMA-*
 26 *TION.—*

1 “(1) *GENERAL INFORMATION.*—An eligible entity
 2 offering a Medicare Prescription Drug plan shall dis-
 3 close, in a clear, accurate, and standardized form to
 4 each enrollee at the time of enrollment, and at least
 5 annually thereafter, the information described in sec-
 6 tion 1852(c)(1) relating to such plan. Such informa-
 7 tion includes the following:

8 “(A) *Access to covered drugs, including ac-*
 9 *cess through pharmacy networks.*

10 “(B) *How any formulary used by the entity*
 11 *functions.*

12 “(C) *Copayments, coinsurance, and deduct-*
 13 *ible requirements.*

14 “(D) *Grievance and appeals processes.*

15 *The information described in the preceding sentence*
 16 *shall also be made available on request to prospective*
 17 *enrollees during open enrollment periods.*

18 “(2) *DISCLOSURE UPON REQUEST OF GENERAL*
 19 *COVERAGE, UTILIZATION, AND GRIEVANCE INFORMA-*
 20 *TION.*—Upon request of an individual eligible to en-
 21 roll in a Medicare Prescription Drug plan, the eligi-
 22 ble entity offering such plan shall provide informa-
 23 tion similar (as determined by the Administrator) to
 24 the information described in subparagraphs (A), (B),
 25 and (C) of section 1852(c)(2) to such individual.

1 “(3) *RESPONSE TO BENEFICIARY QUESTIONS.*—
 2 *An eligible entity offering a Medicare Prescription*
 3 *Drug plan shall have a mechanism for providing on*
 4 *a timely basis specific information to enrollees upon*
 5 *request, including information on the coverage of spe-*
 6 *cific drugs and changes in its formulary.*

7 “(4) *CLAIMS INFORMATION.*—*An eligible entity*
 8 *offering a Medicare Prescription Drug plan must fur-*
 9 *nish to enrolled individuals in a form easily under-*
 10 *standable to such individuals—*

11 *“(A) an explanation of benefits (in accord-*
 12 *ance with section 1806(a) or in a comparable*
 13 *manner); and*

14 *“(B) when prescription drug benefits are*
 15 *provided under this part, a notice of the benefits*
 16 *in relation to the initial coverage limit and an-*
 17 *ual out-of-pocket limit for the current year (ex-*
 18 *cept that such notice need not be provided more*
 19 *often than monthly).*

20 “(5) *APPROVAL OF MARKETING MATERIAL AND*
 21 *APPLICATION FORMS.*—*The provisions of section*
 22 *1851(h) shall apply to marketing material and appli-*
 23 *cation forms under this part in the same manner as*
 24 *such provisions apply to marketing material and ap-*
 25 *plication forms under part C.*

1 “(b) *ACCESS TO COVERED DRUGS.*—

2 “(1) *ACCESS TO NEGOTIATED PRICES FOR PRE-*
 3 *SCRIPTION DRUGS.*—*An eligible entity offering a*
 4 *Medicare Prescription Drug plan shall have in place*
 5 *procedures to ensure that beneficiaries are not charged*
 6 *more than the negotiated price of a covered drug.*
 7 *Such procedures shall include the issuance of a card*
 8 *(or other technology) that may be used by an enrolled*
 9 *beneficiary for the purchase of prescription drugs for*
 10 *which coverage is not otherwise provided under the*
 11 *Medicare Prescription Drug plan.*

12 “(2) *ASSURING PHARMACY ACCESS.*—

13 “(A) *IN GENERAL.*—*An eligible entity offer-*
 14 *ing a Medicare Prescription Drug plan shall se-*
 15 *cure the participation in its network of a suffi-*
 16 *cient number of pharmacies that dispense (other*
 17 *than by mail order) drugs directly to patients to*
 18 *ensure convenient access (as determined by the*
 19 *Administrator and including adequate emer-*
 20 *gency access) for enrolled beneficiaries, in ac-*
 21 *cordance with standards established by the Ad-*
 22 *ministrator under section 1860D–7(g) that en-*
 23 *sure such convenient access. Such standards shall*
 24 *take into account reasonable distances to phar-*
 25 *macy services in both urban and rural areas.*

1 “(B) *USE OF POINT-OF-SERVICE SYSTEM.*—

2 *An eligible entity offering a Medicare Prescrip-*
 3 *tion Drug plan shall establish an optional point-*
 4 *of-service method of operation under which—*

5 “(i) *the plan provides access to any or*
 6 *all pharmacies that are not participating*
 7 *pharmacies in its network; and*

8 “(ii) *the plan may charge beneficiaries*
 9 *through adjustments in copayments any ad-*
 10 *ditional costs associated with the point-of-*
 11 *service option.*

12 *The additional copayments so charged shall not*
 13 *count toward the application of section 1860D–*
 14 *6(c).*

15 “(3) *REQUIREMENTS ON DEVELOPMENT AND AP-*
 16 *PLICATION OF FORMULARIES.*—*If an eligible entity of-*
 17 *fering a Medicare Prescription Drug plan uses a for-*
 18 *mulary, the following requirements must be met:*

19 “(A) *PHARMACY AND THERAPEUTIC (P&T)*
 20 *COMMITTEE.*—

21 “(i) *IN GENERAL.*—*The eligible entity*
 22 *must establish a pharmacy and therapeutic*
 23 *committee that develops and reviews the for-*
 24 *mulary.*

1 “(ii) *COMPOSITION.*—A pharmacy and
 2 *therapeutic committee shall include at least*
 3 *1 academic expert, at least 1 practicing*
 4 *physician, and at least 1 practicing phar-*
 5 *macist, all of whom have expertise in the*
 6 *care of elderly or disabled persons, and a*
 7 *majority of the members of such committee*
 8 *shall consist of individuals who are a prac-*
 9 *ticing physician or a practicing pharmacist*
 10 *(or both).*

11 “(B) *FORMULARY DEVELOPMENT.*—In de-
 12 *veloping and reviewing the formulary, the com-*
 13 *mittee shall base clinical decisions on the*
 14 *strength of scientific evidence and standards of*
 15 *practice, including assessing peer-reviewed med-*
 16 *ical literature, such as randomized clinical*
 17 *trials, pharmacoeconomic studies, outcomes re-*
 18 *search data, and such other information as the*
 19 *committee determines to be appropriate.*

20 “(C) *INCLUSION OF DRUGS IN ALL THERA-*
 21 *PEUTIC CATEGORIES AND CLASSES.*—

22 “(i) *IN GENERAL.*—The formulary
 23 *must include drugs within each therapeutic*
 24 *category and class of covered drugs (as de-*
 25 *finied by the Administrator), although not*

1 *necessarily for all drugs within such cat-*
 2 *egories and classes.*

3 “(ii) *REQUIREMENT.*—*In defining*
 4 *therapeutic categories and classes of covered*
 5 *drugs pursuant to clause (i), the Adminis-*
 6 *trator shall use—*

7 “(I) *the compendia referred to sec-*
 8 *tion 1927(g)(1)(B)(i); and*

9 “(II) *other recognized sources of*
 10 *drug classifications and categorizations*
 11 *determined appropriate by the Admin-*
 12 *istrator.*

13 “(D) *PROVIDER EDUCATION.*—*The com-*
 14 *mittee shall establish policies and procedures to*
 15 *educate and inform health care providers con-*
 16 *cerning the formulary.*

17 “(E) *NOTICE BEFORE REMOVING DRUGS*
 18 *FROM FORMULARY.*—*Any removal of a drug from*
 19 *a formulary shall take effect only after appro-*
 20 *priate notice is made available to beneficiaries,*
 21 *physicians, and pharmacists.*

22 “(F) *APPEALS AND EXCEPTIONS TO APPLI-*
 23 *CATION.*—*The eligible entity must have, as part*
 24 *of the appeals process under subsection (e), a*

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

3 “(c) *COST AND UTILIZATION MANAGEMENT; QUALITY*
 4 *ASSURANCE; MEDICATION THERAPY MANAGEMENT PRO-*
 5 *GRAM.—*

6 “(1) *IN GENERAL.—An eligible entity shall have*
 7 *in place the following with respect to covered drugs:*

8 “(A) *A cost-effective drug utilization man-*
 9 *agement program, including incentives to reduce*
 10 *costs when appropriate.*

11 “(B) *Quality assurance measures to reduce*
 12 *medical errors and adverse drug interactions*
 13 *and to improve medication use, which—*

14 “(i) *shall include a medication therapy*
 15 *management program described in para-*
 16 *graph (2); and*

17 “(ii) *may include beneficiary edu-*
 18 *cation programs, counseling, medication re-*
 19 *fill reminders, and special packaging.*

20 “(C) *A program to control fraud, abuse,*
 21 *and waste.*

22 *Nothing in this section shall be construed as impair-*
 23 *ing an eligible entity from applying cost management*
 24 *tools (including differential payments) under all*
 25 *methods of operation.*

1 “(2) *MEDICATION THERAPY MANAGEMENT PRO-*
2 *GRAM.*—

3 “(A) *IN GENERAL.*—*A medication therapy*
4 *management program described in this para-*
5 *graph is a program of drug therapy management*
6 *and medication administration that is designed*
7 *to assure, with respect to beneficiaries with*
8 *chronic diseases (such as diabetes, asthma, hy-*
9 *pertension, hyperlipidemia, and congestive heart*
10 *failure) or multiple prescriptions, that covered*
11 *drugs under the Medicare Prescription Drug*
12 *plan are appropriately used to optimize thera-*
13 *peutic outcomes through improved medication*
14 *use and to achieve therapeutic goals and reduce*
15 *the risk of adverse events, including adverse drug*
16 *interactions.*

17 “(B) *ELEMENTS.*—*Such program may in-*
18 *clude—*

19 “(i) *enhanced beneficiary under-*
20 *standing of such appropriate use through*
21 *beneficiary education, counseling, and other*
22 *appropriate means;*

23 “(ii) *increased beneficiary adherence*
24 *with prescription medication regimens*
25 *through medication refill reminders, special*

1 *packaging, and other appropriate means;*
 2 *and*

3 “(iii) *detection of patterns of overuse*
 4 *and underuse of prescription drugs.*

5 “(C) *DEVELOPMENT OF PROGRAM IN CO-*
 6 *OPERATION WITH LICENSED PHARMACISTS.—The*
 7 *program shall be developed in cooperation with*
 8 *licensed and practicing pharmacists and physi-*
 9 *cians.*

10 “(D) *CONSIDERATIONS IN PHARMACY*
 11 *FEES.—The eligible entity offering a Medicare*
 12 *Prescription Drug plan shall take into account,*
 13 *in establishing fees for pharmacists and others*
 14 *providing services under the medication therapy*
 15 *management program, the resources and time*
 16 *used in implementing the program.*

17 “(3) *PUBLIC DISCLOSURE OF PHARMACEUTICAL*
 18 *PRICES FOR EQUIVALENT DRUGS.—The eligible entity*
 19 *offering a Medicare Prescription Drug plan shall pro-*
 20 *vide that each pharmacy or other dispenser that ar-*
 21 *ranges for the dispensing of a covered drug shall in-*
 22 *form the beneficiary at the time of purchase of the*
 23 *drug of any differential between the price of the pre-*
 24 *scribed drug to the enrollee and the price of the lowest*

1 *cost generic drug covered under the plan that is thera-*
 2 *peutically equivalent and bioequivalent.*

3 “(d) *GRIEVANCE MECHANISM, COVERAGE DETERMINA-*
 4 *TIONS, AND RECONSIDERATIONS.*—

5 “(1) *IN GENERAL.*—*An eligible entity shall pro-*
 6 *vide meaningful procedures for hearing and resolving*
 7 *grievances between the eligible entity (including any*
 8 *entity or individual through which the eligible entity*
 9 *provides covered benefits) and enrollees with Medicare*
 10 *Prescription Drug plans of the eligible entity under*
 11 *this part in accordance with section 1852(f).*

12 “(2) *APPLICATION OF COVERAGE DETERMINA-*
 13 *TION AND RECONSIDERATION PROVISIONS.*—*The re-*
 14 *quirements of paragraphs (1) through (3) of section*
 15 *1852(g) shall apply to an eligible entity with respect*
 16 *to covered benefits under the Medicare Prescription*
 17 *Drug plan it offers under this part in the same man-*
 18 *ner as such requirements apply to a*
 19 *MedicareAdvantage organization with respect to bene-*
 20 *fits it offers under a MedicareAdvantage plan under*
 21 *part C.*

22 “(3) *REQUEST FOR REVIEW OF TIERED FOR-*
 23 *MULARY DETERMINATIONS.*—*In the case of a Medicare*
 24 *Prescription Drug plan offered by an eligible entity*
 25 *that provides for tiered cost-sharing for drugs in-*

1 *cluded within a formulary and provides lower cost-*
 2 *sharing for preferred drugs included within the for-*
 3 *mulary, an individual who is enrolled in the plan*
 4 *may request coverage of a nonpreferred drug under*
 5 *the terms applicable for preferred drugs if the pre-*
 6 *scribing physician determines that the preferred drug*
 7 *for treatment of the same condition is not as effective*
 8 *for the individual or has adverse effects for the indi-*
 9 *vidual.*

10 *“(e) APPEALS.—*

11 *“(1) IN GENERAL.—Subject to paragraph (2), the*
 12 *requirements of paragraphs (4) and (5) of section*
 13 *1852(g) shall apply to an eligible entity with respect*
 14 *to drugs not included on any formulary in a manner*
 15 *that is similar (as determined by the Administrator)*
 16 *to the manner that such requirements apply to a*
 17 *MedicareAdvantage organization with respect to bene-*
 18 *fits it offers under a MedicareAdvantage plan under*
 19 *part C.*

20 *“(2) FORMULARY DETERMINATIONS.—An indi-*
 21 *vidual who is enrolled in a Medicare Prescription*
 22 *Drug plan offered by an eligible entity may appeal*
 23 *to obtain coverage for a covered drug that is not on*
 24 *a formulary of the entity under the terms applicable*
 25 *for a formulary drug if the prescribing physician de-*

1 *termines that the formulary drug for treatment of the*
 2 *same condition is not as effective for the individual*
 3 *or has adverse effects for the individual.*

4 “(f) *PRIVACY, CONFIDENTIALITY, AND ACCURACY OF*
 5 *ENROLLEE RECORDS.—Insofar as an eligible entity main-*
 6 *tains individually identifiable medical records or other*
 7 *health information regarding eligible beneficiaries enrolled*
 8 *in the Medicare Prescription Drug plan offered by the enti-*
 9 *ty, the entity shall have in place procedures to—*

10 “(1) *safeguard the privacy of any individually*
 11 *identifiable beneficiary information in a manner con-*
 12 *sistent with the Federal regulations (concerning the*
 13 *privacy of individually identifiable health informa-*
 14 *tion) promulgated under section 264(c) of the Health*
 15 *Insurance Portability and Accountability Act of 1996;*

16 “(2) *maintain such records and information in*
 17 *a manner that is accurate and timely;*

18 “(3) *ensure timely access by such beneficiaries to*
 19 *such records and information; and*

20 “(4) *otherwise comply with applicable laws re-*
 21 *lating to patient privacy and confidentiality.*

22 “(g) *UNIFORM MONTHLY PLAN PREMIUM.—An eligible*
 23 *entity shall ensure that the monthly plan premium for a*
 24 *Medicare Prescription Drug plan charged under this part*
 25 *is the same for all eligible beneficiaries enrolled in the plan.*

1 “(h) *CONSUMER SATISFACTION SURVEYS.*—An eligible
 2 entity shall conduct consumer satisfaction surveys with re-
 3 spect to the plan and the entity. The Administrator shall
 4 establish uniform requirements for such surveys.

5 “*PRESCRIPTION DRUG BENEFITS*

6 “*SEC. 1860D–6. (a) REQUIREMENTS.*—

7 “(1) *IN GENERAL.*—For purposes of this part
 8 and part C, the term ‘qualified prescription drug cov-
 9 erage’ means either of the following:

10 “(A) *STANDARD PRESCRIPTION DRUG COV-*
 11 *ERAGE WITH ACCESS TO NEGOTIATED PRICES.*—
 12 Standard prescription drug coverage (as defined
 13 in subsection (c)) and access to negotiated prices
 14 under subsection (e).

15 “(B) *ACTUARIALLY EQUIVALENT PRESCRIP-*
 16 *TION DRUG COVERAGE WITH ACCESS TO NEGO-*
 17 *TIATED PRICES.*—Coverage of covered drugs
 18 which meets the alternative coverage require-
 19 ments of subsection (d) and access to negotiated
 20 prices under subsection (e), but only if it is ap-
 21 proved by the Administrator as provided under
 22 subsection (d).

23 “(2) *PERMITTING ADDITIONAL PRESCRIPTION*
 24 *DRUG COVERAGE.*—

25 “(A) *IN GENERAL.*—Subject to subpara-
 26 graph (B) and section 1860D–13(c)(2), nothing

1 *in this part shall be construed as preventing*
 2 *qualified prescription drug coverage from includ-*
 3 *ing coverage of covered drugs that exceeds the*
 4 *coverage required under paragraph (1).*

5 *“(B) REQUIREMENT.—An eligible entity*
 6 *may not offer a Medicare Prescription Drug*
 7 *plan that provides additional benefits pursuant*
 8 *to subparagraph (A) in an area unless the eligi-*
 9 *ble entity offering such plan also offers a Medi-*
 10 *care Prescription Drug plan in the area that*
 11 *only provides the coverage of prescription drugs*
 12 *that is required under paragraph (1).*

13 *“(3) COST CONTROL MECHANISMS.—In pro-*
 14 *viding qualified prescription drug coverage, the entity*
 15 *offering the Medicare Prescription Drug plan or the*
 16 *MedicareAdvantage plan may use a variety of cost*
 17 *control mechanisms, including the use of formularies,*
 18 *tiered copayments, selective contracting with pro-*
 19 *viders of prescription drugs, and mail order phar-*
 20 *macies.*

21 *“(b) APPLICATION OF SECONDARY PAYOR PROVI-*
 22 *SIONS.—The provisions of section 1852(a)(4) shall apply*
 23 *under this part in the same manner as they apply under*
 24 *part C.*

1 “(c) *STANDARD PRESCRIPTION DRUG COVERAGE.*—
 2 *For purposes of this part and part C, the term ‘standard*
 3 *prescription drug coverage’ means coverage of covered drugs*
 4 *that meets the following requirements:*

5 “(1) *DEDUCTIBLE.*—

6 “(A) *IN GENERAL.*—*The coverage has an*
 7 *annual deductible—*

8 “(i) *for 2006, that is equal to \$275; or*

9 “(ii) *for a subsequent year, that is*
 10 *equal to the amount specified under this*
 11 *paragraph for the previous year increased*
 12 *by the percentage specified in paragraph (5)*
 13 *for the year involved.*

14 “(B) *ROUNDING.*—*Any amount determined*
 15 *under subparagraph (A)(ii) that is not a mul-*
 16 *tiple of \$1 shall be rounded to the nearest mul-*
 17 *tiple of \$1.*

18 “(2) *LIMITS ON COST-SHARING.*—*The coverage*
 19 *has cost-sharing (for costs above the annual deductible*
 20 *specified in paragraph (1) and up to the initial cov-*
 21 *erage limit under paragraph (3)) that is equal to 50*
 22 *percent or that is actuarially consistent (using proc-*
 23 *esses established under subsection (f)) with an average*
 24 *expected payment of 50 percent of such costs.*

25 “(3) *INITIAL COVERAGE LIMIT.*—

1 “(A) *IN GENERAL.*—*Subject to paragraph*
 2 *(4), the coverage has an initial coverage limit on*
 3 *the maximum costs that may be recognized for*
 4 *payment purposes (including the annual deduct-*
 5 *ible)*—

6 “(i) *for 2006, that is equal to \$4,500;*
 7 *or*

8 “(ii) *for a subsequent year, that is*
 9 *equal to the amount specified in this para-*
 10 *graph for the previous year, increased by*
 11 *the annual percentage increase described in*
 12 *paragraph (5) for the year involved.*

13 “(B) *ROUNDING.*—*Any amount determined*
 14 *under subparagraph (A)(ii) that is not a mul-*
 15 *tiple of \$1 shall be rounded to the nearest mul-*
 16 *tiple of \$1.*

17 “(4) *LIMITATION ON OUT-OF-POCKET EXPENDI-*
 18 *TURES BY BENEFICIARY.*—

19 “(A) *IN GENERAL.*—*The coverage provides*
 20 *benefits with cost-sharing that is equal to 10 per-*
 21 *cent after the individual has incurred costs (as*
 22 *described in subparagraph (C)) for covered drugs*
 23 *in a year equal to the annual out-of-pocket limit*
 24 *specified in subparagraph (B).*

25 “(B) *ANNUAL OUT-OF-POCKET LIMIT.*—

1 “(i) *IN GENERAL.*—For purposes of
 2 this part, the ‘annual out-of-pocket limit’
 3 specified in this subparagraph—

4 “(I) for 2006, is equal to \$3,700;

5 or

6 “(II) for a subsequent year, is
 7 equal to the amount specified in this
 8 subparagraph for the previous year,
 9 increased by the annual percentage in-
 10 crease described in paragraph (5) for
 11 the year involved.

12 “(ii) *ROUNDING.*—Any amount deter-
 13 mined under clause (i)(II) that is not a
 14 multiple of \$1 shall be rounded to the near-
 15 est multiple of \$1.

16 “(C) *APPLICATION.*—In applying subpara-
 17 graph (A)—

18 “(i) incurred costs shall only include
 19 costs incurred, with respect to covered
 20 drugs, for the annual deductible (described
 21 in paragraph (1)), cost-sharing (described
 22 in paragraph (2)), and amounts for which
 23 benefits are not provided because of the ap-
 24 plication of the initial coverage limit de-
 25 scribed in paragraph (3) (including costs

1 incurred for covered drugs described in sec-
 2 tion 1860D(a)(2)(C)); and

3 “(ii) such costs shall be treated as in-
 4 curred only if they are paid by the indi-
 5 vidual (or by another individual, such as a
 6 family member, on behalf of the individual),
 7 under section 1860D–19, under title XIX,
 8 or under a State pharmaceutical assistance
 9 program and the individual (or other indi-
 10 vidual) is not reimbursed through insurance
 11 or otherwise, a group health plan, or other
 12 third-party payment arrangement for such
 13 costs.

14 “(5) ANNUAL PERCENTAGE INCREASE.—For pur-
 15 poses of this part, the annual percentage increase
 16 specified in this paragraph for a year is equal to the
 17 annual percentage increase in average per capita ag-
 18 gregate expenditures for covered drugs in the United
 19 States for beneficiaries under this title, as determined
 20 by the Administrator for the 12-month period ending
 21 in July of the previous year.

22 “(d) ALTERNATIVE COVERAGE REQUIREMENTS.—A
 23 Medicare Prescription Drug plan or Medicare Advantage
 24 plan may provide a different prescription drug benefit de-
 25 sign from the standard prescription drug coverage described

1 *in subsection (c) so long as the Administrator determines*
 2 *(based on an actuarial analysis by the Administrator) that*
 3 *the following requirements are met and the plan applies*
 4 *for, and receives, the approval of the Administrator for such*
 5 *benefit design:*

6 “(1) ASSURING AT LEAST ACTUARIALLY EQUIVA-
 7 LENT PRESCRIPTION DRUG COVERAGE.—

8 “(A) ASSURING EQUIVALENT VALUE OF
 9 TOTAL COVERAGE.—*The actuarial value of the*
 10 *total coverage (as determined under subsection*
 11 *(f)) is at least equal to the actuarial value (as*
 12 *so determined) of standard prescription drug*
 13 *coverage.*

14 “(B) ASSURING EQUIVALENT UNSUBSIDIZED
 15 VALUE OF COVERAGE.—*The unsubsidized value*
 16 *of the coverage is at least equal to the unsub-*
 17 *sidized value of standard prescription drug cov-*
 18 *erage. For purposes of this subparagraph, the*
 19 *unsubsidized value of coverage is the amount by*
 20 *which the actuarial value of the coverage (as de-*
 21 *termined under subsection (f)) exceeds the actu-*
 22 *arial value of the amounts associated with the*
 23 *application of section 1860D–17(c) and reinsur-*
 24 *ance payments under section 1860D–20 with re-*
 25 *spect to such coverage.*

“(C) *ASSURING STANDARD PAYMENT FOR COSTS AT INITIAL COVERAGE LIMIT.*—*The coverage is designed, based upon an actuarially representative pattern of utilization (as determined under subsection (f)), to provide for the payment, with respect to costs incurred that are equal to the initial coverage limit under subsection (c)(3), of an amount equal to at least the product of—*

“(i) *such initial coverage limit minus the deductible under subsection (c)(1); and*

“(ii) *the percentage specified in subsection (c)(2).*

Benefits other than qualified prescription drug coverage shall not be taken into account for purposes of this paragraph.

“(2) *DEDUCTIBLE AND LIMITATION ON OUT-OF-POCKET EXPENDITURES BY BENEFICIARIES MAY NOT VARY.*—*The coverage may not vary the deductible under subsection (c)(1) for the year or the limitation on out-of-pocket expenditures by beneficiaries described in subsection (c)(4) for the year.*

“(e) *ACCESS TO NEGOTIATED PRICES.*—

“(1) *ACCESS.*—

“(A) *IN GENERAL.*—*Under qualified prescription drug coverage offered by an eligible en-*

tity or a MedicareAdvantage organization, the
 entity or organization shall provide beneficiaries
 with access to negotiated prices used for payment
 for covered drugs, regardless of the fact that no
 benefits may be payable under the coverage with
 respect to such drugs because of the application
 of the deductible, any cost-sharing, or an initial
 coverage limit (described in subsection (c)(3)).
 For purposes of this part, the term ‘negotiated
 prices’ includes all discounts, direct or indirect
 subsidies, rebates, or other price concessions or
 direct or indirect remunerations.

“(B) MEDICAID RELATED PROVISIONS.—In-
 sofar as a State elects to provide medical assist-
 ance under title XIX for a drug based on the
 prices negotiated under a Medicare Prescription
 Drug plan under this part, the requirements of
 section 1927 shall not apply to such drugs. The
 prices negotiated under a Medicare Prescription
 Drug plan with respect to covered drugs, under
 a MedicareAdvantage plan with respect to such
 drugs, or under a qualified retiree prescription
 drug plan (as defined in section 1860D–20(e)(4))
 with respect to such drugs, on behalf of eligible
 beneficiaries, shall (notwithstanding any other

1 *provision of law) not be taken into account for*
 2 *the purposes of establishing the best price under*
 3 *section 1927(c)(1)(C).*

4 “(2) *CARDS OR OTHER TECHNOLOGY.*—

5 “(A) *IN GENERAL.*—*In providing the access*
 6 *under paragraph (1), the eligible entity or*
 7 *MedicareAdvantage organization shall issue a*
 8 *card or use other technology pursuant to section*
 9 *1860D–5(b)(1).*

10 “(B) *NATIONAL STANDARDS.*—

11 “(i) *DEVELOPMENT.*—*The Adminis-*
 12 *trator shall provide for the development of*
 13 *national standards relating to a standard-*
 14 *ized format for the card or other technology*
 15 *required under subparagraph (A). Such*
 16 *standards shall be compatible with parts C*
 17 *and D of title XI and may be based on*
 18 *standards developed by an appropriate*
 19 *standard setting organization.*

20 “(ii) *CONSULTATION.*—*In developing*
 21 *the standards under clause (i), the Adminis-*
 22 *trator shall consult with the National Coun-*
 23 *cil for Prescription Drug Programs and*
 24 *other standard-setting organizations deter-*
 25 *mined appropriate by the Administrator.*

1 “(iii) *IMPLEMENTATION.*—*The Admin-*
 2 *istrator shall implement the standards de-*
 3 *veloped under clause (i) by January 1,*
 4 *2008.*

5 “(f) *ACTUARIAL VALUATION; DETERMINATION OF AN-*
 6 *NUAL PERCENTAGE INCREASES.*—

7 “(1) *PROCESSES.*—*For purposes of this section,*
 8 *the Administrator shall establish processes and meth-*
 9 *ods—*

10 “(A) *for determining the actuarial valu-*
 11 *ation of prescription drug coverage, including—*

12 “(i) *an actuarial valuation of standard*
 13 *prescription drug coverage and of the rein-*
 14 *surance payments under section 1860D–20;*

15 “(ii) *the use of generally accepted actu-*
 16 *arial principles and methodologies; and*

17 “(iii) *applying the same methodology*
 18 *for determinations of alternative coverage*
 19 *under subsection (d) as is used with respect*
 20 *to determinations of standard prescription*
 21 *drug coverage under subsection (c); and*

22 “(B) *for determining annual percentage in-*
 23 *creases described in subsection (c)(5).*

24 “(2) *USE OF OUTSIDE ACTUARIES.*—*Under the*
 25 *processes under paragraph (1)(A), eligible entities*

1 *and MedicareAdvantage organizations may use actu-*
 2 *arial opinions certified by independent, qualified ac-*
 3 *tuaries to establish actuarial values, but the Adminis-*
 4 *trator shall determine whether such actuarial values*
 5 *meet the requirements under subsection (c)(1).*

6 *“REQUIREMENTS FOR ENTITIES OFFERING MEDICARE PRE-*
 7 *SCRIPTION DRUG PLANS; ESTABLISHMENT OF STAND-*
 8 *ARDS*

9 *“SEC. 1860D–7. (a) GENERAL REQUIREMENTS.—An*
 10 *eligible entity offering a Medicare Prescription Drug plan*
 11 *shall meet the following requirements:*

12 *“(1) LICENSURE.—Subject to subsection (c), the*
 13 *entity is organized and licensed under State law as*
 14 *a risk-bearing entity eligible to offer health insurance*
 15 *or health benefits coverage in each State in which it*
 16 *offers a Medicare Prescription Drug plan.*

17 *“(2) ASSUMPTION OF FINANCIAL RISK.—*

18 *“(A) IN GENERAL.—Subject to subpara-*
 19 *graph (B) and subsections (d)(2) and (e) of sec-*
 20 *tion 1860D–13, to the extent that the entity is at*
 21 *risk pursuant to such section 1860D–16, the en-*
 22 *tity assumes financial risk on a prospective basis*
 23 *for the benefits that it offers under a Medicare*
 24 *Prescription Drug plan and that is not covered*
 25 *under section 1860D–20.*

1 “(B) *REINSURANCE PERMITTED.*—*To the*
 2 *extent that the entity is at risk pursuant to sec-*
 3 *tion 1860D–16, the entity may obtain insurance*
 4 *or make other arrangements for the cost of cov-*
 5 *erage provided to any enrolled member under*
 6 *this part.*

7 “(3) *SOLVENCY FOR UNLICENSED ENTITIES.*—*In*
 8 *the case of an eligible entity that is not described in*
 9 *paragraph (1) and for which a waiver has been ap-*
 10 *proved under subsection (c), such entity shall meet*
 11 *solvency standards established by the Administrator*
 12 *under subsection (d).*

13 “(b) *CONTRACT REQUIREMENTS.*—*The Administrator*
 14 *shall not permit an eligible beneficiary to elect a Medicare*
 15 *Prescription Drug plan offered by an eligible entity under*
 16 *this part, and the entity shall not be eligible for payments*
 17 *under section 1860D–16 or 1860D–20, unless the Adminis-*
 18 *trator has entered into a contract under this subsection with*
 19 *the entity with respect to the offering of such plan. Such*
 20 *a contract with an entity may cover more than 1 Medicare*
 21 *Prescription Drug plan. Such contract shall provide that*
 22 *the entity agrees to comply with the applicable requirements*
 23 *and standards of this part and the terms and conditions*
 24 *of payment as provided for in this part.*

1 “(c) *WAIVER OF CERTAIN REQUIREMENTS IN ORDER*
 2 *TO ENSURE BENEFICIARY CHOICE.*—

3 “(1) *IN GENERAL.*—*In the case of an eligible en-*
 4 *tity that seeks to offer a Medicare Prescription Drug*
 5 *plan in a State, the Administrator shall waive the re-*
 6 *quirement of subsection (a)(1) that the entity be li-*
 7 *censed in that State if the Administrator determines,*
 8 *based on the application and other evidence presented*
 9 *to the Administrator, that any of the grounds for ap-*
 10 *proval of the application described in paragraph (2)*
 11 *have been met.*

12 “(2) *GROUND FOR APPROVAL.*—*The grounds for*
 13 *approval under this paragraph are the grounds for*
 14 *approval described in subparagraphs (B), (C), and*
 15 *(D) of section 1855(a)(2), and also include the appli-*
 16 *cation by a State of any grounds other than those re-*
 17 *quired under Federal law.*

18 “(3) *APPLICATION OF WAIVER PROCEDURES.*—
 19 *With respect to an application for a waiver (or a*
 20 *waiver granted) under this subsection, the provisions*
 21 *of subparagraphs (E), (F), and (G) of section*
 22 *1855(a)(2) shall apply.*

23 “(4) *REFERENCES TO CERTAIN PROVISIONS.*—
 24 *For purposes of this subsection, in applying the pro-*
 25 *visions of section 1855(a)(2) under this subsection to*

1 *Medicare Prescription Drug plans and eligible enti-*
 2 *ties—*

3 “(A) *any reference to a waiver application*
 4 *under section 1855 shall be treated as a reference*
 5 *to a waiver application under paragraph (1);*
 6 *and*

7 “(B) *any reference to solvency standards*
 8 *were treated as a reference to solvency standards*
 9 *established under subsection (d).*

10 “(d) *SOLVENCY STANDARDS FOR NON-LICENSED ENTI-*
 11 *TIES.—*

12 “(1) *ESTABLISHMENT AND PUBLICATION.—The*
 13 *Administrator, in consultation with the National As-*
 14 *sociation of Insurance Commissioners, shall establish*
 15 *and publish, by not later than January 1, 2005, fi-*
 16 *nancial solvency and capital adequacy standards for*
 17 *entities described in paragraph (2).*

18 “(2) *COMPLIANCE WITH STANDARDS.—An eligi-*
 19 *ble entity that is not licensed by a State under sub-*
 20 *section (a)(1) and for which a waiver application has*
 21 *been approved under subsection (c) shall meet sol-*
 22 *vency and capital adequacy standards established*
 23 *under paragraph (1). The Administrator shall estab-*
 24 *lish certification procedures for such eligible entities*

1 *with respect to such solvency standards in the manner*
 2 *described in section 1855(c)(2).*

3 “(e) *LICENSURE DOES NOT SUBSTITUTE FOR OR CON-*
 4 *STITUTE CERTIFICATION.—The fact that an entity is li-*
 5 *censed in accordance with subsection (a)(1) or has a waiver*
 6 *application approved under subsection (c) does not deem*
 7 *the eligible entity to meet other requirements imposed under*
 8 *this part for an eligible entity.*

9 “(f) *INCORPORATION OF CERTAIN*
 10 *MEDICAREADVANTAGE CONTRACT REQUIREMENTS.—The*
 11 *following provisions of section 1857 shall apply, subject to*
 12 *subsection (c)(4), to contracts under this section in the same*
 13 *manner as they apply to contracts under section 1857(a):*

14 “(1) *PROTECTIONS AGAINST FRAUD AND BENE-*
 15 *FICIARY PROTECTIONS.—Section 1857(d).*

16 “(2) *INTERMEDIATE SANCTIONS.—Section*
 17 *1857(g), except that in applying such section—*

18 “(A) *the reference in section 1857(g)(1)(B)*
 19 *to section 1854 is deemed a reference to this*
 20 *part; and*

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

23 “(3) *PROCEDURES FOR TERMINATION.—Section*
 24 *1857(h).*

1 “(g) *OTHER STANDARDS.*—*The Administrator shall*
 2 *establish by regulation other standards (not described in*
 3 *subsection (d)) for eligible entities and Medicare Prescrip-*
 4 *tion Drug plans consistent with, and to carry out, this part.*
 5 *The Administrator shall publish such regulations by Janu-*
 6 *ary 1, 2005.*

7 “(h) *PERIODIC REVIEW AND REVISION OF STAND-*
 8 *ARDS.*—

9 “(1) *IN GENERAL.*—*Subject to paragraph (2), the*
 10 *Administrator shall periodically review the standards*
 11 *established under this section and, based on such re-*
 12 *view, may revise such standards if the Administrator*
 13 *determines such revision to be appropriate.*

14 “(2) *PROHIBITION OF MIDYEAR IMPLEMENTA-*
 15 *TION OF SIGNIFICANT NEW REGULATORY REQUIRE-*
 16 *MENTS.*—*The Administrator may not implement,*
 17 *other than at the beginning of a calendar year, regu-*
 18 *lations under this section that impose new, signifi-*
 19 *cant regulatory requirements on an eligible entity or*
 20 *a Medicare Prescription Drug plan.*

21 “(h) *RELATION TO STATE LAWS.*—

22 “(1) *IN GENERAL.*—*The standards established*
 23 *under this part shall supersede any State law or regu-*
 24 *lation (including standards described in paragraph*
 25 *(2)) with respect to Medicare Prescription Drug plans*

1 *which are offered by eligible entities under this*
 2 *part—*

3 “(A) *to the extent such law or regulation is*
 4 *inconsistent with such standards; and*

5 “(B) *in the same manner as such laws and*
 6 *regulations are superseded under section*
 7 *1856(b)(3).*

8 “(2) *STANDARDS SPECIFICALLY SUPERSEDED.—*
 9 *State standards relating to the following are super-*
 10 *seded under this section:*

11 “(A) *Benefit requirements, including re-*
 12 *quirements relating to cost-sharing and the*
 13 *structure of formularies.*

14 “(B) *Premiums.*

15 “(C) *Requirements relating to inclusion or*
 16 *treatment of providers.*

17 “(D) *Coverage determinations (including*
 18 *related appeals and grievance processes).*

19 “(E) *Requirements relating to marketing*
 20 *materials and summaries and schedules of bene-*
 21 *fits regarding a Medicare Prescription Drug*
 22 *plan.*

23 “(3) *PROHIBITION OF STATE IMPOSITION OF*
 24 *PREMIUM TAXES.—No State may impose a premium*
 25 *tax or similar tax with respect to—*

1 “(A) *monthly beneficiary obligations paid*
 2 *to the Administrator for Medicare Prescription*
 3 *Drug plans under this part; or*

4 “(B) *any payments made by the Adminis-*
 5 *trator under this part to an eligible entity offer-*
 6 *ing such a plan.*

7 “*Subpart 2—Prescription Drug Delivery System*

8 “*ESTABLISHMENT OF SERVICE AREAS*

9 “*SEC. 1860D–10. (a) ESTABLISHMENT.—*

10 “*(1) INITIAL ESTABLISHMENT.—Not later than*
 11 *April 15, 2005, the Administrator shall establish and*
 12 *publish the service areas in which Medicare Prescrip-*
 13 *tion Drug plans may offer benefits under this part.*

14 “*(2) PERIODIC REVIEW AND REVISION OF SERV-*
 15 *ICE AREAS.—The Administrator shall periodically re-*
 16 *view the service areas applicable under this section*
 17 *and, based on such review, may revise such service*
 18 *areas if the Administrator determines such revision to*
 19 *be appropriate.*

20 “*(b) REQUIREMENTS FOR ESTABLISHMENT OF SERV-*
 21 *ICE AREAS.—*

22 “*(1) IN GENERAL.—The Administrator shall es-*
 23 *tablish the service areas under subsection (a) in a*
 24 *manner that—*

1 “(A) maximizes the availability of Medicare
2 *Prescription Drug plans to eligible beneficiaries;*
3 *and*

4 “(B) minimizes the ability of eligible enti-
5 *ties offering such plans to favorably select eligible*
6 *beneficiaries.*

7 “(2) *ADDITIONAL REQUIREMENTS.—The Admin-*
8 *istrator shall establish the service areas under sub-*
9 *section (a) consistent with the following requirements:*

10 “(A) *There shall be at least 10 service areas.*

11 “(B) *Each service area must include at*
12 *least 1 State.*

13 “(C) *The Administrator may not divide*
14 *States so that portions of the State are in dif-*
15 *ferent service areas.*

16 “(D) *To the extent possible, the Adminis-*
17 *trator shall include multistate metropolitan sta-*
18 *tistical areas in a single service area. The Ad-*
19 *ministrator may divide metropolitan statistical*
20 *areas where it is necessary to establish service*
21 *areas of such size and geography as to maximize*
22 *the participation of Medicare Prescription Drug*
23 *plans.*

24 “(3) *MAY CONFORM TO MEDICAREADVANTAGE*
25 *PREFERRED PROVIDER REGIONS.—The Administrator*

1 *may conform the service areas established under this*
 2 *section to the preferred provider regions established*
 3 *under section 1858(a)(3).*

4 *“PUBLICATION OF RISK ADJUSTERS*

5 *“SEC. 1860D–11. (a) PUBLICATION.—Not later than*
 6 *April 15 of each year (beginning in 2005), the Adminis-*
 7 *trator shall publish the risk adjusters established under sub-*
 8 *section (b) to be used in computing—*

9 *“(1) the amount of payment to Medicare Pre-*
 10 *scription Drug plans in the subsequent year under*
 11 *section 1860D–16(a), insofar as it is attributable to*
 12 *standard prescription drug coverage (or actuarially*
 13 *equivalent prescription drug coverage); and*

14 *“(2) the amount of payment to*
 15 *MedicareAdvantage plans in the subsequent year*
 16 *under section 1858A(c), insofar as it is attributable*
 17 *to standard prescription drug coverage (or actuarially*
 18 *equivalent prescription drug coverage).*

19 *“(b) ESTABLISHMENT OF RISK ADJUSTERS.—*

20 *“(1) IN GENERAL.—Subject to paragraph (2), the*
 21 *Administrator shall establish an appropriate method-*
 22 *ology for adjusting the amount of payment to plans*
 23 *referred to in subsection (a) to take into account vari-*
 24 *ation in costs based on the differences in actuarial*
 25 *risk of different enrollees being served. Any such risk*
 26 *adjustment shall be designed in a manner as to not*

1 *result in a change in the aggregate payments de-*
 2 *scribed in paragraphs (1) and (2) of subsection (a).*

3 “(2) *CONSIDERATIONS.*—*In establishing the*
 4 *methodology under paragraph (1), the Administrator*
 5 *may take into account the similar methodologies used*
 6 *under section 1853(a)(3) to adjust payments to*
 7 *MedicareAdvantage organizations.*

8 “(3) *DATA COLLECTION.*—*In order to carry out*
 9 *this subsection, the Administrator shall require—*

10 “(A) *eligible entities to submit data regard-*
 11 *ing drug claims that can be linked at the bene-*
 12 *ficiary level to part A and part B data and such*
 13 *other information as the Administrator deter-*
 14 *mines necessary; and*

15 “(B) *MedicareAdvantage organizations (ex-*
 16 *cept MSA plans or a private fee-for-service plan*
 17 *that does not provide qualified prescription drug*
 18 *coverage) to submit data regarding drug claims*
 19 *that can be linked to other data that such orga-*
 20 *nizations are required to submit to the Adminis-*
 21 *trator and such other information as the Admin-*
 22 *istrator determines necessary.*

23 “*SUBMISSION OF BIDS FOR PROPOSED MEDICARE*
 24 *PRESCRIPTION DRUG PLANS*

25 “*SEC. 1860D–12. (a) SUBMISSION.*—

1 “(1) *IN GENERAL.*—Each eligible entity that in-
 2 tends to offer a Medicare Prescription Drug plan in
 3 an area in a year (beginning with 2006) shall submit
 4 to the Administrator, at such time in the previous
 5 year and in such manner as the Administrator may
 6 specify, such information as the Administrator may
 7 require, including the information described in sub-
 8 section (b).

9 “(2) *ANNUAL SUBMISSION.*—An eligible entity
 10 shall submit the information required under para-
 11 graph (1) with respect to a Medicare Prescription
 12 Drug plan that the entity intends to offer on an an-
 13 nual basis.

14 “(b) *INFORMATION DESCRIBED.*—The information de-
 15 scribed in this subsection includes information on each of
 16 the following:

17 “(1) *The benefits under the plan (as required*
 18 *under section 1860D–6).*

19 “(2) *The actuarial value of the qualified pre-*
 20 *scription drug coverage.*

21 “(3) *The amount of the monthly plan premium*
 22 *under the plan, including an actuarial certification*
 23 *of—*

24 “(A) *the actuarial basis for such monthly*
 25 *plan premium;*

1 “(B) the portion of such monthly plan pre-
 2 mium attributable to standard prescription drug
 3 coverage or actuarially equivalent prescription
 4 drug coverage and, if applicable, to benefits that
 5 are in addition to such coverage; and

6 “(C) the reduction in such monthly plan
 7 premium resulting from the payments provided
 8 under section 1860D–20.

9 “(4) The service area for the plan.

10 “(5) Whether the entity plans to use any funds
 11 in the plan stabilization reserve fund in the Prescrip-
 12 tion Drug Account that are available to the entity to
 13 stabilize or reduce the monthly plan premium sub-
 14 mitted under paragraph (3), and if so, the amount in
 15 such reserve fund that is to be used.

16 “(6) Such other information as the Adminis-
 17 trator may require to carry out this part.

18 “(c) *OPTIONS REGARDING SERVICE AREAS.*—

19 “(1) *IN GENERAL.*—The service area of a Medi-
 20 care Prescription Drug plan shall be either—

21 “(A) the entire area of 1 of the service areas
 22 established by the Administrator under section
 23 1860D–10; or

24 “(B) the entire area covered by the medicare
 25 program.

7 “SEC. 1860D-13. (a) APPROVAL.—

12 “(2) *REQUIREMENTS FOR APPROVAL.*—*The Ad-*
13 *ministrators may not approve a Medicare Prescription*
14 *Drug plan unless the following requirements are met:*

“(B) APPLICATION OF FEHBP STANDARD.—

(i) The portion of the monthly plan premium submitted under section 1860D–12(b) that is attributable to standard prescription drug coverage reasonably and equitably reflects the actuarial value of the standard prescription drug coverage less the actuarial value of the reinsurance payments under section 1860D–20 and the amount of any funds in the plan stabilization reserve

1 *fund in the Prescription Drug Account used to*
 2 *stabilize or reduce the monthly plan premium.*

3 “(ii) *If the plan provides additional pre-*
 4 *scription drug coverage pursuant to section*
 5 *1860D–6(a)(2), the monthly plan premium rea-*
 6 *sonably and equitably reflects the actuarial value*
 7 *of the coverage provided less the actuarial value*
 8 *of the reinsurance payments under section*
 9 *1860D–20 and the amount of any funds in the*
 10 *plan stabilization reserve fund in the Prescrip-*
 11 *tion Drug Account used to stabilize or reduce the*
 12 *monthly plan premium.*

13 “(b) *NEGOTIATION.—In exercising the authority under*
 14 *subsection (a), the Administrator shall have the authority*
 15 *to—*

16 “(1) *negotiate the terms and conditions of the*
 17 *proposed monthly plan premiums submitted and*
 18 *other terms and conditions of a proposed plan; and*

19 “(2) *disapprove, or limit enrollment in, a pro-*
 20 *posed plan based on—*

21 “(A) *the costs to beneficiaries under the*
 22 *plan;*

23 “(B) *the quality of the coverage and benefits*
 24 *under the plan;*

1 “(C) *the adequacy of the network under the*
2 *plan; or*

3 “(D) *other factors determined appropriate*
4 *by the Administrator.*

5 “(c) *SPECIAL RULES FOR APPROVAL.—The Adminis-*
6 *trator may approve a Medicare Prescription Drug plan*
7 *submitted under section 1860D–12 only if the benefits*
8 *under such plan—*

9 “(1) *include the required benefits under section*
10 *1860D–6(a)(1); and*

11 “(2) *are not designed in such a manner that the*
12 *Administrator finds is likely to result in favorable se-*
13 *lection of eligible beneficiaries.*

14 “(d) *ACCESS TO COMPETITIVE COVERAGE.—*

15 “(1) *NUMBER OF CONTRACTS.—The Adminis-*
16 *trator, consistent with the requirements of this part*
17 *and the goal of containing costs under this title, shall,*
18 *with respect to a year, approve at least 2 contracts*
19 *to offer a Medicare Prescription Drug plan in each*
20 *service area (established under section 1860D–10) for*
21 *the year.*

22 “(2) *AUTHORITY TO REDUCE RISK TO ENSURE*
23 *ACCESS.—*

24 “(A) *IN GENERAL.—Subject to subpara-*
25 *graph (B), if the Administrator determines, with*

1 *respect to an area, that the access required under*
 2 *paragraph (1) is not going to be provided in the*
 3 *area during the subsequent year, the Adminis-*
 4 *trator shall—*

5 *“(i) adjust the percents specified in*
 6 *paragraphs (2) and (4) of section 1860D–*
 7 *16(b) in an area in a year; or*

8 *“(ii) increase the percent specified in*
 9 *section 1860D–20(c)(1) in an area in a*
 10 *year.*

11 *The administrator shall exercise the authority*
 12 *under the preceding sentence only so long as*
 13 *(and to the extent) necessary to assure the access*
 14 *guaranteed under paragraph (1).*

15 *“(B) REQUIREMENTS FOR USE OF AUTHOR-*
 16 *ITY.—In exercising authority under subpara-*
 17 *graph (A), the Administrator—*

18 *“(i) shall not provide for the full un-*
 19 *derwriting of financial risk for any eligible*
 20 *entity;*

21 *“(ii) shall not provide for any under-*
 22 *writing of financial risk for a public eligi-*
 23 *ble entity with respect to the offering of a*
 24 *nationwide Medicare Prescription Drug*
 25 *plan; and*

1 “(iii) shall seek to maximize the as-
 2 sumption of financial risk by eligible enti-
 3 ties to ensure fair competition among Medi-
 4 care Prescription Drug plans.

5 “(C) REQUIREMENT TO ACCEPT 2 FULL-
 6 RISK QUALIFIED BIDS BEFORE EXERCISING AU-
 7 THORITY.—The Administrator may not exercise
 8 the authority under subparagraph (A) with re-
 9 spect to an area and year if 2 or more qualified
 10 bids are submitted by eligible entities to offer a
 11 Medicare Prescription Drug plan in the area for
 12 the year under paragraph (1) before the applica-
 13 tion of subparagraph (A).

14 “(D) REPORTS.—The Administrator, in
 15 each annual report to Congress under section
 16 1808(c)(1)(D), shall include information on the
 17 exercise of authority under subparagraph (A).
 18 The Administrator also shall include such rec-
 19 ommendations as may be appropriate to limit
 20 the exercise of such authority.

21 “(e) GUARANTEED ACCESS.—

22 “(1) ACCESS.—In order to assure access to quali-
 23 fied prescription drug coverage in an area, the Ad-
 24 ministrator shall take the following steps:

1 “(A) *DETERMINATION.*—Not later than Sep-
2 tember 1 of each year (beginning in 2005) and
3 for each area (established under section 1860D-
4 10), the Administrator shall make a determina-
5 tion as to whether the access required under sub-
6 section (d)(1) is going to be provided in the area
7 during the subsequent year. Such determination
8 shall be made after the Administrator has exer-
9 cised the authority under subsection (d)(2).

10 “(B) *CONTRACT WITH AN ENTITY TO PRO-*
11 *VIDE COVERAGE IN AN AREA.*—Subject to para-
12 graph (3), if the Administrator makes a deter-
13 mination under subparagraph (A) that the ac-
14 cess required under subsection (d)(1) is not going
15 to be provided in an area during the subsequent
16 year, the Administrator shall enter into a con-
17 tract with an entity to provide eligible bene-
18 ficiaries enrolled under this part (and not, ex-
19 cept for an MSA plan or a private fee-for-service
20 plan that does not provide qualified prescription
21 drug coverage enrolled in a MedicareAdvantage
22 plan) and residing in the area with standard
23 prescription drug coverage (including access to
24 negotiated prices for such beneficiaries pursuant
25 to section 1860D-6(e)) during the subsequent

1 *year. An entity may be awarded a contract for*
 2 *more than 1 of the areas for which the Adminis-*
 3 *trator is required to enter into a contract under*
 4 *this paragraph but the Administrator may enter*
 5 *into only 1 such contract in each such area. An*
 6 *entity with a contract under this part shall meet*
 7 *the requirements described in section 1860D–5*
 8 *and such other requirements determined appro-*
 9 *priate by the Administrator.*

10 *“(C) REQUIREMENT TO ACCEPT 2 REDUCED-*
 11 *RISK QUALIFIED BIDS BEFORE ENTERING INTO*
 12 *CONTRACT.—The Administrator may not enter*
 13 *into a contract under subparagraph (B) with re-*
 14 *spect to an area and year if 2 or more qualified*
 15 *bids are submitted by eligible entities to offer a*
 16 *Medicare Prescription Drug plan in the area for*
 17 *the year after the Administrator has exercised*
 18 *the authority under subsection (d)(2) in the area*
 19 *for the year.*

20 *“(D) ENTITY REQUIRED TO MEET BENE-*
 21 *FICIARY PROTECTION AND OTHER REQUIRE-*
 22 *MENTS.—An entity with a contract under sub-*
 23 *paragraph (B) shall meet the requirements de-*
 24 *scribed in section 1860D–5 and such other re-*

1 *quirements determined appropriate by the Ad-*
 2 *ministrator.*

3 “(E) *COMPETITIVE PROCEDURES.*—*Com-*
 4 *petitive procedures (as defined in section 4(5) of*
 5 *the Office of Federal Procurement Policy Act (41*
 6 *U.S.C. 403(5))) shall be used to enter into a con-*
 7 *tract under subparagraph (B).*

8 “(2) *MONTHLY BENEFICIARY OBLIGATION FOR*
 9 *ENROLLMENT.*—

10 “(A) *IN GENERAL.*—*In the case of an eligi-*
 11 *ble beneficiary receiving access to qualified pre-*
 12 *scription drug coverage through enrollment with*
 13 *an entity with a contract under paragraph*
 14 *(1)(B), the monthly beneficiary obligation of*
 15 *such beneficiary for such enrollment shall be an*
 16 *amount equal to the applicable percent (for the*
 17 *area in which the beneficiary resides, as deter-*
 18 *mined under section 1860D–17(c)) of the month-*
 19 *ly national average premium (as computed*
 20 *under section 1860D–15) for the year as adjusted*
 21 *using the geographic adjuster under subpara-*
 22 *graph (B).*

23 “(B) *ESTABLISHMENT OF GEOGRAPHIC AD-*
 24 *JUSTER.*—*The Administrator shall establish an*
 25 *appropriate methodology for adjusting the*

1 *monthly national average premium (as com-*
 2 *puted under subsection (a)) for the year in an*
 3 *area to take into account differences in drug*
 4 *prices among areas. In establishing such method-*
 5 *ology, the Administrator may take into account*
 6 *differences in drug utilization between eligible*
 7 *beneficiaries in an area and eligible beneficiaries*
 8 *in other areas and the results of the ongoing*
 9 *study required under section 106. Any such ad-*
 10 *justment shall be applied in a manner so as to*
 11 *not result in a change in the aggregate payments*
 12 *made under this part that would have been made*
 13 *if the Administrator had not applied such ad-*
 14 *justment.*

15 “(3) *PAYMENTS UNDER THE CONTRACT.—*

16 “(A) *IN GENERAL.—A contract entered into*
 17 *under paragraph (1)(B) shall provide for—*

18 “(i) *payment for the negotiated costs of*
 19 *covered drugs provided to eligible bene-*
 20 *ficiaries enrolled with the entity; and*

21 “(ii) *payment of prescription manage-*
 22 *ment fees that are tied to performance re-*
 23 *quirements established by the Administrator*
 24 *for the management, administration, and*
 25 *delivery of the benefits under the contract.*

1 “(B) *PERFORMANCE REQUIREMENTS.*—The
 2 performance requirements established by the Ad-
 3 ministrators pursuant to subparagraph (A)(ii)
 4 shall include the following:

5 “(i) *The entity contains costs to the*
 6 *Prescription Drug Account and to eligible*
 7 *beneficiaries enrolled under this part and*
 8 *with the entity.*

9 “(ii) *The entity provides such bene-*
 10 *ficiaries with quality clinical care.*

11 “(iii) *The entity provides such bene-*
 12 *ficiaries with quality services.*

13 “(C) *ENTITY ONLY AT RISK TO THE EXTENT*
 14 *OF THE FEES TIED TO PERFORMANCE REQUIRE-*
 15 *MENTS.*—An entity with a contract under para-
 16 graph (1)(B) shall only be at risk for the provi-
 17 sion of benefits under the contract to the extent
 18 that the management fees paid to the entity are
 19 tied to performance requirements under subpara-
 20 graph (A)(ii).

21 “(4) *ELIGIBLE ENTITY THAT SUBMITTED A BID*
 22 *FOR THE AREA NOT ELIGIBLE TO BE AWARDED THE*
 23 *CONTRACT.*—An eligible entity that submitted a bid to
 24 offer a Medicare Prescription Drug plan for an area
 25 for a year under section 1860D–12, including a bid

1 *submitted after the Administrator has exercised the*
 2 *authority under subsection (d)(2), may not be award-*
 3 *ed a contract under paragraph (1)(B) for that area*
 4 *and year. The previous sentence shall apply to an en-*
 5 *tity that was awarded a contract under paragraph*
 6 *(1)(B) for the area in the previous year and sub-*
 7 *mitted such a bid under section 1860D–12 for the*
 8 *year.*

9 *“(5) TERM OF CONTRACT.—A contract entered*
 10 *into under paragraph (1)(B) shall be for a 1-year pe-*
 11 *riod. Such contract may provide for renewal at the*
 12 *discretion of the Administrator if the Administrator*
 13 *is required to enter into a contract under such para-*
 14 *graph with respect to the area covered by such con-*
 15 *tract for the subsequent year.*

16 *“(6) ENTITY NOT PERMITTED TO MARKET OR*
 17 *BRAND THE CONTRACT.—An entity with a contract*
 18 *under paragraph (1)(B) may not engage in any mar-*
 19 *keting or branding of such contract. For purposes of*
 20 *providing information to beneficiaries under sections*
 21 *1860D–4 and 1860D–5(a), such contract shall be*
 22 *identified as the Medicare plan.*

23 *“(7) RULES FOR AREAS WHERE ONLY 1 COM-*
 24 *PETITIVELY BID PLAN WAS APPROVED.—In the case of*
 25 *an area where (before the application of this sub-*

1 *section) only 1 Medicare Prescription Drug plan was*
 2 *approved for a year—*

3 “(A) the plan may (at the option of the
 4 plan) be offered in the area for the year (under
 5 rules applicable to such plans under this part
 6 and not under this subsection);

7 “(B) eligible beneficiaries described in para-
 8 graph (1)(B) may receive access to qualified pre-
 9 scription drug coverage through enrollment in
 10 the plan or with an entity with a contract under
 11 paragraph (1)(B); and

12 “(C) for purposes of applying section
 13 1860D–3(a)(1)(A)(ii), such plan shall be the
 14 plan designated in the area under such section.

15 “(f) TWO-YEAR CONTRACTS.—*Except for a contract*
 16 *entered into under subsection (e)(1)(B), a contract approved*
 17 *under this part (including a contract under) shall be for*
 18 *a 2-year period.*

19 “COMPUTATION OF MONTHLY STANDARD PRESCRIPTION
 20 DRUG COVERAGE PREMIUMS

21 “SEC. 1860D–14. (a) IN GENERAL.—*For each year*
 22 *(beginning with 2006), the Administrator shall compute a*
 23 *monthly standard prescription drug coverage premium for*
 24 *each Medicare Prescription Drug plan approved under sec-*
 25 *tion 1860D–13 and for each MedicareAdvantage plan.*

1 “(b) *REQUIREMENTS.*—*The monthly standard pre-*
 2 *scription drug coverage premium for a plan for a year shall*
 3 *be equal to—*

4 “(1) *in the case of a plan offered by an eligible*
 5 *entity or MedicareAdvantage organization that pro-*
 6 *vides standard prescription drug coverage or an actu-*
 7 *arially equivalent prescription drug coverage and*
 8 *does not provide additional prescription drug cov-*
 9 *erage pursuant to section 1860D–6(a)(2), the monthly*
 10 *plan premium approved for the plan under section*
 11 *1860D–13 for the year; and*

12 “(2) *in the case of a plan offered by an eligible*
 13 *entity or MedicareAdvantage organization that pro-*
 14 *vides additional prescription drug coverage pursuant*
 15 *to section 1860D–6(a)(2)—*

16 “(A) *an amount that reflects only the actu-*
 17 *arial value of the standard prescription drug*
 18 *coverage offered under the plan; or*

19 “(B) *if determined appropriate by the Ad-*
 20 *ministrator, the monthly plan premium ap-*
 21 *proved under section 1860D–13 for the year for*
 22 *the Medicare Prescription Drug plan (or, if ap-*
 23 *plicable, the MedicareAdvantage plan) that, as*
 24 *required under section 1860D–6(a)(2)(B) for a*

1 *Medicare Prescription Drug plans and a*
 2 *MedicareAdvantage plan—*

3 “(i) *is offered by such entity or organi-*
 4 *zation in the same area as the plan; and*

5 “(ii) *does not provide additional pre-*
 6 *scription drug coverage pursuant to such*
 7 *section.*

8 “*COMPUTATION OF MONTHLY NATIONAL AVERAGE PREMIUM*

9 “*SEC. 1860D–15. (a) COMPUTATION.—*

10 “(1) *IN GENERAL.—For each year (beginning*
 11 *with 2006) the Administrator shall compute a month-*
 12 *ly national average premium equal to the average of*
 13 *the monthly standard prescription drug coverage pre-*
 14 *mium for each Medicare Prescription Drug plan and*
 15 *each MedicareAdvantage plan (as computed under*
 16 *section 1860D–14). Such premium may be adjusted*
 17 *pursuant to any methodology determined under sub-*
 18 *section (b), as determined appropriate by the Admin-*
 19 *istrator.*

20 “(2) *WEIGHTED AVERAGE.—The monthly na-*
 21 *tional average premium computed under paragraph*
 22 *(1) shall be a weighted average, with the weight for*
 23 *each plan being equal to the average number of bene-*
 24 *ficiaries enrolled under such plan in the previous*
 25 *year.*

1 “(b) *GEOGRAPHIC ADJUSTMENT.*—*The Administrator*
 2 *shall establish an appropriate methodology for adjusting the*
 3 *monthly national average premium (as computed under*
 4 *subsection (a)) for the year in an area to take into account*
 5 *differences in prices for covered drugs among different*
 6 *areas. In establishing such methodology, the Administrator*
 7 *may take into account differences in drug utilization be-*
 8 *tween eligible beneficiaries in that area and other eligible*
 9 *beneficiaries. Any such adjustment shall be applied in a*
 10 *manner as to not result in a change in aggregate payments*
 11 *made under this part than would have been made if the*
 12 *Administrator had not applied such adjustment.*

13 “(c) *SPECIAL RULE FOR 2006.*—*For purposes of ap-*
 14 *plying this section for 2006, the Administrator shall estab-*
 15 *lish procedures for determining the weighted average under*
 16 *subsection (a)(2) for 2005.*

17 “*PAYMENTS TO ELIGIBLE ENTITIES*

18 “*SEC. 1860D–16. (a) PAYMENT OF MONTHLY PLAN*
 19 *PREMIUMS.*—*For each year (beginning with 2006), the Ad-*
 20 *ministrator shall pay to each entity offering a Medicare*
 21 *Prescription Drug plan in which an eligible beneficiary is*
 22 *enrolled an amount equal to the full amount of the monthly*
 23 *plan premium approved for the plan under section 1860D–*
 24 *13 on behalf of each eligible beneficiary enrolled in such*
 25 *plan for the year, as adjusted using the risk adjusters that*

1 *apply to the standard prescription drug coverage published*
 2 *under section 1860D–11.*

3 “(b) *PORTION OF TOTAL PAYMENTS OF MONTHLY*
 4 *PLAN PREMIUMS SUBJECT TO RISK.*—

5 “(1) *NOTIFICATION OF SPENDING UNDER THE*
 6 *PLAN.*—

7 “(A) *IN GENERAL.*—*For each year (begin-*
 8 *ning in 2007), the eligible entity offering a*
 9 *Medicare Prescription Drug plan shall notify the*
 10 *Administrator of the following:*

11 “(i) *TOTAL ACTUAL COSTS.*—*The total*
 12 *amount of costs that the entity incurred in*
 13 *providing standard prescription drug cov-*
 14 *erage (or prescription drug coverage that is*
 15 *actuarially equivalent pursuant to section*
 16 *1860D–6(a)(1)(B)) for all enrollees under*
 17 *the plan in the previous year.*

18 “(ii) *ACTUAL COSTS FOR SPECIFIC*
 19 *DRUGS.*—*With respect to the total amount*
 20 *under clause (i) for the year, a breakdown*
 21 *of—*

22 “(I) *each covered drug that con-*
 23 *stitutes a portion of such amount;*

24 “(II) *the negotiated price for the*
 25 *eligible entity for each such drug;*

1 “(III) the number of prescrip-
2 tions; and

3 “(IV) the average beneficiary co-
4 insurance rate for a each covered drug
5 that constitutes a portion of such
6 amount.

7 “(B) CERTAIN EXPENSES NOT INCLUDED.—
8 The amounts under clauses (i) and (ii)(II) of
9 subparagraph (A) may not include—

10 “(i) administrative expenses incurred
11 in providing the coverage described in sub-
12 paragraph (A)(i);

13 “(ii) amounts expended on providing
14 additional prescription drug coverage pur-
15 suant to section 1860D–6(a)(2); or

16 “(iii) amounts expended for which the
17 entity is subsequently provided with rein-
18 surance payments under section 1860D–20.

19 “(2) ADJUSTMENT OF PAYMENT.—

20 “(A) NO ADJUSTMENT IF ALLOWABLE COSTS
21 WITHIN RISK CORRIDOR.—If the allowable costs
22 (specified in paragraph (3)) for the plan for the
23 year are not more than the first threshold upper
24 limit of the risk corridor (specified in paragraph
25 (4)(A)(iii)) and are not less than the first thresh-

1 *old lower limit of the risk corridor (specified in*
 2 *paragraph (4)(A)(i)) for the plan for the year,*
 3 *then no additional payments shall be made by*
 4 *the Administrator and no payments shall be*
 5 *made by (or collected from) the eligible entity of-*
 6 *fering the plan.*

7 *“(B) INCREASE IN PAYMENT IF ALLOWABLE*
 8 *COSTS ABOVE UPPER LIMIT OF RISK COR-*
 9 *RIDOR.—*

10 *“(i) IN GENERAL.—If the allowable*
 11 *costs for the plan for the year are more than*
 12 *the first threshold upper limit of the risk*
 13 *corridor for the plan for the year, then the*
 14 *Administrator shall increase the total of the*
 15 *monthly payments made to the entity offer-*
 16 *ing the plan for the year under subsection*
 17 *(a) by an amount equal to the sum of—*

18 *“(I) the applicable percent (as de-*
 19 *fined in subparagraph (D)) of such al-*
 20 *lowable costs which are more than such*
 21 *first threshold upper limit of the risk*
 22 *corridor and not more than the second*
 23 *threshold upper limit of the risk cor-*
 24 *ridor for the plan for the year (as spec-*
 25 *ified under paragraph (4)(A)(iv)); and*

1 “(II) 90 percent of such allowable
 2 costs which are more than such second
 3 threshold upper limit of the risk cor-
 4 ridor.

5 “(ii) SPECIAL TRANSITIONAL COR-
 6 RIDOR FOR 2006 AND 2007.—If the Adminis-
 7 trator determines with respect to 2006 or
 8 2007 that at least 60 percent of Medicare
 9 Prescription Drug plans and
 10 Medicare Advantage Plans (excluding MSA
 11 plans or private fee-for-service plans that do
 12 not provide qualified prescription drug cov-
 13 erage) have allowable costs for the plan for
 14 the year that are more than the first thresh-
 15 old upper limit of the risk corridor for the
 16 plan for the year and that such plans rep-
 17 resent at least 60 percent of eligible bene-
 18 ficiaries enrolled under this part, clause
 19 (i)(I) shall be applied by substituting ‘90
 20 percent’ for ‘applicable percent’.

21 “(C) PLAN PAYMENT IF ALLOWABLE COSTS
 22 BELOW LOWER LIMIT OF RISK CORRIDOR.—If the
 23 allowable costs for the plan for the year are less
 24 than the first threshold lower limit of the risk
 25 corridor for the plan for the year, then the entity

1 *offering the plan shall make a payment to the*
 2 *Administrator of an amount (or the Adminis-*
 3 *trator shall otherwise recover from the plan an*
 4 *amount) equal to—*

5 *“(i) the applicable percent (as so de-*
 6 *fined) of such allowable costs which are less*
 7 *than such first threshold lower limit of the*
 8 *risk corridor and not less than the second*
 9 *threshold lower limit of the risk corridor for*
 10 *the plan for the year (as specified under*
 11 *paragraph (4)(A)(ii)); and*

12 *“(ii) 90 percent of such allowable costs*
 13 *which are less than such second threshold*
 14 *lower limit of the risk corridor.*

15 *“(D) APPLICABLE PERCENT DEFINED.—For*
 16 *purposes of this paragraph, the term ‘applicable*
 17 *percent’ means—*

18 *“(i) for 2006 and 2007, 75 percent;*
 19 *and*

20 *“(ii) for 2008 and subsequent years, 50*
 21 *percent.*

22 *“(3) ESTABLISHMENT OF ALLOWABLE COSTS.—*

23 *“(A) IN GENERAL.—For each year, the Ad-*
 24 *ministrator shall establish the allowable costs for*
 25 *each Medicare Prescription Drug plan for the*

1 year. The allowable costs for a plan for a year
 2 shall be equal to the amount described in para-
 3 graph (1)(A)(i) for the plan for the year, ad-
 4 justed under subparagraph (B)(ii).

5 “(B) REPRICING OF COSTS.—

6 “(i) CALCULATION OF AVERAGE PLAN
 7 COST.—Utilizing the information obtained
 8 under paragraph (1)(A)(ii) and section
 9 1860D–20(b)(1)(B), for each year (begin-
 10 ning with 2006), the Administrator shall es-
 11 tablish an average negotiated price with re-
 12 spect to all Medicare Prescription Drug
 13 plans for each covered drug.

14 “(ii) ADJUSTMENT IF ACTUAL COSTS
 15 EXCEED AVERAGE COSTS.—With respect to
 16 a Medicare Prescription Drug plan for a
 17 year, the Administrator shall reduce the
 18 amount described in paragraph (1)(A)(i)
 19 for the plan for the year to the extent such
 20 amount is based on costs of specific covered
 21 drugs furnished under the plan in the year
 22 (as specified under paragraph (1)(A)(ii))
 23 for which the negotiated prices are greater
 24 than the average negotiated price for the

1 covered drug for the year (as determined
2 under clause (i)).

3 “(4) *ESTABLISHMENT OF RISK CORRIDORS.*—

4 “(A) *IN GENERAL.*—For each year (begin-
5 ning with 2006), the Administrator shall estab-
6 lish a risk corridor for each Medicare Prescrip-
7 tion Drug plan. The risk corridor for a plan for
8 a year shall be equal to a range as follows:

9 “(i) *FIRST THRESHOLD LOWER*
10 *LIMIT.*—The first threshold lower limit of
11 such corridor shall be equal to—

12 “(I) the target amount described
13 in subparagraph (B) for the plan;
14 minus

15 “(II) an amount equal to the first
16 threshold risk percentage for the plan
17 (as determined under subparagraph
18 (C)(i)) of such target amount.

19 “(ii) *SECOND THRESHOLD LOWER*
20 *LIMIT.*—The second threshold lower limit of
21 such corridor shall be equal to—

22 “(I) the target amount described
23 in subparagraph (B) for the plan;
24 minus

1 “(II) an amount equal to the sec-
 2 ond threshold risk percentage for the
 3 plan (as determined under subpara-
 4 graph (C)(ii)) of such target amount.

5 “(iii) *FIRST THRESHOLD UPPER*
 6 *LIMIT.*—The first threshold upper limit of
 7 such corridor shall be equal to the sum of—
 8 “(I) such target amount; and
 9 “(II) the amount described in
 10 clause (i)(II).

11 “(iv) *SECOND THRESHOLD UPPER*
 12 *LIMIT.*—The second threshold upper limit of
 13 such corridor shall be equal to the sum of—
 14 “(I) such target amount; and
 15 “(II) the amount described in
 16 clause (ii)(II).

17 “(B) *TARGET AMOUNT DESCRIBED.*—The
 18 target amount described in this paragraph is,
 19 with respect to a Medicare Prescription Drug
 20 plan offered by an eligible entity in a year—

21 “(i) in the case of a plan offered by an
 22 eligible entity that provides standard pre-
 23 scription drug coverage or actuarially
 24 equivalent prescription drug coverage and
 25 does not provide additional prescription

1 *drug coverage pursuant to section 1860D–*
 2 *6(a)(2), an amount equal to the total of the*
 3 *monthly plan premiums paid to such entity*
 4 *for such plan for the year pursuant to sub-*
 5 *section (a), reduced by the percentage speci-*
 6 *fied in subparagraph (D); and*

7 “(ii) *in the case of a plan offered by*
 8 *an eligible entity that provides additional*
 9 *prescription drug coverage pursuant to sec-*
 10 *tion 1860D–6(a)(2), an amount equal to the*
 11 *total of the monthly plan premiums paid to*
 12 *such entity for such plan for the year pur-*
 13 *suant to subsection (a) that are related to*
 14 *standard prescription drug coverage (deter-*
 15 *mined using the rules under section 1860D–*
 16 *14(b)), reduced by the percentage specified*
 17 *in subparagraph (D).*

18 “(C) *FIRST AND SECOND THRESHOLD RISK*
 19 *PERCENTAGE DEFINED.—*

20 “(i) *FIRST THRESHOLD RISK PER-*
 21 *CENTAGE.—Subject to clause (iii), for pur-*
 22 *poses of this section, the first threshold risk*
 23 *percentage is—*

24 “(I) *for 2006 and 2007, and 2.5*
 25 *percent;*

1 “(II) for 2008 through 2011, 5
2 percent; and

3 “(III) for 2012 and subsequent
4 years, a percentage established by the
5 Administrator, but in no case less than
6 5 percent.

7 “(ii) SECOND THRESHOLD RISK PER-
8 CENTAGE.—Subject to clause (iii), for pur-
9 poses of this section, the second threshold
10 risk percentage is—

11 “(I) for 2006 and 2007, 5.0 per-
12 cent;

13 “(II) for 2008 through 2011, 10
14 percent

15 “(III) for 2012 and subsequent
16 years, a percentage established by the
17 Administrator that is greater than the
18 percent established for the year under
19 clause (i)(III), but in no case less than
20 10 percent.

21 “(iii) REDUCTION OF RISK PERCENT-
22 AGE TO ENSURE 2 PLANS IN AN AREA.—
23 Pursuant to paragraph (2) of section
24 1860D–13(d), the Administrator may re-
25 duce the applicable first or second threshold

1 *risk percentage in an area in a year in*
 2 *order to ensure the access to plans required*
 3 *under paragraph (1) of such section.*

4 “(D) *TARGET AMOUNT NOT TO INCLUDE AD-*
 5 *MINISTRATIVE EXPENSES NEGOTIATED BETWEEN*
 6 *THE ADMINISTRATOR AND THE ENTITY OFFERING*
 7 *THE PLAN.—For each year (beginning in 2006),*
 8 *the Administrator and the entity offering a*
 9 *Medicare Prescription Drug plan shall negotiate,*
 10 *as part of the negotiation process described in*
 11 *section 1860D–13(b) during the previous year,*
 12 *the percentage of the payments to the entity*
 13 *under subsection (a) with respect to the plan*
 14 *that are attributable and reasonably incurred for*
 15 *administrative expenses for providing standard*
 16 *prescription drug coverage or actuarially equiva-*
 17 *lent prescription drug coverage in the year.*

18 “(5) *PLANS AT RISK FOR ENTIRE AMOUNT OF*
 19 *ADDITIONAL PRESCRIPTION DRUG COVERAGE.—An el-*
 20 *igible entity that offers a Medicare Prescription Drug*
 21 *plan that provides additional prescription drug cov-*
 22 *erage pursuant to section 1860D–6(a)(2) shall be at*
 23 *full financial risk for the provision of such additional*
 24 *coverage.*

1 “(6) *NO EFFECT ON ELIGIBLE BENEFICIARIES.*—
 2 *No change in payments made by reason of this sub-*
 3 *section shall affect the beneficiary obligation under*
 4 *section 1860D–17 for the year in which such change*
 5 *in payments is made.*

6 “(7) *DISCLOSURE OF INFORMATION.*—

7 “(A) *IN GENERAL.*—*Each contract under*
 8 *this part shall provide that—*

9 “(i) *the entity offering a Medicare Pre-*
 10 *scription Drug plan shall provide the Ad-*
 11 *ministrator with such information as the*
 12 *Administrator determines is necessary to*
 13 *carry out this section; and*

14 “(ii) *the Administrator shall have the*
 15 *right to inspect and audit any books and*
 16 *records of the eligible entity that pertain to*
 17 *the information regarding costs provided to*
 18 *the Administrator under paragraph (1).*

19 “(B) *RESTRICTION ON USE OF INFORMA-*
 20 *TION.*—*Information disclosed or obtained pursu-*
 21 *ant to the provisions of this section may be used*
 22 *by officers and employees of the Department of*
 23 *Health and Human Services only for the pur-*
 24 *poses of, and to the extent necessary in, carrying*
 25 *out this section.*

1 “(c) *STABILIZATION RESERVE FUND.*—

2 “(1) *ESTABLISHMENT.*—

3 “(A) *IN GENERAL.*—*There is established,*
 4 *within the Prescription Drug Account, a sta-*
 5 *bilization reserve fund in which the Adminis-*
 6 *trator shall deposit amounts on behalf of eligible*
 7 *entities in accordance with paragraph (2) and*
 8 *such amounts shall be made available by the Sec-*
 9 *retary for the use of eligible entities in contract*
 10 *year 2008 and subsequent contract years in ac-*
 11 *cordance with paragraph (3).*

12 “(B) *REVERSION OF UNUSED AMOUNTS.*—

13 *Any amount in the stabilization reserve fund es-*
 14 *tablished under subparagraph (A) that is not ex-*
 15 *pended by an eligible entity in accordance with*
 16 *paragraph (3) or that was deposited for the use*
 17 *of an eligible entity that no longer has a contract*
 18 *under this part shall revert for the use of the*
 19 *Prescription Drug Account.*

20 “(2) *DEPOSIT OF AMOUNTS FOR 5 YEARS.*—

21 “(A) *IN GENERAL.*—*If the target amount for*
 22 *a Medicare Prescription Drug plan for 2006,*
 23 *2007, 2008, 2009, or 2010 (as determined under*
 24 *subsection (b)(4)(B)) exceeds the applicable costs*

1 *for the plan for the year by more than 3 percent,*
 2 *then—*

3 “(i) *the entity offering the plan shall*
 4 *make a payment to the Administrator of an*
 5 *amount (or the Administrator shall other-*
 6 *wise recover from the plan an amount)*
 7 *equal to the portion of such excess that is in*
 8 *excess of 3 percent of the target amount;*
 9 *and*

10 “(ii) *the Administrator shall deposit*
 11 *an amount equal to the amount collected or*
 12 *otherwise recovered under clause (i) in the*
 13 *stabilization reserve fund on behalf of the el-*
 14 *igible entity offering such plan.*

15 “(B) *APPLICABLE COSTS.—For purposes of*
 16 *subparagraph (A), the term ‘applicable costs’*
 17 *means, with respect to a Medicare Prescription*
 18 *Drug plan and year, an amount equal the sum*
 19 *of—*

20 “(i) *the allowable costs for the plan*
 21 *and year (as determined under subsection*
 22 *(b)(3)(A); and*

23 “(ii) *the total amount by which month-*
 24 *ly payments to the plan were reduced (or*

1 *otherwise recovered from the plan) for the*
 2 *year under subsection (b)(2)(C).*

3 *“(3) USE OF RESERVE FUND TO STABILIZE OR*
 4 *REDUCE MONTHLY PLAN PREMIUMS.—*

5 *“(A) IN GENERAL.—For any contract year*
 6 *beginning after 2007, an eligible entity offering*
 7 *a Medicare Prescription Drug plan may use*
 8 *funds in the stabilization reserve fund in the*
 9 *Prescription Drug Account that were deposited*
 10 *in such fund on behalf of the entity to stabilize*
 11 *or reduce monthly plan premiums submitted*
 12 *under section 1860D–12(b)(3).*

13 *“(B) PROCEDURES.—The Administrator*
 14 *shall establish procedures for—*

15 *“(i) reducing monthly plan premiums*
 16 *submitted under section 1860D–12(b)(3)*
 17 *pursuant to subparagraph (A); and*

18 *“(ii) making payments from the plan*
 19 *stabilization reserve fund in the Prescrip-*
 20 *tion Drug Account to eligible entities that*
 21 *inform the Secretary under section 1860D–*
 22 *12(b)(5) of the entity’s intent to use funds*
 23 *in such reserve fund to reduce such pre-*
 24 *miums.*

1 “(d) *PORTION OF PAYMENTS OF MONTHLY PLAN PRE-*
 2 *MIUMS ATTRIBUTABLE TO ADMINISTRATIVE EXPENSES*
 3 *TIED TO PERFORMANCE REQUIREMENTS.*—

4 “(1) *IN GENERAL.*—*The Administrator shall es-*
 5 *tablish procedures to adjust the portion of the pay-*
 6 *ments made to an entity under subsection (a) that are*
 7 *attributable to administrative expenses (as deter-*
 8 *mined pursuant to subsection (b)(4)(D)) to ensure*
 9 *that the entity meets the performance requirements*
 10 *described in clauses (ii) and (iii) of section 1860D-*
 11 *13(e)(4)(B).*

12 “(2) *NO EFFECT ON ELIGIBLE BENEFICIARIES.*—
 13 *No change in payments made by reason of this sub-*
 14 *section shall affect the beneficiary obligation under*
 15 *section 1860D-17 for the year in which such change*
 16 *in payments is made.*

17 “(e) *PAYMENT TERMS.*—

18 “(1) *ADMINISTRATOR PAYMENTS.*—*Payments to*
 19 *an entity offering a Medicare Prescription Drug plan*
 20 *under this section shall be made in a manner deter-*
 21 *mined by the Administrator and based upon the man-*
 22 *ner in which payments are made under section*
 23 *1853(a) (relating to payments to Medicare Advantage*
 24 *organizations).*

1 “(2) *PLAN PAYMENTS.*—*The Administrator shall*
 2 *establish a process for collecting (or other otherwise*
 3 *recovering) amounts that an entity offering a Medi-*
 4 *care Prescription Drug plan is required to make to*
 5 *the Administrator under this section.*

6 “(f) *PAYMENTS TO MEDICAREADVANTAGE PLANS.*—
 7 *For provisions related to payments to MedicareAdvantage*
 8 *organizations offering MedicareAdvantage plans for quali-*
 9 *fied prescription drug coverage made available under the*
 10 *plan, see section 1858A(c).*

11 “(g) *SECONDARY PAYER PROVISIONS.*—*The provisions*
 12 *of section 1862(b) shall apply to the benefits provided under*
 13 *this part.*

14 “*COMPUTATION OF MONTHLY BENEFICIARY OBLIGATION*

15 “*SEC. 1860D–17. (a) BENEFICIARIES ENROLLED IN A*
 16 *MEDICARE PRESCRIPTION DRUG PLAN.*—*In the case of an*
 17 *eligible beneficiary enrolled under this part and in a Medi-*
 18 *care Prescription Drug plan, the monthly beneficiary obli-*
 19 *gation for enrollment in such plan in a year shall be deter-*
 20 *mined as follows:*

21 “(1) *MONTHLY PLAN PREMIUM EQUALS MONTHLY*
 22 *NATIONAL AVERAGE PREMIUM.*—*If the amount of the*
 23 *monthly plan premium approved by the Adminis-*
 24 *trator under section 1860D–13 for a Medicare Pre-*
 25 *scription Drug plan for the year is equal to the*
 26 *monthly national average premium (as computed*

1 *under section 1860D–15) for the year, the monthly*
 2 *beneficiary obligation of the eligible beneficiary in*
 3 *that year shall be an amount equal to the applicable*
 4 *percent (for the area in which the beneficiary resides,*
 5 *as determined in subsection (c)) of the amount of the*
 6 *monthly national average premium.*

7 “(2) *MONTHLY PLAN PREMIUM LESS THAN*
 8 *MONTHLY NATIONAL AVERAGE PREMIUM.—If the*
 9 *amount of the monthly plan premium approved by*
 10 *the Administrator under section 1860D–13 for the*
 11 *Medicare Prescription Drug plan for the year is less*
 12 *than the monthly national average premium (as com-*
 13 *puted under section 1860D–15) for the year, the*
 14 *monthly beneficiary obligation of the eligible bene-*
 15 *ficiary in that year shall be an amount equal to—*

16 “(A) *the applicable percent (for the area in*
 17 *which the beneficiary resides) of the amount of*
 18 *the monthly national average premium; minus*

19 “(B) *the amount by which the monthly na-*
 20 *tional average premium exceeds the amount of*
 21 *the monthly plan premium approved by the Ad-*
 22 *ministrator for the plan.*

23 “(3) *MONTHLY PLAN PREMIUM EXCEEDS MONTH-*
 24 *LY NATIONAL AVERAGE PREMIUM.—If the amount of*
 25 *the monthly plan premium approved by the Adminis-*

1 *trator under section 1860D–13 for a Medicare Pre-*
 2 *scription Drug plan for the year exceeds the monthly*
 3 *national average premium (as computed under sec-*
 4 *tion 1860D–15) for the year, the monthly beneficiary*
 5 *obligation of the eligible beneficiary in that year shall*
 6 *be an amount equal to the sum of—*

7 *“(A) the applicable percent (for the area in*
 8 *which the beneficiary resides) of the amount of*
 9 *the monthly national average premium; plus*

10 *“(B) the amount by which the monthly plan*
 11 *premium approved by the Administrator for the*
 12 *plan exceeds the amount of the monthly national*
 13 *average premium.*

14 *“(b) BENEFICIARIES ENROLLED IN A*
 15 *MEDICAREADVANTAGE PLAN.—In the case of an eligible*
 16 *beneficiary that is enrolled in a MedicareAdvantage plan*
 17 *(except for an MSA plan or a private fee-for-service plan*
 18 *that does not provide qualified prescription drug coverage),*
 19 *the Medicare monthly beneficiary obligation for qualified*
 20 *prescription drug coverage shall be determined pursuant to*
 21 *section 1858A(d).*

22 *“(c) APPLICABLE PERCENT.—*

23 *“(1) IN GENERAL.—For purposes of this section,*
 24 *except as provided in section 1860D–19 (relating to*
 25 *premium subsidies for low-income individuals), the*

1 *term applicable percent for any year is the percentage*
 2 *equal to a fraction—*

3 *“(A) the numerator of which is 32 percent;*

4 *and*

5 *“(B) the denominator of which is 100 per-*
 6 *cent minus a percentage equal to—*

7 *“(i) the total reinsurance payments*
 8 *which the Administrator estimates will be*
 9 *made under section 1860D–20 to qualifying*
 10 *entities described in subparagraphs (A) and*
 11 *(B) of subsection (e)(3) of such section dur-*
 12 *ing the year; divided by*

13 *“(ii) the sum of—*

14 *“(I) the amount estimated under*
 15 *clause (i) for the year; and*

16 *“(II) the total payments which the*
 17 *Administrator estimates will be made*
 18 *under sections 1860D–16 and 1858A(c)*
 19 *during the year that relate to standard*
 20 *prescription drug coverage (or actuari-*
 21 *ally equivalent prescription drug cov-*
 22 *erage).*

23 *“(2) GEOGRAPHIC ADJUSTMENT.—*

24 *“(A) ADJUSTMENT.—The applicable percent*
 25 *determined under paragraph (1) for a year shall*

1 *be adjusted using the methodology established*
 2 *under subparagraph (B).*

3 *“(B) METHODOLOGY.—The Administrator*
 4 *shall establish an appropriate methodology for*
 5 *adjusting the applicable percent referred to in*
 6 *paragraph (1) to take into account variations in*
 7 *input prices for covered drugs in different service*
 8 *areas established under section 1860D–10. Any*
 9 *such adjustment shall be applied in a manner as*
 10 *to not result in a change in aggregate payments*
 11 *made under this part than would have been*
 12 *made if the Administrator had not applied such*
 13 *adjustment.*

14 *“COLLECTION OF MONTHLY BENEFICIARY OBLIGATION*

15 *“SEC. 1860D–18. (a) COLLECTION OF AMOUNT IN*
 16 *SAME MANNER AS PART B PREMIUM.—*

17 *“(1) IN GENERAL.—Subject to paragraph (2), the*
 18 *amount of the monthly beneficiary obligation (deter-*
 19 *mined under section 1860D–17) applicable to an eli-*
 20 *gible beneficiary under this part (after application of*
 21 *any increase under section 1860D–2(b)(1)(A)) shall*
 22 *be collected and credited to the Prescription Drug Ac-*
 23 *count in the same manner as the monthly premium*
 24 *determined under section 1839 is collected and cred-*
 25 *ited to the Federal Supplementary Medical Insurance*
 26 *Trust Fund under section 1840.*

1 “(2) *PROCEDURES FOR SPONSOR TO PAY OBLIGA-*
 2 *TION ON BEHALF OF RETIREE.*—*The Administrator*
 3 *shall establish procedures under which an eligible ben-*
 4 *eficiary enrolled in a Medicare Prescription Drug*
 5 *plan may elect to have the sponsor (as defined in*
 6 *paragraph (5) of section 1860D–20(e)) of employ-*
 7 *ment-based retiree health coverage (as defined in*
 8 *paragraph (4)(B) of such section) in which the bene-*
 9 *ficiary is enrolled pay the amount of the monthly*
 10 *beneficiary obligation applicable to the beneficiary*
 11 *under this part directly to the Administrator.*

12 “(b) *INFORMATION NECESSARY FOR COLLECTION.*—*In*
 13 *order to carry out subsection (a), the Administrator shall*
 14 *transmit to the Commissioner of Social Security—*

15 “(1) *by the beginning of each year, the name, so-*
 16 *cial security account number, monthly beneficiary ob-*
 17 *ligation owed by each individual enrolled in a Medi-*
 18 *care Prescription Drug plan for each month during*
 19 *the year, and other information determined appro-*
 20 *priate by the Administrator; and*

21 “(2) *periodically throughout the year, informa-*
 22 *tion to update the information previously transmitted*
 23 *under this paragraph for the year.*

24 “(c) *COLLECTION FOR BENEFICIARIES ENROLLED IN*
 25 *A MEDICAREADVANTAGE PLAN.*—*For provisions related to*

1 *the collection of the monthly beneficiary obligation for*
 2 *qualified prescription drug coverage under a*
 3 *MedicareAdvantage plan, see section 1858A(e).*

4 “*PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-*
 5 *INCOME INDIVIDUALS*”

6 “*SEC. 1860D–19. (a) AMOUNT OF SUBSIDIES.—*

7 “*(1) FULL PREMIUM SUBSIDY AND REDUCTION*
 8 *OF COST-SHARING FOR QUALIFIED MEDICARE BENE-*
 9 *FICIARIES.—In the case of a qualified medicare bene-*
 10 *ficiary (as defined in paragraph (4)(A))—*

11 “*(A) section 1860D–17 shall be applied—*

12 “*(i) in subsection (c), by substituting*
 13 *‘0 percent’ for the applicable percent that*
 14 *would otherwise apply under such section in*
 15 *the service area in which the qualified*
 16 *medicare beneficiary resides; and*

17 “*(ii) in subsection (a)(3)(B), by sub-*
 18 *stituting ‘the amount of the monthly plan*
 19 *premium for the Medicare Prescription*
 20 *Drug plan with the lowest monthly plan*
 21 *premium in the area that the beneficiary*
 22 *resides’ for ‘the amount of the monthly na-*
 23 *tional average premium’, but only if there*
 24 *is no Medicare Prescription Drug plan of-*
 25 *fered in the area in which the individual re-*
 26 *sides that has a monthly plan premium for*

1 *the year that is equal to or less than the*
 2 *monthly national average premium (as*
 3 *computed under section 1860D–15) for the*
 4 *year;*

5 *“(B) the annual deductible applicable under*
 6 *section 1860D–6(c)(1) in a year shall be reduced*
 7 *to \$0;*

8 *“(C) section 1860D–6(c)(2) shall be applied*
 9 *by substituting ‘2.5 percent’ for ‘50 percent’ each*
 10 *place it appears;*

11 *“(D) such individual shall be responsible for*
 12 *cost-sharing for the cost of any covered drug pro-*
 13 *vided in the year (after the individual has*
 14 *reached such initial coverage limit and before the*
 15 *individual has reached the annual out-of-pocket*
 16 *limit under section 1860D–6(c)(4)(A)), that is*
 17 *equal to 5.0 percent; and*

18 *“(E) section 1860D–6(c)(4)(A) shall be ap-*
 19 *plied by substituting ‘2.5 percent’ for ‘10 per-*
 20 *cent’.*

21 *In no case may the application of subparagraph (A)*
 22 *result in a monthly beneficiary obligation that is*
 23 *below 0.*

24 *“(2) FULL PREMIUM SUBSIDY AND REDUCTION*
 25 *OF COST-SHARING FOR SPECIFIED LOW INCOME MEDI-*

1 *CARE BENEFICIARIES AND QUALIFYING INDIVID-*
 2 *UALS.—In the case of a specified low income medicare*
 3 *beneficiary (as defined in paragraph (4)(B)) or a*
 4 *qualifying individual (as defined in paragraph*
 5 *(4)(C))—*

6 *“(A) section 1860D–17 shall be applied—*

7 *“(i) in subsection (c), by substituting*
 8 *‘0 percent’ for the applicable percent that*
 9 *would otherwise apply under such section in*
 10 *the service area in which the specified low*
 11 *income medicare beneficiary or the quali-*
 12 *fying individual (as the case may be) re-*
 13 *sides; and*

14 *“(ii) in subsection (a)(3)(B), by sub-*
 15 *stituting ‘the amount of the monthly plan*
 16 *premium for the Medicare Prescription*
 17 *Drug plan with the lowest monthly plan*
 18 *premium in the area that the beneficiary*
 19 *resides’ for ‘the amount of the monthly na-*
 20 *tional average premium’, but only if there*
 21 *is no Medicare Prescription Drug plan of-*
 22 *fered in the area in which the individual re-*
 23 *sides that has a monthly plan premium for*
 24 *the year that is equal to or less than the*
 25 *monthly national average premium (as*

1 *computed under section 1860D–15) for the*
 2 *year;*

3 *“(B) the annual deductible applicable under*
 4 *section 1860D–6(c)(1) in a year shall be reduced*
 5 *to \$0;*

6 *“(C) section 1860D–6(c)(2) shall be applied*
 7 *by substituting ‘5.0 percent’ for ‘50 percent’ each*
 8 *place it appears;*

9 *“(D) such individual shall be responsible for*
 10 *cost-sharing for the cost of any covered drug pro-*
 11 *vided in the year (after the individual has*
 12 *reached such initial coverage limit and before the*
 13 *individual has reached the annual out-of-pocket*
 14 *limit under section 1860D–6(c)(4)(A)), that is*
 15 *equal to 10.0 percent; and*

16 *“(E) section 1860D–6(c)(4)(A) shall be ap-*
 17 *plied by substituting ‘2.5 percent’ for ‘10 per-*
 18 *cent’.*

19 *In no case may the application of subparagraph (A)*
 20 *result in a monthly beneficiary obligation that is*
 21 *below 0.*

22 *“(3) SLIDING SCALE PREMIUM SUBSIDY AND RE-*
 23 *DUCTION OF COST-SHARING FOR SUBSIDY-ELIGIBLE*
 24 *INDIVIDUALS.—*

1 “(A) *IN GENERAL.*—*In the case of a sub-*
 2 *sidy-eligible individual (as defined in paragraph*
 3 *(4)(D))—*

4 “(i) *section 1860D–17 shall be ap-*
 5 *plied—*

6 “(I) *in subsection (c), by sub-*
 7 *stituting ‘subsidy percent’ for the per-*
 8 *centage that would otherwise apply*
 9 *under such section in the service area*
 10 *in which the subsidy-eligible indi-*
 11 *vidual resides; and*

12 “(II) *in subparagraphs (A) and*
 13 *(B) of subsection (a)(3), by sub-*
 14 *stituting ‘the amount of the monthly*
 15 *plan premium for the Medicare Pre-*
 16 *scription Drug plan with the lowest*
 17 *monthly plan premium in the area*
 18 *that the beneficiary resides’ for ‘the*
 19 *amount of the monthly national aver-*
 20 *age premium’, but only if there is no*
 21 *Medicare Prescription Drug plan of-*
 22 *fered in the area in which the indi-*
 23 *vidual resides that has a monthly plan*
 24 *premium for the year that is equal to*
 25 *or less than the monthly national aver-*

1 *age premium (as computed under sec-*
 2 *tion 1860D–15) for the year; and*

3 *“(ii) the annual deductible applicable*
 4 *under section 1860D–6(c)(1) in a year shall*
 5 *be reduced to \$50;*

6 *“(iii) section 1860D–6(c)(2) shall be*
 7 *applied by substituting ‘10.0 percent’ for*
 8 *‘50 percent’ each place it appears;*

9 *“(iv) such individual shall be respon-*
 10 *sible for cost-sharing for the cost of any cov-*
 11 *ered drug provided in the year (after the in-*
 12 *dividual has reached such initial coverage*
 13 *limit and before the individual has reached*
 14 *the annual out-of-pocket limit under section*
 15 *1860D–6(c)(4)(A)), that is equal to 20.0*
 16 *percent; and*

17 *“(v) such individual shall be respon-*
 18 *sible for the cost-sharing described in section*
 19 *1860D–6(c)(4)(A).*

20 *In no case may the application of clause (i) re-*
 21 *sult in a monthly beneficiary obligation that is*
 22 *below 0.*

23 *“(B) SUBSIDY PERCENT DEFINED.—For*
 24 *purposes of subparagraph (A)(i), the term ‘sub-*
 25 *sidy percent’ means, with respect to a State, a*

percent determined on a linear sliding scale
ranging from—

“(i) 0 percent with respect to a subsidy-eligible individual residing in the State whose income does not exceed 135 percent of the poverty line; to

“(ii) the highest percentage that would otherwise apply under section 1860D–17 in the service area in which the subsidy-eligible individual resides, in the case of a subsidy-eligible individual residing in the State whose income equals 160 percent of the poverty line.

“(4) DEFINITIONS.—In this part:

“(A) QUALIFIED MEDICARE BENEFICIARY.—Subject to subparagraph (H), the term ‘qualified medicare beneficiary’ means an individual who—

“(i) is enrolled under this part, including an individual who is enrolled under a MedicareAdvantage plan;

“(ii) is described in section 1905(p)(1);
and

“(iii) is not—

1 “(I) a specified low-income medi-
2 care beneficiary;

3 “(II) a qualifying individual; or

4 “(III) a dual eligible individual.

5 “(B) SPECIFIED LOW INCOME MEDICARE
6 BENEFICIARY.—Subject to subparagraph (H), the
7 term ‘specified low income medicare beneficiary’
8 means an individual who—

9 “(i) is enrolled under this part, includ-
10 ing an individual who is enrolled under a
11 MedicareAdvantage plan;

12 “(ii) is described in section
13 1902(a)(10)(E)(iii); and

14 “(iii) is not—

15 “(I) a qualified medicare bene-
16 ficiary;

17 “(II) a qualifying individual; or

18 “(III) a dual eligible individual.

19 “(C) QUALIFYING INDIVIDUAL.—Subject to
20 subparagraph (H), the term ‘qualifying indi-
21 vidual’ means an individual who—

22 “(i) is enrolled under this part, includ-
23 ing an individual who is enrolled under a
24 MedicareAdvantage plan;

1 “(ii) is described in section
2 1902(a)(10)(E)(iv) (without regard to any
3 termination of the application of such sec-
4 tion under title XIX); and

5 “(iii) is not—

6 “(I) a qualified medicare bene-
7 ficiary;

8 “(II) a specified low-income medi-
9 care beneficiary; or

10 “(III) a dual eligible individual.

11 “(D) *SUBSIDY-ELIGIBLE INDIVIDUAL*.—Sub-
12 ject to subparagraph (H), the term ‘subsidy-eli-
13 ble individual’ means an individual—

14 “(i) who is enrolled under this part,
15 including an individual who is enrolled
16 under a MedicareAdvantage plan;

17 “(ii) whose income is less than 160
18 percent of the poverty line; and

19 “(iii) who is not—

20 “(I) a qualified medicare bene-
21 ficiary;

22 “(II) a specified low-income medi-
23 care beneficiary;

24 “(III) a qualifying individual; or

25 “(IV) a dual eligible individual.

1 “(E) *DUAL ELIGIBLE INDIVIDUAL*.—

2 “(i) *IN GENERAL*.—The term ‘dual eli-
3 gible individual’ means an individual who
4 is—

5 “(I) *enrolled under title XIX or*
6 *under a waiver under section 1115 of*
7 *the requirements of such title for med-*
8 *ical assistance that is not less than the*
9 *medical assistance provided to an indi-*
10 *vidual described in section*
11 *1902(a)(10)(A)(i) and includes covered*
12 *outpatient drugs (as such term is de-*
13 *finied for purposes of section 1927); and*

14 “(II) *entitled to benefits under*
15 *part A and enrolled under part B.*

16 “(ii) *INCLUSION OF MEDICALLY*
17 *NEEDY*.—Such term includes an individual
18 *described in section 1902(a)(10)(C).*

19 “(F) *POVERTY LINE*.—The term ‘poverty
20 line’ has the meaning given such term in section
21 673(2) of the Community Services Block Grant
22 Act (42 U.S.C. 9902(2)), including any revision
23 required by such section.

24 “(G) *ELIGIBILITY DETERMINATIONS*.—Be-
25 ginning on November 1, 2005, the determination

1 *of whether an individual residing in a State is*
 2 *an individual described in subparagraph (A),*
 3 *(B), (C), (D), or (E) and, for purposes of para-*
 4 *graph (3), the amount of an individual's income,*
 5 *shall be determined under the State medicaid*
 6 *plan for the State under section 1935(a). In the*
 7 *case of a State that does not operate such a med-*
 8 *icaid plan (either under title XIX or under a*
 9 *statewide waiver granted under section 1115),*
 10 *such determination shall be made under arrange-*
 11 *ments made by the Administrator.*

12 “(H) *NONAPPLICATION TO DUAL ELIGIBLE*
 13 *INDIVIDUALS AND TERRITORIAL RESIDENTS.—In*
 14 *the case of an individual who is a dual eligible*
 15 *individual or an individual who is not a resi-*
 16 *dent of the 50 States or the District of Colum-*
 17 *bia—*

18 “(i) *the subsidies provided under this*
 19 *section shall not apply; and*

20 “(ii) *such individuals may be provided*
 21 *with medical assistance for covered out-*
 22 *patient drugs (as such term is defined for*
 23 *purposes of section 1927) in accordance*
 24 *with section 1935 under the State medicaid*
 25 *program under title XIX.*

1 “(b) *RULES IN APPLYING COST-SHARING SUB-*
 2 *SIDIES.—Nothing in this section shall be construed as pre-*
 3 *venting an eligible entity offering a Medicare Prescription*
 4 *Drug plan or a MedicareAdvantage organization offering*
 5 *a MedicareAdvantage plan from waiving or reducing the*
 6 *amount of the deductible or other cost-sharing otherwise ap-*
 7 *plicable pursuant to section 1860D–6(a)(2).*

8 “(c) *ADMINISTRATION OF SUBSIDY PROGRAM.—The*
 9 *Administrator shall establish a process whereby, in the case*
 10 *of an individual eligible for a cost-sharing subsidy under*
 11 *subsection (a) who is enrolled in a Medicare Prescription*
 12 *Drug plan or a MedicareAdvantage plan—*

13 “(1) *the Administrator provides for a notifica-*
 14 *tion of the eligible entity or MedicareAdvantage orga-*
 15 *nization involved that the individual is eligible for a*
 16 *cost-sharing subsidy and the amount of the subsidy*
 17 *under such subsection;*

18 “(2) *the entity or organization involved reduces*
 19 *the cost-sharing otherwise imposed by the amount of*
 20 *the applicable subsidy and submits to the Adminis-*
 21 *trator information on the amount of such reduction;*
 22 *and*

23 “(3) *the Administrator periodically and on a*
 24 *timely basis reimburses the entity or organization for*
 25 *the amount of such reductions.*

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

5 “(d) *RELATION TO MEDICAID PROGRAM.*—*For provi-*
 6 *sions providing for eligibility determinations and addi-*
 7 *tional Federal payments for expenditures related to pro-*
 8 *viding prescription drug coverage for dual eligible individ-*
 9 *uals and territorial residents under the medicaid program,*
 10 *see section 1935.*

11 *“REINSURANCE PAYMENTS FOR EXPENSES INCURRED IN*
 12 *PROVIDING PRESCRIPTION DRUG COVERAGE ABOVE*
 13 *THE ANNUAL OUT-OF-POCKET THRESHOLD*

14 *“SEC. 1860D–20. (a) REINSURANCE PAYMENTS.*—

15 “(1) *IN GENERAL.*—*Subject to section 1860D–*
 16 *21(b), the Administrator shall provide in accordance*
 17 *with this section for payment to a qualifying entity*
 18 *of the reinsurance payment amount (as specified in*
 19 *subsection (c)(1)) for costs incurred by the entity in*
 20 *providing prescription drug coverage for a qualifying*
 21 *covered individual after the individual has reached*
 22 *the annual out-of-pocket threshold specified in section*
 23 *1860D–6(c)(4)(B) for the year.*

24 “(2) *BUDGET AUTHORITY.*—*This section con-*
 25 *stitutes budget authority in advance of appropri-*
 26 *ations Acts and represents the obligation of the Admin-*

1 *istrator to provide for the payment of amounts pro-*
 2 *vided under this section.*

3 *“(b) NOTIFICATION OF SPENDING UNDER THE PLAN*
 4 *FOR COSTS INCURRED IN PROVIDING PRESCRIPTION DRUG*
 5 *COVERAGE ABOVE THE ANNUAL OUT-OF-POCKET THRESH-*
 6 *OLD.—*

7 *“(1) IN GENERAL.—Each qualifying entity shall*
 8 *notify the Administrator of the following with respect*
 9 *to a qualifying covered individual for a coverage*
 10 *year:*

11 *“(A) TOTAL ACTUAL COSTS.—The total*
 12 *amount (if any) of costs that the qualifying enti-*
 13 *ty incurred in providing prescription drug cov-*
 14 *erage for the individual in the year after the in-*
 15 *dividual had reached the annual out-of-pocket*
 16 *threshold specified in section 1860D–6(c)(4)(B)*
 17 *for the year.*

18 *“(B) ACTUAL COSTS FOR SPECIFIC*
 19 *DRUGS.—With respect to the total amount under*
 20 *subparagraph (A) for the year, a breakdown of—*

21 *“(i) each covered drug that constitutes*
 22 *a portion of such amount;*

23 *“(ii) the negotiated price for the quali-*
 24 *fying entity for each such drug;*

25 *“(iii) the number of prescriptions; and*

1 “(iv) *the average beneficiary coinsur-*
 2 *ance rate for a each covered drug that con-*
 3 *stitutes a portion of such amount.*

4 “(2) *CERTAIN EXPENSES NOT INCLUDED.—The*
 5 *amounts under subparagraphs (A) and (B)(ii) of*
 6 *paragraph (1) may not include—*

7 “(A) *administrative expenses incurred in*
 8 *providing the coverage described in paragraph*
 9 *(1)(A); or*

10 “(B) *amounts expended on providing addi-*
 11 *tional prescription drug coverage pursuant to*
 12 *section 1860D–6(a)(2).*

13 “(3) *RESTRICTION ON USE OF INFORMATION.—*
 14 *The restriction specified in section 1860D–16(b)(7)(B)*
 15 *shall apply to information disclosed or obtained pur-*
 16 *suant to the provisions of this section.*

17 “(c) *REINSURANCE PAYMENT AMOUNT.—*

18 “(1) *IN GENERAL.—The reinsurance payment*
 19 *amount under this subsection for a qualifying covered*
 20 *individual for a coverage year is an amount equal to*
 21 *80 percent of the allowable costs (as specified in para-*
 22 *graph (2)) incurred by the qualifying entity with re-*
 23 *spect to the individual and year.*

24 “(2) *ALLOWABLE COSTS.—*

1 “(A) *IN GENERAL.*—*In the case of a quali-*
 2 *fying entity that has incurred costs described in*
 3 *subsection (b)(1)(A) with respect to a qualifying*
 4 *covered individual for a coverage year, the Ad-*
 5 *ministrator shall establish the allowable costs for*
 6 *the individual and year. Such allowable costs*
 7 *shall be equal to the amount described in such*
 8 *subsection for the individual and year, adjusted*
 9 *under subparagraph (B).*

10 “(B) *REPRICING OF COSTS IF ACTUAL*
 11 *COSTS EXCEED AVERAGE COSTS.*—*The Adminis-*
 12 *trator shall reduce the amount described in sub-*
 13 *section (b)(1)(A) with respect to a qualifying*
 14 *covered individual for a coverage year to the ex-*
 15 *tent such amount is based on costs of specific*
 16 *covered drugs furnished under the plan in the*
 17 *year (as specified under subsection (b)(1)(B))*
 18 *that are greater than the average cost for the cov-*
 19 *ered drug for the year (as determined under sec-*
 20 *tion 1860D–16(b)(3)(A)).*

21 “(d) *PAYMENT METHODS.*—

22 “(1) *IN GENERAL.*—*Payments under this section*
 23 *shall be based on such a method as the Administrator*
 24 *determines. The Administrator may establish a pay-*
 25 *ment method by which interim payments of amounts*

1 *under this section are made during a year based on*
 2 *the Administrator’s best estimate of amounts that will*
 3 *be payable after obtaining all of the information.*

4 “(2) *SOURCE OF PAYMENTS.—Payments under*
 5 *this section shall be made from the Prescription Drug*
 6 *Account.*

7 “(e) *DEFINITIONS.—In this section:*

8 “(1) *COVERAGE YEAR.—The term ‘coverage year’*
 9 *means a calendar year in which covered drugs are*
 10 *dispensed if a claim for payment is made under the*
 11 *plan for such drugs, regardless of when the claim is*
 12 *paid.*

13 “(2) *QUALIFYING COVERED INDIVIDUAL.—The*
 14 *term ‘qualifying covered individual’ means an indi-*
 15 *vidual who—*

16 “(A) *is enrolled in this part and in a Medi-*
 17 *care Prescription Drug plan;*

18 “(B) *is enrolled in this part and in a*
 19 *MedicareAdvantage plan (except for an MSA*
 20 *plan or a private fee-for-service plan that does*
 21 *not provide qualified prescription drug cov-*
 22 *erage); or*

23 “(C) *is eligible for, but not enrolled in, the*
 24 *program under this part, and is covered under*
 25 *a qualified retiree prescription drug plan.*

1 “(3) *QUALIFYING ENTITY.*—*The term ‘qualifying*
 2 *entity’ means any of the following that has entered*
 3 *into an agreement with the Administrator to provide*
 4 *the Administrator with such information as may be*
 5 *required to carry out this section:*

6 “(A) *An eligible entity offering a Medicare*
 7 *Prescription Drug plan under this part.*

8 “(B) *A MedicareAdvantage organization of-*
 9 *fering a MedicareAdvantage plan under part C*
 10 *(except for an MSA plan or a private fee-for-*
 11 *service plan that does not provide qualified pre-*
 12 *scription drug coverage).*

13 “(C) *The sponsor of a qualified retiree pre-*
 14 *scription drug plan.*

15 “(4) *QUALIFIED RETIREE PRESCRIPTION DRUG*
 16 *PLAN.*—

17 “(A) *IN GENERAL.*—*The term ‘qualified re-*
 18 *tiree prescription drug plan’ means employment-*
 19 *based retiree health coverage if, with respect to a*
 20 *qualifying covered individual who is covered*
 21 *under the plan, the following requirements are*
 22 *met:*

23 “(i) *ASSURANCE.*—*The sponsor of the*
 24 *plan shall annually attest, and provide such*
 25 *assurances as the Administrator may re-*

1 *quire, that the coverage meets or exceeds the*
 2 *requirements for qualified prescription drug*
 3 *coverage.*

4 “(ii) *DISCLOSURE OF INFORMATION.—*
 5 *The sponsor complies with the requirements*
 6 *described in clauses (i) and (ii) of section*
 7 *1860D–16(b)(7)(A).*

8 “(B) *EMPLOYMENT-BASED RETIREE*
 9 *HEALTH COVERAGE.—The term ‘employment-*
 10 *based retiree health coverage’ means health in-*
 11 *surance or other coverage, whether provided by*
 12 *voluntary insurance coverage or pursuant to*
 13 *statutory or contractual obligation, of health care*
 14 *costs for retired individuals (or for such individ-*
 15 *uals and their spouses and dependents) based on*
 16 *their status as former employees or labor union*
 17 *members.*

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

21 “*DIRECT SUBSIDY FOR SPONSOR OF A QUALIFIED RETIREE*
 22 *PRESCRIPTION DRUG PLAN FOR PLAN ENROLLEES EL-*
 23 *IGIBLE FOR, BUT NOT ENROLLED IN, THIS PART*

24 “*SEC. 1860D–21. (a) DIRECT SUBSIDY.—*

25 “(1) *IN GENERAL.—The Administrator shall pro-*
 26 *vide for the payment to a sponsor of a qualified re-*

1 *three prescription drug plan (as defined in section*
 2 *1860D–20(e)(4)) for each qualifying covered indi-*
 3 *vidual (described in subparagraph (C) of section*
 4 *1860D–20(e)(2)) enrolled in the plan for each month*
 5 *for which such individual is so enrolled.*

6 “(2) *AMOUNT OF PAYMENT.*—

7 “(A) *IN GENERAL.*—*The amount of the pay-*
 8 *ment under paragraph (1) shall be an amount*
 9 *equal to the direct subsidy percent (for the area*
 10 *for the year) of the monthly national average*
 11 *premium for the year (determined under section*
 12 *1860D–15), as adjusted using the risk adjusters*
 13 *that apply to the standard prescription drug*
 14 *coverage published under section 1860D–11.*

15 “(B) *DIRECT SUBSIDY PERCENT.*—*For pur-*
 16 *poses of subparagraph (A), the term ‘direct sub-*
 17 *sidy percent’ means the percentage equal to—*

18 “(i) *100 percent; minus*

19 “(ii) *the applicable percent for the year*
 20 *and for the area in which the individual re-*
 21 *sides for the year (as determined under sec-*
 22 *tion 1860D–17(c)).*

23 “(b) *PAYMENT METHODS.*—

24 “(1) *IN GENERAL.*—*Payments under this section*
 25 *shall be based on such a method as the Administrator*

1 *determines. The Administrator may establish a pay-*
 2 *ment method by which interim payments of amounts*
 3 *under this section are made during a year based on*
 4 *the Administrator's best estimate of amounts that will*
 5 *be payable after obtaining all of the information.*

6 “(2) *SOURCE OF PAYMENTS.—Payments under*
 7 *this section shall be made from the Prescription Drug*
 8 *Account.*

9 “*Subpart 3—Miscellaneous Provisions*

10 “*PRESCRIPTION DRUG ACCOUNT IN THE FEDERAL*
 11 *SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND*

12 “*SEC. 1860D–25. (a) ESTABLISHMENT.—*

13 “(1) *IN GENERAL.—There is created within the*
 14 *Federal Supplementary Medical Insurance Trust*
 15 *Fund established by section 1841 an account to be*
 16 *known as the ‘Prescription Drug Account’ (in this*
 17 *section referred to as the ‘Account’).*

18 “(2) *FUNDS.—The Account shall consist of such*
 19 *gifts and bequests as may be made as provided in sec-*
 20 *tion 201(i)(1), and such amounts as may be deposited*
 21 *in, or appropriated to, the Account as provided in*
 22 *this part.*

23 “(3) *SEPARATE FROM REST OF TRUST FUND.—*
 24 *Funds provided under this part to the Account shall*

1 *be kept separate from all other funds within the Fed-*
 2 *eral Supplementary Medical Insurance Trust Fund.*

3 *“(b) PAYMENTS FROM ACCOUNT.—*

4 *“(1) IN GENERAL.—The Managing Trustee shall*
 5 *pay from time to time from the Account such*
 6 *amounts as the Secretary certifies are necessary to*
 7 *make payments to operate the program under this*
 8 *part, including—*

9 *“(A) payments to eligible entities under sec-*
 10 *tion 1860D–16;*

11 *“(B) payments under 1860D–19 for low-in-*
 12 *come subsidy payments for cost-sharing;*

13 *“(C) reinsurance payments under section*
 14 *1860D–20;*

15 *“(D) payments to sponsors of qualified re-*
 16 *tiree prescription drug plans under section*
 17 *1860D–21;*

18 *“(E) payments to MedicareAdvantage orga-*
 19 *nizations for the provision of qualified prescrip-*
 20 *tion drug coverage under section 1858A(c); and*

21 *“(F) payments with respect to administra-*
 22 *tive expenses under this part in accordance with*
 23 *section 201(g).*

24 *“(2) TREATMENT IN RELATION TO PART B PRE-*
 25 *MIUM.—Amounts payable from the Account shall not*

1 *be taken into account in computing actuarial rates or*
 2 *premium amounts under section 1839.*

3 *“(c) APPROPRIATIONS TO COVER BENEFITS AND AD-*
 4 *MINISTRATIVE COSTS.—There are appropriated to the Ac-*
 5 *count in a fiscal year, out of any moneys in the Treasury*
 6 *not otherwise appropriated, an amount equal to the pay-*
 7 *ments and transfers made from the Account in the year.*

8 *“OTHER RELATED PROVISIONS*

9 *“SEC. 1860D–26. (a) RESTRICTION ON ENROLLMENT*
 10 *IN A MEDICARE PRESCRIPTION DRUG PLAN OFFERED BY*
 11 *A SPONSOR OF EMPLOYMENT-BASED RETIREE HEALTH*
 12 *COVERAGE.—*

13 *“(1) IN GENERAL.—In the case of a Medicare*
 14 *Prescription Drug plan offered by an eligible entity*
 15 *that is a sponsor (as defined in paragraph (5) of sec-*
 16 *tion 1860D–20(e)) of employment-based retiree health*
 17 *coverage (as defined in paragraph (4)(B) of such sec-*
 18 *tion), notwithstanding any other provision of this*
 19 *part and in accordance with regulations of the Ad-*
 20 *ministrator, the entity offering the plan may restrict*
 21 *the enrollment of eligible beneficiaries enrolled under*
 22 *this part to eligible beneficiaries who are enrolled in*
 23 *such coverage.*

24 *“(2) LIMITATION.—The sponsor of the employ-*
 25 *ment-based retiree health coverage described in para-*
 26 *graph (1) may not offer enrollment in the Medicare*

1 *Prescription Drug plan described in such paragraph*
 2 *based on the health status of eligible beneficiaries en-*
 3 *rolled for such coverage.*

4 “(b) *COORDINATION WITH STATE PHARMACEUTICAL*
 5 *ASSISTANCE PROGRAMS.—*

6 “(1) *IN GENERAL.—An eligible entity offering a*
 7 *Medicare Prescription Drug plan, or a*
 8 *MedicareAdvantage organization offering a*
 9 *MedicareAdvantage plan (other than an MSA plan or*
 10 *a private fee-for-service plan that does not provide*
 11 *qualified prescription drug coverage), may enter into*
 12 *an agreement with a State pharmaceutical assistance*
 13 *program described in paragraph (2) to coordinate the*
 14 *coverage provided under the plan with the assistance*
 15 *provided under the State pharmaceutical assistance*
 16 *program.*

17 “(2) *STATE PHARMACEUTICAL ASSISTANCE PRO-*
 18 *GRAM DESCRIBED.—For purposes of paragraph (1), a*
 19 *State pharmaceutical assistance program described in*
 20 *this paragraph is a program that has been established*
 21 *pursuant to a waiver under section 1115 or otherwise.*

22 “(c) *REGULATIONS TO CARRY OUT THIS PART.—*

23 “(1) *AUTHORITY FOR INTERIM FINAL REGULA-*
 24 *TIONS.—The Secretary may promulgate initial regu-*

1 *lations implementing this part in interim final form*
 2 *without prior opportunity for public comment.*

3 (2) *FINAL REGULATIONS.—A final regulation re-*
 4 *flecting public comments must be published within 1*
 5 *year of the interim final regulation promulgated*
 6 *under paragraph (1).”.*

7 (b) *CONFORMING AMENDMENTS TO FEDERAL SUPPLE-*
 8 *MENTARY MEDICAL INSURANCE TRUST FUND.—Section*
 9 *1841 (42 U.S.C. 1395t) is amended—*

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

11 (A) *by striking “and” before “such*
 12 *amounts”; and*

13 (B) *by inserting before the period the fol-*
 14 *lowing: “, and such amounts as may be depos-*
 15 *ited in, or appropriated to, the Prescription*
 16 *Drug Account established by section 1860D–25”;*

17 (2) *in subsection (g), by inserting after “by this*
 18 *part,” the following: “the payments provided for*
 19 *under part D (in which case the payments shall be*
 20 *made from the Prescription Drug Account in the*
 21 *Trust Fund),”;*

22 (3) *in subsection (h), by inserting after*
 23 *“1840(d)” the following: “and sections 1860D–18 and*
 24 *1858A(e) (in which case the payments shall be made*

1 *from the Prescription Drug Account in the Trust*
 2 *Fund)*”; and

3 (4) *in subsection (i), by inserting after “section*
 4 *1840(b)(1)” the following: “, sections 1860D–18 and*
 5 *1858A(e) (in which case the payments shall be made*
 6 *from the Prescription Drug Account in the Trust*
 7 *Fund),”.*

8 (c) *CONFORMING REFERENCES TO PREVIOUS PART*
 9 *D.—Any reference in law (in effect before the date of enact-*
 10 *ment of this Act) to part D of title XVIII of the Social*
 11 *Security Act is deemed a reference to part F of such title*
 12 *(as in effect after such date).*

13 (d) *SUBMISSION OF LEGISLATIVE PROPOSAL.—Not*
 14 *later than 6 months after the date of the enactment of this*
 15 *Act, the Secretary shall submit to the appropriate commit-*
 16 *tees of Congress a legislative proposal providing for such*
 17 *technical and conforming amendments in the law as are*
 18 *required by the provisions of this Act.*

19 **SEC. 102. STUDY AND REPORT ON PERMITTING PART B**
 20 **ONLY INDIVIDUALS TO ENROLL IN MEDICARE**
 21 **VOLUNTARY PRESCRIPTION DRUG DELIVERY**
 22 **PROGRAM.**

23 (a) *STUDY.—The Administrator of the Center for*
 24 *Medicare Choices (as established under section 1808 of the*
 25 *Social Security Act, as added by section 301(a)) shall con-*

1 *duct a study on the need for rules relating to permitting*
 2 *individuals who are enrolled under part B of title XVIII*
 3 *of the Social Security Act but are not entitled to benefits*
 4 *under part A of such title to buy into the medicare vol-*
 5 *untary prescription drug delivery program under part D*
 6 *of such title (as so added).*

7 (b) *REPORT.*—Not later than January 1, 2005, the Ad-
 8 *ministrator of the Center for Medicare Choices shall submit*
 9 *a report to Congress on the study conducted under sub-*
 10 *section (a), together with any recommendations for legisla-*
 11 *tion that the Administrator determines to be appropriate*
 12 *as a result of such study.*

13 **SEC. 103. RULES RELATING TO MEDIGAP POLICIES THAT**
 14 **PROVIDE PRESCRIPTION DRUG COVERAGE.**

15 (a) *RULES RELATING TO MEDIGAP POLICIES THAT*
 16 *PROVIDE PRESCRIPTION DRUG COVERAGE.*—Section 1882
 17 (42 U.S.C. 1395ss) is amended by adding at the end the
 18 *following new subsection:*

19 “(v) *RULES RELATING TO MEDIGAP POLICIES THAT*
 20 *PROVIDE PRESCRIPTION DRUG COVERAGE.*—

21 “(1) *PROHIBITION ON SALE, ISSUANCE, AND RE-*
 22 *NEWAL OF POLICIES THAT PROVIDE PRESCRIPTION*
 23 *DRUG COVERAGE TO PART D ENROLLEES.*—

24 “(A) *IN GENERAL.*—Notwithstanding any
 25 *other provision of law, on or after January 1,*

1 2006, no medicare supplemental policy that pro-
 2 vides coverage of expenses for prescription drugs
 3 may be sold, issued, or renewed under this sec-
 4 tion to an individual who is enrolled under part
 5 D.

6 “(B) *PENALTIES.*—The penalties described
 7 in subsection (d)(3)(A)(ii) shall apply with re-
 8 spect to a violation of subparagraph (A).

9 “(2) *ISSUANCE OF SUBSTITUTE POLICIES IF THE*
 10 *POLICYHOLDER OBTAINS PRESCRIPTION DRUG COV-*
 11 *ERAGE UNDER PART D.*—

12 “(A) *IN GENERAL.*—The issuer of a medi-
 13 care supplemental policy—

14 “(i) may not deny or condition the
 15 issuance or effectiveness of a medicare sup-
 16 plemental policy that has a benefit package
 17 classified as ‘A’, ‘B’, ‘C’, ‘D’, ‘E’, ‘F’ (in-
 18 cluding the benefit package classified as ‘F’
 19 with a high deductible feature, as described
 20 in subsection (p)(11)), or ‘G’ (under the
 21 standards established under subsection
 22 (p)(2)) and that is offered and is available
 23 for issuance to new enrollees by such issuer;

24 “(ii) may not discriminate in the pric-
 25 ing of such policy, because of health status,

1 *claims experience, receipt of health care, or*
 2 *medical condition; and*

3 “(iii) may not impose an exclusion of
 4 *benefits based on a pre-existing condition*
 5 *under such policy,*

6 *in the case of an individual described in sub-*
 7 *paragraph (B) who seeks to enroll under the pol-*
 8 *icy during the open enrollment period established*
 9 *under section 1860D–2(b)(2) and who submits*
 10 *evidence that they meet the requirements under*
 11 *subparagraph (B) along with the application for*
 12 *such medicare supplemental policy.*

13 “(B) *INDIVIDUAL DESCRIBED.*—An indi-
 14 *vidual described in this subparagraph is an in-*
 15 *dividual who—*

16 “(i) enrolls in the medicare prescrip-
 17 *tion drug delivery program under part D;*
 18 *and*

19 “(ii) at the time of such enrollment
 20 *was enrolled and terminates enrollment in*
 21 *a medicare supplemental policy which has a*
 22 *benefit package classified as ‘H’, ‘T’, or ‘J’*
 23 *(including the benefit package classified as*
 24 *‘J’ with a high deductible feature, as de-*
 25 *scribed in section 1882(p)(11)) under the*

1 standards referred to in subparagraph
 2 (A)(i) or terminates enrollment in a policy
 3 to which such standards do not apply but
 4 which provides benefits for prescription
 5 drugs.

6 “(C) *ENFORCEMENT.*—The provisions of
 7 subparagraph (A) shall be enforced as though
 8 they were included in subsection (s).

9 “(3) *NOTICE REQUIRED TO BE PROVIDED TO*
 10 *CURRENT POLICYHOLDERS WITH PRESCRIPTION DRUG*
 11 *COVERAGE.*—No medicare supplemental policy of an
 12 issuer shall be deemed to meet the standards in sub-
 13 section (c) unless the issuer provides written notice
 14 during the 60-day period immediately preceding the
 15 period established for the open enrollment period es-
 16 tablished under section 1860D–2(b)(2), to each indi-
 17 vidual who is a policyholder or certificate holder of
 18 a medicare supplemental policy issued by that issuer
 19 that provides some coverage of expenses for prescrip-
 20 tion drugs (at the most recent available address of
 21 that individual) of—

22 “(A) the ability to enroll in a new medicare
 23 supplemental policy pursuant to paragraph (2);
 24 and

1 “(B) the fact that, so long as such indi-
 2 vidual retains coverage under such policy, the
 3 individual shall be ineligible for coverage of pre-
 4 scription drugs under part D.”.

5 (b) *RULE OF CONSTRUCTION.*—

6 (1) *IN GENERAL.*—Nothing in this Act shall be
 7 construed to require an issuer of a medicare supple-
 8 mental policy under section 1882 of the Social Secu-
 9 rity Act (42 U.S.C. 1395rr) to participate as an eligi-
 10 ble entity under part D of such Act, as added by sec-
 11 tion 101, as a condition for issuing such policy.

12 (2) *PROHIBITION ON STATE REQUIREMENT.*—A
 13 State may not require an issuer of a medicare supple-
 14 mental policy under section 1882 of the Social Secu-
 15 rity Act (42 U.S.C. 1395rr) to participate as an eligi-
 16 ble entity under part D of such Act, as added by sec-
 17 tion 101, as a condition for issuing such policy.

18 **SEC. 104. MEDICAID AND OTHER AMENDMENTS RELATED**
 19 **TO LOW-INCOME BENEFICIARIES.**

20 (a) *DETERMINATIONS OF ELIGIBILITY FOR LOW-IN-*
 21 *COME SUBSIDIES.*—

22 (1) *REQUIREMENT.*—Section 1902 (42 U.S.C.
 23 1396a) is amended—

24 (A) in subsection (a)—

1 (i) by striking “and” at the end of
2 paragraph (64);

3 (ii) by striking the period at the end of
4 paragraph (65) and inserting “; and”; and

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

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

9 (2) NEW SECTION.—Title XIX (42 U.S.C. 1396
10 et seq.) is amended—

11 (A) by redesignating section 1935 as section
12 1936; and

13 (B) by inserting after section 1934 the fol-
14 lowing new section:

15 “SPECIAL PROVISIONS RELATING TO MEDICARE

16 PRESCRIPTION DRUG BENEFIT

17 “SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGI-
18 BILITY DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—

19 As a condition of its State plan under this title under sec-
20 tion 1902(a)(66) and receipt of any Federal financial as-
21 sistance under section 1903(a), a State shall satisfy the fol-
22 lowing:

23 “(1) DETERMINATION OF ELIGIBILITY FOR TRAN-
24 SITIONAL PRESCRIPTION DRUG ASSISTANCE CARD
25 PROGRAM FOR ELIGIBLE LOW-INCOME BENE-
26 FICIARIES.—For purposes of section 1807A, submit to

1 *the Secretary an eligibility plan under which the*
 2 *State—*

3 *“(A) establishes eligibility standards con-*
 4 *sistent with the provisions of that section;*

5 *“(B) establishes procedures for providing*
 6 *presumptive eligibility for eligible low-income*
 7 *beneficiaries (as defined in section 1807A(i)(2))*
 8 *under that section in a manner that is similar*
 9 *to the manner in which presumptive eligibility*
 10 *is provided to children and pregnant women*
 11 *under this title;*

12 *“(C) makes determinations of eligibility*
 13 *and income for purposes of identifying eligible*
 14 *low-income beneficiaries (as so defined) under*
 15 *that section; and*

16 *“(D) communicates to the Secretary deter-*
 17 *minations of eligibility or discontinuation of eli-*
 18 *gibility under that section for purposes of noti-*
 19 *fying prescription drug card sponsors under that*
 20 *section of the identity of eligible medicare low-*
 21 *income beneficiaries.*

22 *“(2) DETERMINATION OF ELIGIBILITY FOR PRE-*
 23 *MIUM AND COST-SHARING SUBSIDIES UNDER PART D*
 24 *OF TITLE XVIII FOR LOW-INCOME INDIVIDUALS.—Be-*

1 *ginning November 1, 2005, for purposes of section*
 2 *1860D–19—*

3 *“(A) make determinations of eligibility for*
 4 *premium and cost-sharing subsidies under and*
 5 *in accordance with such section;*

6 *“(B) establish procedures for providing pre-*
 7 *sumptive eligibility for individuals eligible for*
 8 *subsidies under that section in a manner that is*
 9 *similar to the manner in which presumptive eli-*
 10 *gibility is provided to children and pregnant*
 11 *women under this title;*

12 *“(C) inform the Administrator of the Center*
 13 *for Medicare Choices of such determinations in*
 14 *cases in which such eligibility is established; and*

15 *“(D) otherwise provide such Administrator*
 16 *with such information as may be required to*
 17 *carry out part D of title XVIII (including sec-*
 18 *tion 1860D–19).*

19 *“(3) AGREEMENT TO ESTABLISH INFORMATION*
 20 *AND ENROLLMENT SITES AT SOCIAL SECURITY FIELD*
 21 *OFFICES.—Enter into an agreement with the Com-*
 22 *missioner of Social Security to use all Social Security*
 23 *field offices located in the State as information and*
 24 *enrollment sites for making the eligibility determina-*
 25 *tions required under paragraphs (1) and (2).*

1 “(b) *FEDERAL SUBSIDY OF ADMINISTRATIVE*
2 *COSTS.*—

3 “(1) *ENHANCED MATCH FOR ELIGIBILITY DETER-*
4 *MINATIONS.*—*Subject to paragraphs (2) and (4), with*
5 *respect to calendar quarters beginning on or after*
6 *January 1, 2004, the amounts expended by a State*
7 *in carrying out subsection (a) are expenditures reim-*
8 *bursable under section 1903(a)(7) except that, in ap-*
9 *plying such section with respect to such expenditures*
10 *incurred for—*

11 “(A) *such calendar quarters occurring in*
12 *fiscal year 2004 or 2005, ‘75 percent’ shall be*
13 *substituted for ‘50 per centum’;*

14 “(B) *calendar quarters occurring in fiscal*
15 *year 2006, ‘70 percent’ shall be substituted for*
16 *‘50 per centum’;*

17 “(C) *calendar quarters occurring in fiscal*
18 *year 2007, ‘65 percent’ shall be substituted for*
19 *‘50 per centum’; and*

20 “(D) *calendar quarters occurring in fiscal*
21 *year 2008 or any fiscal year thereafter, ‘60 per-*
22 *cent’ shall be substituted for ‘50 per centum’.*

23 “(2) *100 PERCENT MATCH FOR ELIGIBILITY DE-*
24 *TERMINATIONS FOR SUBSIDY-ELIGIBLE INDIVID-*
25 *UALS.*—*In the case of amounts expended by a State*

1 *on or after November 1, 2005, to determine whether*
 2 *an individual is a subsidy-eligible individual for pur-*
 3 *poses of section 1860D–19, such expenditures shall be*
 4 *reimbursed under section 1903(a)(7) by substituting*
 5 *‘100 percent’ for ‘50 per centum’.*

6 “(3) *ENHANCED MATCH FOR UPDATES OR IM-*
 7 *PROVEMENTS TO ELIGIBILITY DETERMINATION SYS-*
 8 *TEMS.—With respect to calendar quarters occurring*
 9 *in fiscal year 2004, 2005, or 2006, the Secretary, in*
 10 *addition to amounts otherwise paid under section*
 11 *1903(a), shall pay to each State which has a plan ap-*
 12 *proved under this title, for each such quarter an*
 13 *amount equal to 90 percent of so much of the sums*
 14 *expended during such quarter as are attributable to*
 15 *the design, development, acquisition, or installation of*
 16 *improved eligibility determination systems (including*
 17 *hardware and software for such systems) in order to*
 18 *carry out the requirements of subsection (a) and sec-*
 19 *tion 1807A(h)(1). No payment shall be made to a*
 20 *State under the preceding sentence unless the State’s*
 21 *improved eligibility determination system—*

22 “(A) *satisfies such standards for improve-*
 23 *ment as the Secretary may establish; and*

24 “(B) *complies, and is compatible, with the*
 25 *standards established under part C of title XI*

1 *and any regulations promulgated under section*
 2 *264(c) of the Health Insurance Portability and*
 3 *Accountability Act of 1996 (42 U.S.C. 1320d–2*
 4 *note).*

5 “(4) *COORDINATION.—The State shall provide*
 6 *the Secretary with such information as may be nec-*
 7 *essary to properly allocate expenditures described in*
 8 *paragraph (1), (2), or (3) that may otherwise be*
 9 *made for similar eligibility determinations or expend-*
 10 *itures.*

11 “(c) *FEDERAL PAYMENT OF MEDICARE PART B PRE-*
 12 *MIUM FOR STATES PROVIDING PRESCRIPTION DRUG COV-*
 13 *ERAGE FOR DUAL ELIGIBLE INDIVIDUALS.—*

14 “(1) *IN GENERAL.—Subject to paragraph (4), in*
 15 *the case of a State that provides medical assistance*
 16 *for covered drugs (as such term is defined in section*
 17 *1860D(a)(2)) to dual eligible individuals under this*
 18 *title that satisfies the minimum standards described*
 19 *in paragraph (2), the Secretary shall be responsible*
 20 *in accordance with section 1841(f)(2) for paying 100*
 21 *percent of the medicare cost-sharing described in sec-*
 22 *tion 1905(p)(3)(A)(ii) (relating to premiums under*
 23 *section 1839) for individuals—*

24 “(A) *who are dual eligible individuals or*
 25 *qualified medicare beneficiaries; and*

1 “(B) whose family income is at least 74
 2 percent, but not more than 100 percent, of the
 3 poverty line (as defined in section 2110(c)(5))
 4 applicable to a family of the size involved.

5 “(2) MINIMUM STANDARDS DESCRIBED.—For
 6 purposes of paragraph (1), the minimum standards
 7 described in this paragraph are the following:

8 “(A) In providing medical assistance for
 9 dual eligible individuals for such covered drugs,
 10 the State satisfies the requirements of this title
 11 (including limitations on cost-sharing imposed
 12 under section 1916) applicable to the provision
 13 of medical assistance for prescribed drugs to dual
 14 eligible individuals.

15 “(B) In providing medical assistance for
 16 dual eligible individuals for such covered drugs,
 17 the State provides such individuals with bene-
 18 ficiary protections that the Secretary determines
 19 are equivalent to the beneficiary protections ap-
 20 plicable under section 1860D–5 to eligible enti-
 21 ties offering a Medicare Prescription Drug plan
 22 under part D of title XVIII.

23 “(C) In providing medical assistance for
 24 such individuals for such covered drugs, the
 25 State does not impose a limitation on the num-

1 *ber of prescriptions an individual may have*
 2 *filled.*

3 “(3) *NONAPPLICATION.*—*Section 1927(d)(2)(E)*
 4 *shall not apply to a State for purposes of providing*
 5 *medical assistance for covered drugs (as such term is*
 6 *defined in section 1860D(a)(2)) to dual eligible indi-*
 7 *viduals that satisfies the minimum standards de-*
 8 *scribed in paragraph (2).*

9 “(4) *LIMITATION.*—*Paragraph (1) shall not*
 10 *apply to any State before January 1, 2006.*

11 “(d) *FEDERAL PAYMENT OF MEDICARE PART A COST-*
 12 *SHARING FOR CERTAIN STATES.*—

13 “(1) *IN GENERAL.*—*Subject to paragraph (2), in*
 14 *the case of a State that, as of the date of enactment*
 15 *of the Prescription Drug and Medicare Improvement*
 16 *Act of 2003, provides medical assistance for individ-*
 17 *uals described in section 1902(a)(10)(A)(ii)(X), the*
 18 *Secretary shall be responsible in accordance with sec-*
 19 *tion 1817(g)(2), for paying 100 percent of the medi-*
 20 *care cost-sharing described in subparagraphs (B) and*
 21 *(C) of section 1905(p)(3) (relating to coinsurance*
 22 *and deductibles established under title XVIII) for the*
 23 *individuals provided medical assistance under section*
 24 *1902(a)(10)(A)(ii)(X), but only—*

1 “(A) with respect to such medicare cost-
 2 sharing that is incurred under part A of title
 3 XVIII; and

4 “(B) for so long as the State elects to pro-
 5 vide medical assistance under section
 6 1902(a)(10)(A)(ii)(X).

7 “(2) LIMITATION.—Paragraph (1) shall not
 8 apply to any State before January 1, 2006.

9 “(e) TREATMENT OF TERRITORIES.—

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

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

14 “(B) if the State establishes a plan de-
 15 scribed in paragraph (2), the amount otherwise
 16 determined under section 1108(f) (as increased
 17 under section 1108(g)) for the State shall be fur-
 18 ther increased by the amount specified in para-
 19 graph (3).

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

22 “(A) provides medical assistance with re-
 23 spect to the provision of covered drugs (as de-
 24 fined in section 1860D(a)(2)) to individuals de-

1 scribed in subparagraph (A), (B), (C), or (D) of
2 section 1860D–19(a)(3); and

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

7 “(3) INCREASED AMOUNT.—

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

11 “(i) the aggregate amount specified in
12 subparagraph (B); and

13 “(ii) the amount specified in section
14 1108(g)(1) for that State, divided by the
15 sum of the amounts specified in such section
16 for all such States.

17 “(B) AGGREGATE AMOUNT.—The aggregate
18 amount specified in this subparagraph for—

19 “(i) the last 3 quarters of fiscal year
20 2006, is equal to \$22,500,000;

21 “(ii) fiscal year 2007, is equal to
22 \$30,000,000; and

23 “(iii) any subsequent fiscal year, is
24 equal to the aggregate amount specified in
25 this subparagraph for the previous fiscal

1 year increased by the annual percentage in-
 2 crease specified in section 1860D–6(c)(5) for
 3 the calendar year beginning in such fiscal
 4 year.

5 “(4) *NONAPPLICATION.*—Section 1927(d)(2)(E)
 6 shall not apply to a State described in paragraph (1)
 7 for purposes of providing medical assistance described
 8 in paragraph (2)(A).

9 “(5) *REPORT.*—The Secretary shall submit to
 10 Congress a report on the application of this subsection
 11 and may include in the report such recommendations
 12 as the Secretary deems appropriate.”.

13 “(f) *DEFINITIONS.*—For purposes of this section, the
 14 terms ‘qualified medicare beneficiary’, ‘subsidy-eligible in-
 15 dividual’, and ‘dual eligible individual’ have the meanings
 16 given such terms in subparagraphs (A), (D), and (E), re-
 17 spectively, of section 1860D–19(a)(4).”.

18 (B) *CONFORMING AMENDMENT.*—Section
 19 1108(f) (42 U.S.C. 1308(f)) is amended by in-
 20 serting “and section 1935(e)(1)(B)” after “Sub-
 21 ject to subsection (g)”.

22 (3) *TRANSFER OF FEDERALLY ASSUMED POR-*
 23 *TIONS OF MEDICARE COST-SHARING.*—

24 (A) *TRANSFER OF ASSUMPTION OF PART B*
 25 *PREMIUM FOR STATES PROVIDING PRESCRIPTION*

1 *DRUG COVERAGE FOR DUAL ELIGIBLE INDIVID-*
 2 *UALS TO THE FEDERAL SUPPLEMENTARY MED-*
 3 *ICAL INSURANCE TRUST FUND.—Section 1841(f)*
 4 *(42 U.S.C. 1395t(f)) is amended—*

5 *(i) by inserting “(1)” after “(f)”;* and

6 *(ii) by adding at the end the following*

7 *new paragraph:*

8 *“(2) There shall be transferred periodically (but not*
 9 *less often than once each fiscal year) to the Trust Fund from*
 10 *the Treasury amounts which the Secretary of Health and*
 11 *Human Services shall have certified are equivalent to the*
 12 *amounts determined under section 1935(c)(1) with respect*
 13 *to all States for a fiscal year.”.*

14 *(B) TRANSFER OF ASSUMPTION OF PART A*
 15 *COST-SHARING FOR CERTAIN STATES.—Section*
 16 *1817(g) (42 U.S.C. 1395i(g)) is amended—*

17 *(i) by inserting “(1)” after “(g)”;* and

18 *(ii) by adding at the end the following*

19 *new paragraph:*

20 *“(2) There shall be transferred periodically (but not*
 21 *less often than once each fiscal year) to the Trust Fund from*
 22 *the Treasury amounts which the Secretary of Health and*
 23 *Human Services shall have certified are equivalent to the*
 24 *amounts determined under section 1935(d)(1) with respect*
 25 *to certain States for a fiscal year.”.*

1 (4) *AMENDMENT TO BEST PRICE.*—Section
 2 1927(c)(1)(C)(i) (42 U.S.C. 1396r–8(c)(1)(C)(i)), as
 3 amended by section 111(b), is amended—

4 (A) by striking “and” at the end of sub-
 5 clause (IV);

6 (B) by striking the period at the end of sub-
 7 clause (V) and inserting “; and”; and

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

10 “(VI) any prices charged which
 11 are negotiated under a Medicare Pre-
 12 scription Drug plan under part D of
 13 title XVIII with respect to covered
 14 drugs, under a Medicare Advantage
 15 plan under part C of such title with
 16 respect to such drugs, or under a quali-
 17 fied retiree prescription drug plan (as
 18 defined in section 1860D–20(f)(1))
 19 with respect to such drugs, on behalf of
 20 eligible beneficiaries (as defined in sec-
 21 tion 1860D(a)(3))”.

22 (c) *EXTENSION OF MEDICARE COST-SHARING FOR*
 23 *PART B PREMIUM FOR QUALIFYING INDIVIDUALS*
 24 *THROUGH 2008.*—

1 (1) *IN GENERAL.*—Section 1902(a)(10)(E)(iv)
 2 (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended to read
 3 as follows:

4 “(iv) subject to sections 1933 and
 5 1905(p)(4), for making medical assistance avail-
 6 able (but only for premiums payable with respect
 7 to months during the period beginning with Jan-
 8 uary 1998, and ending with December 2008) for
 9 medicare cost-sharing described in section
 10 1905(p)(3)(A)(ii) for individuals who would be
 11 qualified medicare beneficiaries described in sec-
 12 tion 1905(p)(1) but for the fact that their income
 13 exceeds the income level established by the State
 14 under section 1905(p)(2) and is at least 120 per-
 15 cent, but less than 135 percent, of the official
 16 poverty line (referred to in such section) for a
 17 family of the size involved and who are not oth-
 18 erwise eligible for medical assistance under the
 19 State plan;”.

20 (2) *TOTAL AMOUNT AVAILABLE FOR ALLOCA-*
 21 *TION.*—Section 1933(c) (42 U.S.C. 1396u–3(c)) is
 22 amended—

23 (A) in paragraph (1)—

24 (i) in subparagraph (D), by striking

25 “and” at the end;

1 (ii) in subparagraph (E)—

2 (I) by striking “fiscal year 2002”

3 and inserting “each of fiscal years

4 2002 through 2008”; and

5 (II) by striking the period and in-

6 serting “; and”; and

7 (iii) by adding at the end the following

8 new subparagraph:

9 “(F) the first quarter of fiscal year 2009,

10 \$100,000,000.”; and

11 (B) in paragraph (2)(A), by striking “the

12 sum of” and all that follows through

13 “1902(a)(10)(E)(iv)(II) in the State; to” and in-

14 serting “twice the total number of individuals

15 described in section 1902(a)(10)(E)(iv) in the

16 State; to”.

17 (d) *OUTREACH BY THE COMMISSIONER OF SOCIAL SE-*

18 *CURITY.*—Section 1144 (42 U.S.C. 1320b–14) is amended—

19 (1) in the section heading, by inserting “AND

20 *SUBSIDIES FOR LOW-INCOME INDIVIDUALS UNDER*

21 *TITLE XVIII*” after “*COST-SHARING*”;

22 (2) in subsection (a)—

23 (A) in paragraph (1)—

24 (i) in subparagraph (A), by inserting

25 “for the transitional prescription drug as-

1 *sistance card program under section 1807A,*
 2 *or for premium and cost-sharing subsidies*
 3 *under section 1860D–19” before the semi-*
 4 *colon; and*

5 *(ii) in subparagraph (B), by inserting*
 6 *“, program, and subsidies” after “medical*
 7 *assistance”; and*
 8 *(B) in paragraph (2)—*

9 *(i) in the matter preceding subpara-*
 10 *graph (A), by inserting “, the transitional*
 11 *prescription drug assistance card program*
 12 *under section 1807A, or premium and cost-*
 13 *sharing subsidies under section 1860D–19”*
 14 *after “assistance”; and*

15 *(ii) in subparagraph (A), by striking*
 16 *“such eligibility” and inserting “eligibility*
 17 *for medicare cost-sharing under the med-*
 18 *icaid program”; and*

19 *(3) in subsection (b)—*

20 *(A) in paragraph (1)(A), by inserting “, for*
 21 *the transitional prescription drug assistance*
 22 *card program under section 1807A, or for pre-*
 23 *mium and cost-sharing subsidies for low-income*
 24 *individuals under section 1860D–19” after*
 25 *“1933”; and*

1 (B) in paragraph (2), by inserting “, pro-
2 gram, and subsidies” after “medical assistance”.

3 (e) *REPORT REGARDING VOLUNTARY ENROLLMENT OF*
4 *DUAL ELIGIBLE INDIVIDUALS IN PART D.*—Not later than
5 January 1, 2005, the Secretary shall submit a report to
6 Congress that contains such recommendations for legisla-
7 tion as the Secretary determines are necessary in order to
8 establish a voluntary option for dual eligible individuals
9 (as defined in 1860D–19(a)(4)(E) of the Social Security
10 Act (as added by section 101)) to enroll under part D of
11 title XVIII of such Act for prescription drug coverage.

12 **SEC. 105. EXPANSION OF MEMBERSHIP AND DUTIES OF**
13 **MEDICARE PAYMENT ADVISORY COMMISSION**
14 **(MEDPAC).**

15 (a) *EXPANSION OF MEMBERSHIP.*—

16 (1) *IN GENERAL.*—Section 1805(c) (42 U.S.C.
17 1395b–6(c)) is amended—

18 (A) in paragraph (1), by striking “17” and
19 inserting “19”; and

20 (B) in paragraph (2)(B), by inserting “ex-
21 perts in the area of pharmacology and prescrip-
22 tion drug benefit programs,” after “other health
23 professionals,”.

24 (2) *INITIAL TERMS OF ADDITIONAL MEMBERS.*—

1 (A) *IN GENERAL.*—For purposes of stag-
 2 gering the initial terms of members of the Medi-
 3 care Payment Advisory Commission under sec-
 4 tion 1805(c)(3) of the Social Security Act (42
 5 U.S.C. 1395b–6(c)(3)), the initial terms of the 2
 6 additional members of the Commission provided
 7 for by the amendment under paragraph (1)(A)
 8 are as follows:

9 (i) One member shall be appointed for
 10 1 year.

11 (ii) One member shall be appointed for
 12 2 years.

13 (B) *COMMENCEMENT OF TERMS.*—Such
 14 terms shall begin on January 1, 2005.

15 (b) *EXPANSION OF DUTIES.*—Section 1805(b)(2) (42
 16 U.S.C. 1395b–6(b)(2)) is amended by adding at the end the
 17 following new subparagraph:

18 “(D) *VOLUNTARY PRESCRIPTION DRUG DE-*
 19 *LIVERY PROGRAM.*—Specifically, the Commission
 20 shall review, with respect to the voluntary pre-
 21 scription drug delivery program under part D,
 22 competition among eligible entities offering
 23 Medicare Prescription Drug plans and bene-
 24 ficiary access to such plans and covered drugs,
 25 particularly in rural areas.”.

1 **SEC. 106. STUDY REGARDING VARIATIONS IN SPENDING**
2 **AND DRUG UTILIZATION.**

3 (a) *STUDY.*—The Secretary shall study on an ongoing
4 basis variations in spending and drug utilization under
5 part D of title XVIII of the Social Security Act for covered
6 drugs to determine the impact of such variations on pre-
7 miums imposed by eligible entities offering Medicare Pre-
8 scription Drug plans under that part. In conducting such
9 study, the Secretary shall examine the impact of geographic
10 adjustments of the monthly national average premium
11 under section 1860D–15 of such Act on—

12 (1) maximization of competition under part D of
13 title XVIII of such Act; and

14 (2) the ability of eligible entities offering Medi-
15 care Prescription Drug plans to contain costs for cov-
16 ered drugs.

17 (b) *REPORT.*—Beginning with 2007, the Secretary
18 shall submit annual reports to Congress on the study re-
19 quired under subsection (a).

1 ***Subtitle B—Medicare Prescription***
 2 ***Drug Discount Card and Transi-***
 3 ***tional Assistance for Low-In-***
 4 ***come Beneficiaries***

5 ***SEC. 111. MEDICARE PRESCRIPTION DRUG DISCOUNT CARD***
 6 ***AND TRANSITIONAL ASSISTANCE FOR LOW-***
 7 ***INCOME BENEFICIARIES.***

8 *(a) IN GENERAL.—Title XVIII is amended by insert-*
 9 *ing after section 1806 the following new sections:*

10 *“MEDICARE PRESCRIPTION DRUG DISCOUNT CARD*
 11 *ENDORSEMENT PROGRAM*

12 *“SEC. 1807. (a) ESTABLISHMENT.—There is estab-*
 13 *lished a medicare prescription drug discount card endorse-*
 14 *ment program under which the Secretary shall—*

15 *“(1) endorse prescription drug discount card*
 16 *programs offered by prescription drug card sponsors*
 17 *that meet the requirements of this section; and*

18 *“(2) make available to eligible beneficiaries in-*
 19 *formation regarding such endorsed programs.*

20 *“(b) ELIGIBILITY, ELECTION OF PROGRAM, AND EN-*
 21 *ROLLMENT FEES.—*

22 *“(1) ELIGIBILITY AND ELECTION OF PROGRAM.—*

23 *“(A) IN GENERAL.—Subject to subpara-*
 24 *graph (B), the Secretary shall establish proce-*
 25 *dures—*

1 “(i) for identifying eligible bene-
2 ficiaries; and

3 “(ii) under which such beneficiaries
4 may make an election to enroll in any pre-
5 scription drug discount card program en-
6 dorsed under this section and disenroll from
7 such a program.

8 “(B) *LIMITATION.*—An eligible beneficiary
9 may not be enrolled in more than 1 prescription
10 drug discount card program at any time.

11 “(2) *ENROLLMENT FEES.*—

12 “(A) *IN GENERAL.*—A prescription drug
13 card sponsor may charge an annual enrollment
14 fee to each eligible beneficiary enrolled in a pre-
15 scription drug discount card program offered by
16 such sponsor.

17 “(B) *AMOUNT.*—No enrollment fee charged
18 under subparagraph (A) may exceed \$25.

19 “(C) *UNIFORM ENROLLMENT FEE.*—A pre-
20 scription drug card sponsor shall ensure that the
21 enrollment fee for a prescription drug discount
22 card program endorsed under this section is the
23 same for all eligible medicare beneficiaries en-
24 rolled in the program.

1 “(D) *COLLECTION.*—*Any enrollment fee*
 2 *shall be collected by the prescription drug card*
 3 *sponsor.*

4 “(c) *PROVIDING INFORMATION TO ELIGIBLE BENE-*
 5 *FICIARIES.*—

6 “(1) *PROMOTION OF INFORMED CHOICE.*—

7 “(A) *BY THE SECRETARY.*—*In order to pro-*
 8 *mote informed choice among endorsed prescrip-*
 9 *tion drug discount card programs, the Secretary*
 10 *shall provide for the dissemination of informa-*
 11 *tion which compares the costs and benefits of*
 12 *such programs. Such dissemination shall be co-*
 13 *ordinated with the dissemination of educational*
 14 *information on other medicare options.*

15 “(B) *BY PRESCRIPTION DRUG CARD SPON-*
 16 *SORS.*—*Each prescription drug card sponsor*
 17 *shall make available to each eligible beneficiary*
 18 *(through the Internet and otherwise) informa-*
 19 *tion—*

20 “(i) *that the Secretary identifies as*
 21 *being necessary to promote informed choice*
 22 *among endorsed prescription drug discount*
 23 *card programs by eligible beneficiaries, in-*
 24 *cluding information on enrollment fees, ne-*
 25 *gotiated prices for prescription drugs*

1 *charged to beneficiaries, and services relat-*
 2 *ing to prescription drugs offered under the*
 3 *program;*

4 “(ii) *on how any formulary used by*
 5 *such sponsor functions.*

6 “(2) *USE OF MEDICARE TOLL-FREE NUMBER.—*
 7 *The Secretary shall provide through the 1-800-MEDI-*
 8 *CARE toll free telephone number for the receipt and*
 9 *response to inquiries and complaints concerning the*
 10 *medicare prescription drug discount card endorse-*
 11 *ment program established under this section and pre-*
 12 *scription drug discount card programs endorsed*
 13 *under such program.*

14 “(d) *BENEFICIARY PROTECTIONS.—*

15 “(1) *IN GENERAL.—Each prescription drug dis-*
 16 *count card program endorsed under this section shall*
 17 *meet such requirements as the Secretary identifies to*
 18 *protect and promote the interest of eligible bene-*
 19 *ficiaries, including requirements that—*

20 “(A) *relate to appeals by eligible bene-*
 21 *ficiaries and marketing practices; and*

22 “(B) *ensure that beneficiaries are not*
 23 *charged more than the lower of the negotiated re-*
 24 *tail price or the usual and customary price.*

1 “(2) *ENSURING PHARMACY ACCESS.*—Each pre-
2 scription drug card sponsor offering a prescription
3 drug discount card program endorsed under this sec-
4 tion shall secure the participation in its network of
5 a sufficient number of pharmacies that dispense
6 (other than by mail order) drugs directly to patients
7 to ensure convenient access (as determined by the Sec-
8 retary and including adequate emergency access) for
9 enrolled beneficiaries. Such standards shall take into
10 account reasonable distances to pharmacy services in
11 both urban and rural areas.

12 “(3) *QUALITY ASSURANCE.*—Each prescription
13 drug card sponsor offering a prescription drug dis-
14 count card program endorsed under this section shall
15 have in place adequate procedures for assuring that
16 quality service is provided to eligible beneficiaries en-
17 rolled in a prescription drug discount card program
18 offered by such sponsor.

19 “(4) *CONFIDENTIALITY OF ENROLLEE*
20 *RECORDS.*—Insofar as a prescription drug card spon-
21 sor maintains individually identifiable medical
22 records or other health information regarding eligible
23 beneficiaries enrolled in a prescription drug discount
24 card program endorsed under this section, the pre-
25 scription drug card sponsor shall have in place proce-

1 *dures to safeguard the privacy of any individually*
 2 *identifiable beneficiary information in a manner that*
 3 *the Secretary determines is consistent with the Fed-*
 4 *eral regulations (concerning the privacy of individ-*
 5 *ually identifiable health information) promulgated*
 6 *under section 264(c) of the Health Insurance Port-*
 7 *ability and Accountability Act of 1996.*

8 “(5) *NO OTHER FEES.*—A prescription drug
 9 card sponsor may not charge any fee to an eligible
 10 beneficiary under a prescription drug discount card
 11 program endorsed under this section other than an
 12 enrollment fee charged under subsection (b)(2)(A).

13 “(6) *PRICES.*—

14 “(A) *AVOIDANCE OF HIGH PRICED*
 15 *DRUGS.*—A prescription drug card sponsor may
 16 not recommend switching an eligible beneficiary
 17 to a drug with a higher negotiated price absent
 18 a recommendation by a licensed health profes-
 19 sional that there is a clinical indication with re-
 20 spect to the patient for such a switch.

21 “(B) *PRICE STABILITY.*—Negotiated prices
 22 charged for prescription drugs covered under a
 23 prescription drug discount card program en-
 24 dorsed under this section may not change more
 25 frequently than once every 60 days.

1 “(e) *PRESCRIPTION DRUG BENEFITS.*—

2 “(1) *IN GENERAL.*—Each prescription drug card
3 sponsor may only provide benefits that relate to pre-
4 scription drugs (as defined in subsection (i)(2)) under
5 a prescription drug discount card program endorsed
6 under this section.

7 “(2) *SAVINGS TO ELIGIBLE BENEFICIARIES.*—

8 “(A) *IN GENERAL.*—Subject to subpara-
9 graph (D), each prescription drug card sponsor
10 shall provide eligible beneficiaries who enroll in
11 a prescription drug discount card program of-
12 fered by such sponsor that is endorsed under this
13 section with access to negotiated prices used by
14 the sponsor with respect to prescription drugs
15 dispensed to eligible beneficiaries.

16 “(B) *INAPPLICABILITY OF MEDICAID BEST*
17 *PRICE RULES.*—The requirements of section 1927
18 relating to manufacturer best price shall not
19 apply to the negotiated prices for prescription
20 drugs made available under a prescription drug
21 discount card program endorsed under this sec-
22 tion.

23 “(C) *GUARANTEED ACCESS TO NEGOTIATED*
24 *PRICES.*—The Secretary, in consultation with the
25 Inspector General of the Department of Health

1 *and Human Services, shall establish procedures*
 2 *to ensure that eligible beneficiaries have access to*
 3 *the negotiated prices for prescription drugs pro-*
 4 *vided under subparagraph (A).*

5 “(D) *APPLICATION OF FORMULARY RE-*
 6 *STRICTIONS.—A drug prescribed for an eligible*
 7 *beneficiary that would otherwise be a covered*
 8 *drug under this section shall not be so considered*
 9 *under a prescription drug discount card pro-*
 10 *gram if the program excludes the drug under a*
 11 *formulary.*

12 “(3) *BENEFICIARY SERVICES.—Each prescrip-*
 13 *tion drug discount card program endorsed under this*
 14 *section shall provide pharmaceutical support services,*
 15 *such as education, counseling, and services to prevent*
 16 *adverse drug interactions.*

17 “(4) *DISCOUNT CARDS.—Each prescription drug*
 18 *card sponsor shall issue a card to eligible beneficiaries*
 19 *enrolled in a prescription drug discount card pro-*
 20 *gram offered by such sponsor that the beneficiary may*
 21 *use to obtain benefits under the program.*

22 “(f) *SUBMISSION OF APPLICATIONS FOR ENDORSE-*
 23 *MENT AND APPROVAL.—*

24 “(1) *SUBMISSION OF APPLICATIONS FOR EN-*
 25 *DORSEMENT.—Each prescription drug card sponsor*

1 *that seeks endorsement of a prescription drug dis-*
 2 *count card program under this section shall submit*
 3 *to the Secretary, at such time and in such manner*
 4 *as the Secretary may specify, such information as the*
 5 *Secretary may require.*

6 “(2) *APPROVAL.*—*The Secretary shall review the*
 7 *information submitted under paragraph (1) and shall*
 8 *determine whether to endorse the prescription drug*
 9 *discount card program to which such information re-*
 10 *lates. The Secretary may not approve a program un-*
 11 *less the program and prescription drug card sponsor*
 12 *offering the program comply with the requirements*
 13 *under this section.*

14 “(g) *REQUIREMENTS ON DEVELOPMENT AND APPLICA-*
 15 *TION OF FORMULARIES.*—*If a prescription drug card spon-*
 16 *sor offering a prescription drug discount card program uses*
 17 *a formulary, the following requirements must be met:*

18 “(1) *PHARMACY AND THERAPEUTIC (P&T) COM-*
 19 *MITTEE.*—

20 “(A) *IN GENERAL.*—*The eligible entity must*
 21 *establish a pharmacy and therapeutic committee*
 22 *that develops and reviews the formulary.*

23 “(B) *COMPOSITION.*—*A pharmacy and*
 24 *therapeutic committee shall include at least 1*
 25 *academic expert, at least 1 practicing physician,*

1 *and at least 1 practicing pharmacist, all of*
 2 *whom have expertise in the care of elderly or dis-*
 3 *abled persons, and a majority of the members of*
 4 *such committee shall consist of individuals who*
 5 *are a practicing physician or a practicing phar-*
 6 *macist (or both).*

7 “(2) *FORMULARY DEVELOPMENT.*—*In developing*
 8 *and reviewing the formulary, the committee shall base*
 9 *clinical decisions on the strength of scientific evidence*
 10 *and standards of practice, including assessing peer-*
 11 *reviewed medical literature, such as randomized clin-*
 12 *ical trials, pharmacoeconomic studies, outcomes re-*
 13 *search data, and such other information as the com-*
 14 *mittee determines to be appropriate.*

15 “(3) *INCLUSION OF DRUGS IN ALL THERAPEUTIC*
 16 *CATEGORIES AND CLASSES.*—

17 “(A) *IN GENERAL.*—*The formulary must in-*
 18 *clude drugs within each therapeutic category and*
 19 *class of covered outpatient drugs (as defined by*
 20 *the Secretary), although not necessarily for all*
 21 *drugs within such categories and classes.*

22 “(B) *REQUIREMENT.*—*In defining thera-*
 23 *peutic categories and classes of covered out-*
 24 *patient drugs pursuant to subparagraph (A), the*
 25 *Secretary shall use the compendia referred to sec-*

1 *tion 1927(g)(1)(B)(i) or other recognized sources*
 2 *for categorizing drug therapeutic categories and*
 3 *classes.*

4 “(4) *PROVIDER EDUCATION.*—*The committee*
 5 *shall establish policies and procedures to educate and*
 6 *inform health care providers concerning the for-*
 7 *mulary.*

8 “(5) *NOTICE BEFORE REMOVING DRUGS FROM*
 9 *FORMULARY.*—*Any removal of a drug from a for-*
 10 *mulary shall take effect only after appropriate notice*
 11 *is made available to beneficiaries and pharmacies.*

12 “(h) *FRAUD AND ABUSE PREVENTION.*—

13 “(1) *IN GENERAL.*—*The Secretary shall provide*
 14 *appropriate oversight to ensure compliance of en-*
 15 *dorsed programs with the requirements of this section,*
 16 *including verification of the negotiated prices and*
 17 *services provided.*

18 “(2) *DISQUALIFICATION FOR ABUSIVE PRAC-*
 19 *TICES.*—*The Secretary may implement intermediate*
 20 *sanctions and may revoke the endorsement of a pro-*
 21 *gram that the Secretary determines no longer meets*
 22 *the requirements of this section or that has engaged*
 23 *in false or misleading marketing practices.*

24 “(3) *AUTHORITY WITH RESPECT TO CIVIL MONEY*
 25 *PENALTIES.*—*The Secretary may impose a civil*

1 *money penalty in an amount not to exceed \$10,000*
 2 *for any violation of this section. The provisions of sec-*
 3 *tion 1128A (other than subsections (a) and (b)) shall*
 4 *apply to a civil money penalty under the previous*
 5 *sentence in the same manner as such provisions apply*
 6 *to a penalty or proceeding under section 1128A(a).*

7 “(4) *REPORTING TO SECRETARY.*—*Each pre-*
 8 *scription drug card sponsor offering a prescription*
 9 *drug discount card program endorsed under this sec-*
 10 *tion shall report information relating to program per-*
 11 *formance, use of prescription drugs by eligible bene-*
 12 *ficiaries enrolled in the program, financial informa-*
 13 *tion of the sponsor, and such other information as the*
 14 *Secretary may specify. The Secretary may not dis-*
 15 *close any proprietary data reported under this para-*
 16 *graph.*

17 “(5) *DRUG UTILIZATION REVIEW.*—*The Sec-*
 18 *retary may use claims data from parts A and B for*
 19 *purposes of conducting a drug utilization review pro-*
 20 *gram.*

21 “(i) *DEFINITIONS.*—*In this section:*

22 “(1) *ELIGIBLE BENEFICIARY.*—

23 “(A) *IN GENERAL.*—*The term ‘eligible bene-*
 24 *ficiary’ means an individual who—*

1 “(i) is entitled to, or enrolled for, benefits
2 under part A and enrolled under part B; and

3 “(ii) is not a dual eligible individual
4 (as defined in subparagraph (B)).

5 “(B) DUAL ELIGIBLE INDIVIDUAL.—

6 “(i) IN GENERAL.—The term ‘dual eli-
7 gible individual’ means an individual who
8 is—

9 “(I) enrolled under title XIX or
10 under a waiver under section 1115 of
11 the requirements of such title for med-
12 ical assistance that is not less than the
13 medical assistance provided to an indi-
14 vidual described in section
15 1902(a)(10)(A)(i) and includes covered
16 outpatient drugs (as such term is de-
17 fined for purposes of section 1927); and

18 “(II) entitled to benefits under
19 part A and enrolled under part B.

20 “(ii) INCLUSION OF MEDICALLY
21 NEEDY.—Such term includes an individual
22 described in section 1902(a)(10)(C).

23 “(2) PRESCRIPTION DRUG.—

1 “(A) *IN GENERAL.*—*Except as provided in*
 2 *subparagraph (B), the term ‘prescription drug’*
 3 *means—*

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

8 “(ii) *a biological product or insulin*
 9 *described in subparagraph (B) or (C) of*
 10 *such section,*

11 *and such term includes a vaccine licensed under*
 12 *section 351 of the Public Health Service Act and*
 13 *any use of a covered outpatient drug for a medi-*
 14 *cally accepted indication (as defined in section*
 15 *1927(k)(6)).*

16 “(B) *EXCLUSIONS.*—*The term ‘prescription*
 17 *drug’ does not include drugs or classes of drugs,*
 18 *or their medical uses, which may be excluded*
 19 *from coverage or otherwise restricted under sec-*
 20 *tion 1927(d)(2), other than subparagraph (E)*
 21 *thereof (relating to smoking cessation agents), or*
 22 *under section 1927(d)(3).*

23 “(3) *NEGOTIATED PRICE.*—*The term ‘negotiated*
 24 *price’ includes all discounts, direct or indirect sub-*

1 *sidies, rebates, price concessions, and direct or indi-*
 2 *rect remunerations.*

3 “(4) *PRESCRIPTION DRUG CARD SPONSOR.*—*The*
 4 *term ‘prescription drug card sponsor’ means any en-*
 5 *tity with demonstrated experience and expertise in*
 6 *operating a prescription drug discount card program,*
 7 *an insurance program that provides coverage for pre-*
 8 *scription drugs, or a similar program that the Sec-*
 9 *retary determines to be appropriate to provide eligible*
 10 *beneficiaries with the benefits under a prescription*
 11 *drug discount card program endorsed by the Sec-*
 12 *retary under this section, including—*

13 “(A) *a pharmaceutical benefit management*
 14 *company;*

15 “(B) *a wholesale or retail pharmacist deliv-*
 16 *ery system;*

17 “(C) *an insurer (including an insurer that*
 18 *offers medicare supplemental policies under sec-*
 19 *tion 1882);*

20 “(D) *any other entity; or*

21 “(E) *any combination of the entities de-*
 22 *scribed in subparagraphs (A) through (D).*

23 “*TRANSITIONAL PRESCRIPTION DRUG ASSISTANCE CARD*
 24 *PROGRAM FOR ELIGIBLE LOW-INCOME BENEFICIARIES*

25 “*SEC. 1807A. (a) ESTABLISHMENT.*—

1 “(1) *IN GENERAL.*—*There is established a pro-*
 2 *gram under which the Secretary shall award con-*
 3 *tracts to prescription drug card sponsors offering a*
 4 *prescription drug discount card that has been en-*
 5 *dorsed by the Secretary under section 1807 under*
 6 *which such sponsors shall offer a prescription drug*
 7 *assistance card program to eligible low-income bene-*
 8 *ficiaries in accordance with the requirements of this*
 9 *section.*

10 “(2) *APPLICATION OF DISCOUNT CARD PROVI-*
 11 *SIONS.*—*Except as otherwise provided in this section,*
 12 *the provisions of section 1807 shall apply to the pro-*
 13 *gram established under this section.*

14 “(b) *ELIGIBILITY, ELECTION OF PROGRAM, AND EN-*
 15 *ROLLMENT FEES.*—

16 “(1) *ELIGIBILITY AND ELECTION OF PROGRAM.*—

17 “(A) *IN GENERAL.*—*Subject to the suc-*
 18 *ceeding provisions of this paragraph, the enroll-*
 19 *ment procedures established under section*
 20 *1807(b)(1)(A)(ii) shall apply for purposes of this*
 21 *section.*

22 “(B) *ENROLLMENT OF ANY ELIGIBLE LOW-*
 23 *INCOME BENEFICIARY.*—*Each prescription drug*
 24 *card sponsor offering a prescription drug assist-*
 25 *ance card program under this section shall per-*

mit any eligible low-income beneficiary to enroll in such program if it serves the geographic area in which the beneficiary resides.

“(C) *SIMULTANEOUS ENROLLMENT IN PRESCRIPTION DRUG DISCOUNT CARD PROGRAM.*—An eligible low-income beneficiary who enrolls in a prescription drug assistance card program offered by a prescription drug card sponsor under this section shall be simultaneously enrolled in a prescription drug discount card program offered by such sponsor.

“(2) *WAIVER OF ENROLLMENT FEES.*—

“(A) *IN GENERAL.*—A prescription drug card sponsor may not charge an enrollment fee to any eligible low-income beneficiary enrolled in a prescription drug discount card program offered by such sponsor.

“(B) *PAYMENT BY SECRETARY.*—Under a contract awarded under subsection (f)(2), the Secretary shall pay to each prescription drug card sponsor an amount equal to any enrollment fee charged under section 1807(b)(2)(A) on behalf of each eligible low-income beneficiary enrolled in a prescription drug discount card program under paragraph (1)(C) offered by such sponsor.

1 “(c) *ADDITIONAL BENEFICIARY PROTECTIONS.*—

2 “(1) *PROVIDING INFORMATION TO ELIGIBLE*
 3 *LOW-INCOME BENEFICIARIES.*—*In addition to the in-*
 4 *formation provided to eligible beneficiaries under sec-*
 5 *tion 1807(c), the prescription drug card sponsor*
 6 *shall—*

7 “(A) *periodically notify each eligible low-in-*
 8 *come beneficiary enrolled in a prescription drug*
 9 *assistance card program offered by such sponsor*
 10 *of the amount of coverage for prescription drugs*
 11 *remaining under subsection (d)(2)(A); and*

12 “(B) *notify each eligible low-income bene-*
 13 *ficiary enrolled in a prescription drug assistance*
 14 *card program offered by such sponsor of the*
 15 *grievance and appeals processes under the pro-*
 16 *gram.*

17 “(2) *CONVENIENT ACCESS IN LONG-TERM CARE*
 18 *FACILITIES.*—*For purposes of determining whether*
 19 *convenient access has been provided under section*
 20 *1807(d)(2) with respect to eligible low-income bene-*
 21 *ficiaries enrolled in a prescription drug assistance*
 22 *card program, the Secretary may only make a deter-*
 23 *mination that such access has been provided if an ap-*
 24 *propriate arrangement is in place for eligible low-in-*
 25 *come beneficiaries who are in a long-term care facil-*

1 *ity (as defined by the Secretary) to receive prescrip-*
 2 *tion drug benefits under the program.*

3 “(3) *COORDINATION OF BENEFITS.*—

4 “(A) *IN GENERAL.*—*The Secretary shall es-*
 5 *tablish procedures under which eligible low-in-*
 6 *come beneficiaries who are enrolled for coverage*
 7 *described in subparagraph (B) and enrolled in a*
 8 *prescription drug assistance card program have*
 9 *access to the prescription drug benefits available*
 10 *under such program.*

11 “(B) *COVERAGE DESCRIBED.*—*Coverage de-*
 12 *scribed in this subparagraph is as follows:*

13 “(i) *Coverage of prescription drugs*
 14 *under a State pharmaceutical assistance*
 15 *program.*

16 “(ii) *Enrollment in a*
 17 *Medicare+Choice plan under part C.*

18 “(4) *GRIEVANCE MECHANISM.*—*Each prescrip-*
 19 *tion drug card sponsor with a contract under this sec-*
 20 *tion shall provide in accordance with section 1852(f)*
 21 *meaningful procedures for hearing and resolving*
 22 *grievances between the prescription drug card sponsor*
 23 *(including any entity or individual through which*
 24 *the prescription drug card sponsor provides covered*

benefits) and enrollees in a prescription drug assistance card program offered by such sponsor.

“(5) *APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.*—

“(A) *IN GENERAL.*—The requirements of paragraphs (1) through (3) of section 1852(g) shall apply with respect to covered benefits under a prescription drug assistance card program under this section in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

“(B) *REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.*—In the case of a prescription drug assistance card program offered by a prescription drug card sponsor that provides for tiered pricing for drugs included within a formulary and provides lower prices for preferred drugs included within the formulary, an eligible low-income beneficiary who is enrolled in the program may request coverage of a nonpreferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition is not as effective for the eli-

1 *gible low-income beneficiary or has adverse ef-*
 2 *fects for the eligible low-income beneficiary.*

3 “(C) *FORMULARY DETERMINATIONS.—An*
 4 *eligible low-income beneficiary who is enrolled in*
 5 *a prescription drug assistance card program of-*
 6 *fered by a prescription drug card sponsor may*
 7 *appeal to obtain coverage for a covered drug that*
 8 *is not on a formulary of the entity if the pre-*
 9 *scribing physician determines that the formulary*
 10 *drug for treatment of the same condition is not*
 11 *as effective for the eligible low-income beneficiary*
 12 *or has adverse effects for the eligible low-income*
 13 *beneficiary.*

14 “(6) *APPEALS.—*

15 “(A) *IN GENERAL.—Subject to subpara-*
 16 *graph (B), a prescription drug card sponsor*
 17 *shall meet the requirements of paragraphs (4)*
 18 *and (5) of section 1852(g) with respect to drugs*
 19 *not included on any formulary in a similar*
 20 *manner (as determined by the Secretary) as such*
 21 *requirements apply to a Medicare+Choice orga-*
 22 *nization with respect to benefits it offers under*
 23 *a Medicare+Choice plan under part C.*

24 “(B) *FORMULARY DETERMINATIONS.—An*
 25 *eligible low-income beneficiary who is enrolled in*

1 *a prescription drug assistance card program of-*
 2 *fered by a prescription drug card sponsor may*
 3 *appeal to obtain coverage for a covered drug that*
 4 *is not on a formulary of the entity if the pre-*
 5 *scribing physician determines that the formulary*
 6 *drug for treatment of the same condition is not*
 7 *as effective for the eligible low-income beneficiary*
 8 *or has adverse effects for the eligible low-income*
 9 *beneficiary.*

10 “(C) *APPEALS AND EXCEPTIONS TO APPLI-*
 11 *CATION.—The prescription drug card sponsor*
 12 *must have, as part of the appeals process under*
 13 *this paragraph, a process for timely appeals for*
 14 *denials of coverage based on the application of*
 15 *the formulary.*

16 “(d) *PRESCRIPTION DRUG BENEFITS.—*

17 “(1) *IN GENERAL.—Subject to paragraph (5), all*
 18 *the benefits available under a prescription drug dis-*
 19 *count card program offered by a prescription drug*
 20 *card sponsor and endorsed under section 1807 shall*
 21 *be available to eligible low-income beneficiaries en-*
 22 *rolled in a prescription drug assistance card program*
 23 *offered by such sponsor.*

24 “(2) *ASSISTANCE FOR ELIGIBLE LOW-INCOME*
 25 *BENEFICIARIES.—*

1 “(A) \$600 ANNUAL ASSISTANCE.—Subject to
2 subparagraphs (B) and (C) and paragraph (5),
3 each prescription drug card sponsor with a con-
4 tract under this section shall provide coverage for
5 the first \$600 of expenses for prescription drugs
6 incurred during each calendar year by an eligi-
7 ble low-income beneficiary enrolled in a pre-
8 scription drug assistance card program offered
9 by such sponsor.

10 “(B) COINSURANCE.—

11 “(i) IN GENERAL.—The prescription
12 drug card sponsor shall determine an
13 amount of coinsurance to collect from each
14 eligible low-income beneficiary enrolled in a
15 prescription drug assistance card program
16 offered by such sponsor for which coverage
17 is available under subparagraph (A).

18 “(ii) AMOUNT.—The amount of coin-
19 surance collected under clause (i) shall be at
20 least 10 percent of the negotiated price of
21 each prescription drug dispensed to an eli-
22 gible low-income beneficiary.

23 “(iii) CONSTRUCTION.—Amounts col-
24 lected under clause (i) shall not be counted

1 *against the total amount of coverage avail-*
 2 *able under subparagraph (A).*

3 “(C) *REDUCTION FOR LATE ENROLL-*
 4 *MENT.—For each month during a calendar quar-*
 5 *ter in which an eligible low-income beneficiary is*
 6 *not enrolled in a prescription drug assistance*
 7 *card program offered by a prescription drug*
 8 *card sponsor with a contract under this section,*
 9 *the amount of assistance available under sub-*
 10 *paragraph (A) shall be reduced by \$50.*

11 “(D) *CREDITING OF UNUSED BENEFITS TO-*
 12 *WARD FUTURE YEARS.—The dollar amount of*
 13 *coverage described in subparagraph (A) shall be*
 14 *increased by any amount of coverage described*
 15 *in such subparagraph that was not used during*
 16 *the previous calendar year.*

17 “(E) *WAIVER TO ENSURE PROVISION OF*
 18 *BENEFIT.—The Secretary may waive such re-*
 19 *quirements of this section and section 1807 as*
 20 *may be necessary to ensure that each eligible*
 21 *low-income beneficiaries has access to the assist-*
 22 *ance described in subparagraph (A).*

23 “(3) *ADDITIONAL DISCOUNTS.—A prescription*
 24 *drug card sponsor with a contract under this section*
 25 *shall provide each eligible low-income beneficiary en-*

1 *rolled in a prescription drug assistance program of-*
 2 *fered by the sponsor with access to negotiated prices*
 3 *that reflect a minimum average discount of at least*
 4 *20 percent of the average wholesale price for prescrip-*
 5 *tion drugs covered under that program.*

6 “(4) *ASSISTANCE CARDS.—Each prescription*
 7 *drug card sponsor shall permit eligible low-income*
 8 *beneficiaries enrolled in a prescription drug assist-*
 9 *ance card program offered by such sponsor to use the*
 10 *discount card issued under section 1807(e)(4) to ob-*
 11 *tain benefits under the program.*

12 “(5) *APPLICATION OF FORMULARY RESTRIC-*
 13 *TIONS.—A drug prescribed for an eligible low-income*
 14 *beneficiary that would otherwise be a covered drug*
 15 *under this section shall not be so considered under a*
 16 *prescription drug assistance card program if the pro-*
 17 *gram excludes the drug under a formulary and such*
 18 *exclusion is not successfully resolved under paragraph*
 19 *(4), (5), or (6) of subsection (c).*

20 “(e) *REQUIREMENTS FOR PRESCRIPTION DRUG CARD*
 21 *SPONSORS THAT OFFER PRESCRIPTION DRUG ASSISTANCE*
 22 *CARD PROGRAMS.—*

23 “(1) *IN GENERAL.—Each prescription drug card*
 24 *sponsor shall—*

1 “(A) process claims made by eligible low-in-
2 come beneficiaries;

3 “(B) negotiate with brand name and ge-
4 neric prescription drug manufacturers and oth-
5 ers for low prices on prescription drugs;

6 “(C) track individual beneficiary expendi-
7 tures in a format and periodicity specified by
8 the Secretary; and

9 “(D) perform such other functions as the
10 Secretary may assign.

11 “(2) DATA EXCHANGES.—Each prescription drug
12 card sponsor shall receive data exchanges in a format
13 specified by the Secretary and shall maintain real-
14 time beneficiary files.

15 “(3) PUBLIC DISCLOSURE OF PHARMACEUTICAL
16 PRICES FOR EQUIVALENT DRUGS.—The prescription
17 drug card sponsor offering the prescription drug as-
18 sistance card program shall provide that each phar-
19 macy or other dispenser that arranges for the dis-
20 pensing of a covered drug shall inform the eligible
21 low-income beneficiary at the time of purchase of the
22 drug of any differential between the price of the pre-
23 scribed drug to the enrollee and the price of the lowest
24 priced generic drug covered under the plan that is

1 *therapeutically equivalent and bioequivalent and*
 2 *available at such pharmacy or other dispenser.*

3 “(f) *SUBMISSION OF BIDS AND AWARDING OF CON-*
 4 *TRACTS.—*

5 “(1) *SUBMISSION OF BIDS.—Each prescription*
 6 *drug card sponsor that seeks to offer a prescription*
 7 *drug assistance card program under this section shall*
 8 *submit to the Secretary, at such time and in such*
 9 *manner as the Secretary may specify, such informa-*
 10 *tion as the Secretary may require.*

11 “(2) *AWARDING OF CONTRACTS.—The Secretary*
 12 *shall review the information submitted under para-*
 13 *graph (1) and shall determine whether to award a*
 14 *contract to the prescription drug card sponsor offer-*
 15 *ing the program to which such information relates.*
 16 *The Secretary may not approve a program unless the*
 17 *program and prescription drug card sponsor offering*
 18 *the program comply with the requirements under this*
 19 *section.*

20 “(3) *NUMBER OF CONTRACTS.—There shall be no*
 21 *limit on the number of prescription drug card spon-*
 22 *sors that may be awarded contracts under paragraph*
 23 *(2).*

24 “(4) *CONTRACT PROVISIONS.—*

1 “(A) *DURATION.*—A contract awarded
2 under paragraph (2) shall be for the lifetime of
3 the program under this section.

4 “(B) *WITHDRAWAL.*—A prescription drug
5 card sponsor that desires to terminate the con-
6 tract awarded under paragraph (2) may termi-
7 nate such contract without penalty if such spon-
8 sor gives notice—

9 “(i) to the Secretary 90 days prior to
10 the termination of such contract; and

11 “(ii) to each eligible low-income bene-
12 ficiary that is enrolled in a prescription
13 drug assistance card program offered by
14 such sponsor 60 days prior to such termi-
15 nation.

16 “(C) *SERVICE AREA.*—The service area
17 under the contract shall be the same as the area
18 served by the prescription drug card sponsor
19 under section 1807.

20 “(5) *SIMULTANEOUS APPROVAL OF DISCOUNT*
21 *CARD AND ASSISTANCE PROGRAMS.*—A prescription
22 drug card sponsor may submit an application for en-
23 dorsement under section 1807 as part of the bid sub-
24 mitted under paragraph (1) and the Secretary may

1 *approve such application at the same time as the Sec-*
 2 *retary awards a contract under this section.*

3 “(g) *PAYMENTS TO PRESCRIPTION DRUG CARD SPON-*
 4 *SORS.—*

5 “(1) *IN GENERAL.—The Secretary shall pay to*
 6 *each prescription drug card sponsor offering a pre-*
 7 *scription drug assistance card program in which an*
 8 *eligible low-income beneficiary is enrolled an amount*
 9 *equal to the amount agreed to by the Secretary and*
 10 *the sponsor in the contract awarded under subsection*
 11 *(f)(2).*

12 “(2) *PAYMENT FROM PART B TRUST FUND.—The*
 13 *costs of providing benefits under this section shall be*
 14 *payable from the Federal Supplementary Medical In-*
 15 *surance Trust Fund established under section 1841.*

16 “(h) *ELIGIBILITY DETERMINATIONS MADE BY STATES;*
 17 *PRESUMPTIVE ELIGIBILITY.—States shall perform the func-*
 18 *tions described in section 1935(a)(1).*

19 “(i) *APPROPRIATIONS.—There are appropriated from*
 20 *the Federal Supplementary Medical Insurance Trust Fund*
 21 *established under section 1841 such sums as may be nec-*
 22 *essary to carry out the program under this section.*

23 “(j) *DEFINITIONS.—In this section:*

24 “(1) *ELIGIBLE BENEFICIARY; NEGOTIATED*
 25 *PRICE; PRESCRIPTION DRUG.—The terms ‘eligible ben-*

1 *eficiary’, ‘negotiated price’, and ‘prescription drug’*
 2 *have the meanings given those terms in section*
 3 *1807(i).*

4 *“(2) ELIGIBLE LOW-INCOME BENEFICIARY.—*

5 *“(A) IN GENERAL.—Subject to subpara-*
 6 *graphs (B) and (C), the term ‘eligible low-income*
 7 *beneficiary’ means an individual who—*

8 *“(i) is an eligible beneficiary (as de-*
 9 *fined in section 1807(i)); and*

10 *“(ii) is described in clause (iii) or (iv)*
 11 *of section 1902(a)(10)(E) or in section*
 12 *1905(p)(1).*

13 *“(3) PRESCRIPTION DRUG CARD SPONSOR.—The*
 14 *term ‘prescription drug card sponsor’ has the mean-*
 15 *ing given that term in section 1807(i), except that*
 16 *such sponsor shall also be an entity that the Secretary*
 17 *determines is—*

18 *“(A) is appropriate to provide eligible low-*
 19 *income beneficiaries with the benefits under a*
 20 *prescription drug assistance card program under*
 21 *this section; and*

22 *“(B) is able to manage the monetary assist-*
 23 *ance made available under subsection (d)(2);*

24 *“(C) agrees to submit to audits by the Sec-*
 25 *retary; and*

1 “(D) provides such other assurances as the
2 Secretary may require.

3 “(4) STATE.—The term ‘State’ has the meaning
4 given such term for purposes of title XIX.”.

5 (b) EXCLUSION OF PRICES FROM DETERMINATION OF
6 BEST PRICE.—Section 1927(c)(1)(C)(i) (42 U.S.C. 1396r–
7 8(c)(1)(C)(i)) is amended—

8 (1) by striking “and” at the end of subclause
9 (III);

10 (2) by striking the period at the end of subclause
11 (IV) and inserting “; and”; and

12 (3) by adding at the end the following new sub-
13 clause:

14 “(V) any negotiated prices
15 charged under the medicare prescrip-
16 tion drug discount card endorsement
17 program under section 1807 or under
18 the transitional prescription drug as-
19 sistance card program for eligible low-
20 income beneficiaries under section
21 1807A.”.

22 (c) EXCLUSION OF PRESCRIPTION DRUG ASSISTANCE
23 CARD COSTS FROM DETERMINATION OF PART B MONTHLY
24 PREMIUM.—Section 1839(g) of the Social Security Act (42
25 U.S.C. 1395r(g)) is amended—

(1) by striking “attributable to the application of section” and inserting “attributable to—

“(1) the application of section”;

(2) by striking the period and inserting “; and”;
and

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

“(2) the prescription drug assistance card program under section 1807A.”.

(d) REGULATIONS.—

(1) AUTHORITY FOR INTERIM FINAL REGULATIONS.—The Secretary may promulgate initial regulations implementing sections 1807 and 1807A of the Social Security Act (as added by this section) in interim final form without prior opportunity for public comment.

(2) FINAL REGULATIONS.—A final regulation reflecting public comments must be published within 1 year of the interim final regulation promulgated under paragraph (1).

(3) EXEMPTION FROM THE PAPERWORK REDUCTION ACT.—The promulgation of the regulations under this subsection and the administration the programs established by sections 1807 and 1807A of the Social Security Act (as added by this section) shall

1 *be made without regard to chapter 35 of title 44,*
 2 *United States Code (commonly known as the “Paper-*
 3 *work Reduction Act”).*

4 *(e) IMPLEMENTATION; TRANSITION.—*

5 *(1) IMPLEMENTATION.—The Secretary shall im-*
 6 *plement the amendments made by this section in a*
 7 *manner that discounts are available to eligible bene-*
 8 *ficiaries under section 1807 of the Social Security Act*
 9 *and assistance is available to eligible low-income*
 10 *beneficiaries under section 1807A of such Act not*
 11 *later than January 1, 2004.*

12 *(2) TRANSITION.—The Secretary shall provide*
 13 *for an appropriate transition and discontinuation of*
 14 *the programs under section 1807 and 1807A of the*
 15 *Social Security Act. Such transition and discontinu-*
 16 *ation shall ensure that such programs continue to op-*
 17 *erate until the date on which the first enrollment pe-*
 18 *riod under part D ends.*

19 ***Subtitle C—Standards for***
 20 ***Electronic Prescribing***

21 ***SEC. 121. STANDARDS FOR ELECTRONIC PRESCRIBING.***

22 *Title XI (42 U.S.C. 1301 et seq.) is amended by adding*
 23 *at the end the following new part:*

1 *“PART D—ELECTRONIC PRESCRIBING*

2 *“STANDARDS FOR ELECTRONIC PRESCRIBING*

3 *“SEC. 1180. (a) STANDARDS.—*

4 *“(1) DEVELOPMENT AND ADOPTION.—*

5 *“(A) IN GENERAL.—The Secretary shall de-*
6 *velop or adopt standards for transactions and*
7 *data elements for such transactions (in this sec-*
8 *tion referred to as ‘standards’) to enable the elec-*
9 *tronic transmission of medication history, eligi-*
10 *bility, benefit, and other prescription informa-*
11 *tion.*

12 *“(B) CONSULTATION.—In developing and*
13 *adopting the standards under subparagraph (A),*
14 *the Secretary shall consult with representatives*
15 *of physicians, hospitals, pharmacists, standard*
16 *setting organizations, pharmacy benefit man-*
17 *agers, beneficiary information exchange net-*
18 *works, technology experts, and representatives of*
19 *the Departments of Veterans Affairs and Defense*
20 *and other interested parties.*

21 *“(2) OBJECTIVE.—Any standards developed or*
22 *adopted under this part shall be consistent with the*
23 *objectives of improving—*

24 *“(A) patient safety; and*

1 “(B) *the quality of care provided to pa-*
 2 *tients.*

3 “(3) *REQUIREMENTS.—Any standards developed*
 4 *or adopted under this part shall comply with the fol-*
 5 *lowing:*

6 “(A) *ELECTRONIC TRANSMITTAL OF PRE-*
 7 *SCRIPTIONS.—*

8 “(i) *IN GENERAL.—Except as provided*
 9 *in clause (ii), the standards require that*
 10 *prescriptions be written and transmitted*
 11 *electronically.*

12 “(ii) *EXCEPTIONS.—The standards*
 13 *shall not require a prescription to be writ-*
 14 *ten and transmitted electronically—*

15 “(I) *in emergency cases and other*
 16 *exceptional circumstances recognized*
 17 *by the Administrator; or*

18 “(II) *if the patient requests that*
 19 *the prescription not be transmitted*
 20 *electronically.*

21 *If a patient makes a request under sub-*
 22 *clause (II), no additional charges may be*
 23 *imposed on the patient for making such re-*
 24 *quest.*

1 “(B) *PATIENT-SPECIFIC MEDICATION HIS-*
 2 *TORY, ELIGIBILITY, BENEFIT, AND OTHER PRE-*
 3 *SCRIPTION INFORMATION.*—

4 “(i) *IN GENERAL.*—*The standards shall*
 5 *accommodate electronic transmittal of pa-*
 6 *tient-specific medication history, eligibility,*
 7 *benefit, and other prescription information*
 8 *among prescribing and dispensing profes-*
 9 *sionals at the point of care.*

10 “(ii) *REQUIRED INFORMATION.*—*The*
 11 *information described in clause (i) shall in-*
 12 *clude the following:*

13 “(I) *Information (to the extent*
 14 *available and feasible) on the drugs*
 15 *being prescribed for that patient and*
 16 *other information relating to the medi-*
 17 *cation history of the patient that may*
 18 *be relevant to the appropriate prescrip-*
 19 *tion for that patient.*

20 “(II) *Cost-effective alternatives (if*
 21 *any) to the drug prescribed.*

22 “(III) *Information on eligibility*
 23 *and benefits, including the drugs in-*
 24 *cluded in the applicable formulary and*

1 *any requirements for prior authoriza-*
 2 *tion.*

3 “(IV) *Information on potential*
 4 *interactions with drugs listed on the*
 5 *medication history, graded by severity*
 6 *of the potential interaction.*

7 “(V) *Other information to im-*
 8 *prove the quality of patient care and*
 9 *to reduce medical errors.*

10 “(C) *UNDUE BURDEN.—The standards shall*
 11 *be designed so that, to the extent practicable, the*
 12 *standards do not impose an undue administra-*
 13 *tive burden on the practice of medicine, phar-*
 14 *macy, or other health professions.*

15 “(D) *COMPATIBILITY WITH ADMINISTRATIVE*
 16 *SIMPLIFICATION AND PRIVACY LAWS.—The stand-*
 17 *ards shall be—*

18 “(i) *consistent with the Federal regula-*
 19 *tions (concerning the privacy of individ-*
 20 *ually identifiable health information) pro-*
 21 *mulgated under section 264(c) of the Health*
 22 *Insurance Portability and Accountability*
 23 *Act of 1996; and*

24 “(ii) *compatible with the standards*
 25 *adopted under part C.*

1 “(4) *TRANSFER OF INFORMATION.*—*The Sec-*
 2 *retary shall develop and adopt standards for transfer-*
 3 *ring among prescribing and insurance entities and*
 4 *other necessary entities appropriate standard data*
 5 *elements needed for the electronic exchange of medica-*
 6 *tion history, eligibility, benefit, and other prescrip-*
 7 *tion drug information and other health information*
 8 *determined appropriate in compliance with the*
 9 *standards adopted or modified under this part.*

10 “(b) *TIMETABLE FOR ADOPTION OF STANDARDS.*—

11 “(1) *IN GENERAL.*—*The Secretary shall adopt*
 12 *the standards under this part by January 1, 2006.*

13 “(2) *ADDITIONS AND MODIFICATIONS TO STAND-*
 14 *ARDS.*—*The Secretary shall, in consultation with ap-*
 15 *propriate representatives of interested parties, review*
 16 *the standards developed or adopted under this part*
 17 *and adopt modifications to the standards (including*
 18 *additions to the standards), as determined appro-*
 19 *priate. Any addition or modification to such stand-*
 20 *ards shall be completed in a manner which minimizes*
 21 *the disruption and cost of compliance.*

22 “(c) *COMPLIANCE WITH STANDARDS.*—

23 “(1) *REQUIREMENT FOR ALL INDIVIDUALS AND*
 24 *ENTITIES THAT TRANSMIT OR RECEIVE PRESCRIP-*
 25 *TIONS ELECTRONICALLY.*—

1 “(A) *IN GENERAL.*—*Individuals or entities*
 2 *that transmit or receive electronic medication*
 3 *history, eligibility, benefit and prescription in-*
 4 *formation, shall comply with the standards*
 5 *adopted or modified under this part.*

6 “(B) *RELATION TO STATE LAWS.*—*The*
 7 *standards adopted or modified under this part*
 8 *shall supersede any State law or regulations per-*
 9 *taining to the electronic transmission of medica-*
 10 *tion history, eligibility, benefit and prescription*
 11 *information.*

12 “(2) *TIMETABLE FOR COMPLIANCE.*—

13 “(A) *INITIAL COMPLIANCE.*—

14 “(i) *IN GENERAL.*—*Not later than 24*
 15 *months after the date on which an initial*
 16 *standard is adopted under this part, each*
 17 *individual or entity to whom the standard*
 18 *applies shall comply with the standard.*

19 “(ii) *SPECIAL RULE FOR SMALL*
 20 *HEALTH PLANS.*—*In the case of a small*
 21 *health plan, as defined by the Secretary for*
 22 *purposes of section 1175(b)(1)(B), clause (i)*
 23 *shall be applied by substituting ‘36 months’*
 24 *for ‘24 months’.*

1 “(d) *CONSULTATION WITH ATTORNEY GENERAL.*—The
 2 *Secretary shall consult with the Attorney General before de-*
 3 *veloping, adopting, or modifying a standard under this*
 4 *part to ensure that the standard accommodates secure elec-*
 5 *tronic transmission of prescriptions for controlled sub-*
 6 *stances in a manner that minimizes the possibility of viola-*
 7 *tions under the Comprehensive Drug Abuse Prevention and*
 8 *Control Act of 1970 and related Federal laws.*

9 “GRANTS TO HEALTH CARE PROVIDERS TO IMPLEMENT
 10 *ELECTRONIC PRESCRIPTION PROGRAMS*

11 “SEC. 1180A. (a) *IN GENERAL.*—The Secretary is au-
 12 *thorized to make grants to health care providers for the pur-*
 13 *pose of assisting such entities to implement electronic pre-*
 14 *scription programs that comply with the standards adopted*
 15 *or modified under this part.*

16 “(b) *APPLICATION.*—No grant may be made under this
 17 *section except pursuant to a grant application that is sub-*
 18 *mitted in a time, manner, and form approved by the Sec-*
 19 *retary.*

20 “(c) *AUTHORIZATION OF APPROPRIATIONS.*—There are
 21 *authorized to be appropriated for each of fiscal years 2006,*
 22 *2007, and 2008, such sums as may be necessary to carry*
 23 *out this section.”.*

Subtitle D—Other Provisions

SEC. 131. ADDITIONAL REQUIREMENTS FOR ANNUAL FINANCIAL REPORT AND OVERSIGHT ON MEDICAL CARE PROGRAM.

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

“(l) COMBINED REPORT ON OPERATION AND STATUS OF THE TRUST FUND AND THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (INCLUDING THE PRESCRIPTION DRUG ACCOUNT).—In addition to the duty of the Board of Trustees to report to Congress under subsection (b), on the date the Board submits the report required under subsection (b)(2), the Board shall submit to Congress a report on the operation and status of the Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 (including the Prescription Drug Account within such Trust Fund), in this subsection referred to as the ‘Trust Funds’. Such report shall include the following information:

“(1) OVERALL SPENDING FROM THE GENERAL FUND OF THE TREASURY.—A statement of total amounts obligated during the preceding fiscal year from the General Revenues of the Treasury to the Trust Funds, separately stated in terms of the total amount and in terms of the percentage such amount

1 *bears to all other amounts obligated from such Gen-*
 2 *eral Revenues during such fiscal year, for each of the*
 3 *following amounts:*

4 “(A) *MEDICARE BENEFITS.*—*The amount*
 5 *expended for payment of benefits covered under*
 6 *this title.*

7 “(B) *ADMINISTRATIVE AND OTHER EX-*
 8 *PENSES.*—*The amount expended for payments*
 9 *not related to the benefits described in subpara-*
 10 *graph (A).*

11 “(2) *HISTORICAL OVERVIEW OF SPENDING.*—
 12 *From the date of the inception of the program of in-*
 13 *surance under this title through the fiscal year in-*
 14 *volved, a statement of the total amounts referred to in*
 15 *paragraph (1), separately stated for the amounts de-*
 16 *scribed in subparagraphs (A) and (B) of such para-*
 17 *graph.*

18 “(3) *10-YEAR AND 50-YEAR PROJECTIONS.*—*An*
 19 *estimate of total amounts referred to in paragraph*
 20 *(1), separately stated for the amounts described in*
 21 *subparagraphs (A) and (B) of such paragraph, re-*
 22 *quired to be obligated for payment for benefits covered*
 23 *under this title for each of the 10 fiscal years suc-*
 24 *ceeding the fiscal year involved and for the 50-year*
 25 *period beginning with the succeeding fiscal year.*

1 “(4) *RELATION TO OTHER MEASURES OF*
 2 *GROWTH.*—*A comparison of the rate of growth of the*
 3 *total amounts referred to in paragraph (1), separately*
 4 *stated for the amounts described in subparagraphs*
 5 *(A) and (B) of such paragraph, to the rate of growth*
 6 *for the same period in—*

7 “(A) *the gross domestic product;*

8 “(B) *health insurance costs in the private*
 9 *sector;*

10 “(C) *employment-based health insurance*
 11 *costs in the public and private sectors; and*

12 “(D) *other areas as determined appropriate*
 13 *by the Board of Trustees.”.*

14 (b) *EFFECTIVE DATE.*—*The amendment made by sub-*
 15 *section (a) shall apply with respect to fiscal years beginning*
 16 *on or after the date of enactment of this Act.*

17 (c) *CONGRESSIONAL HEARINGS.*—*It is the sense of*
 18 *Congress that the committees of jurisdiction of Congress*
 19 *shall hold hearings on the reports submitted under section*
 20 *1817(l) of the Social Security Act (as added by subsection*
 21 *(a)).*

22 **SEC. 132. TRUSTEES’ REPORT ON MEDICARE’S UNFUNDED**
 23 **OBLIGATIONS.**

24 (a) *REPORT.*—*The report submitted under sections*
 25 *1817(b)(2) and 1841(b)(2) of the Social Security Act (42*

1 *U.S.C. 1395i(b)(2) and 1395t(b)(2)) during 2004 shall in-*
 2 *clude an analysis of the total amount of the unfunded obli-*
 3 *gations of the Medicare program under title XVIII of the*
 4 *Social Security Act.*

5 **(b) MATTERS ANALYZED.**—*The analysis described in*
 6 *subsection (A) shall compare the long-term obligations of*
 7 *the Medicare program to the dedicated funding sources for*
 8 *that program (other than general revenue transfers), includ-*
 9 *ing the combined obligations of the Federal Hospital Insur-*
 10 *ance Trust Fund established under section 1817 of such Act*
 11 *(42 U.S.C. 1395i) and the Federal Supplementary Medical*
 12 *Insurance Trust Fund established under section 1841 of*
 13 *such Act (42 U.S.C. 1395t).*

14 ***TITLE II—MEDICAREADVANTAGE***
 15 ***Subtitle A—MedicareAdvantage***
 16 ***Competition***

17 ***SEC. 201. ELIGIBILITY, ELECTION, AND ENROLLMENT.***

18 *Section 1851 (42 U.S.C. 1395w–21) is amended to*
 19 *read as follows:*

20 ***“ELIGIBILITY, ELECTION, AND ENROLLMENT***

21 ***“SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS***
 22 ***THROUGH MEDICAREADVANTAGE PLANS.—***

23 ***“(1) IN GENERAL.***—*Subject to the provisions of*
 24 *this section, each MedicareAdvantage eligible indi-*
 25 *vidual (as defined in paragraph (3)) is entitled to*
 26 *elect to receive benefits under this title—*

1 “(A) through—

2 “(i) the original Medicare fee-for-serv-
3 ice program under parts A and B; and

4 “(ii) the voluntary prescription drug
5 delivery program under part D; or

6 “(B) through enrollment in a
7 MedicareAdvantage plan under this part.

8 “(2) TYPES OF MEDICAREADVANTAGE PLANS
9 THAT MAY BE AVAILABLE.—A MedicareAdvantage
10 plan may be any of the following types of plans of
11 health insurance:

12 “(A) COORDINATED CARE PLANS.—Coordi-
13 nated care plans which provide health care serv-
14 ices, including health maintenance organization
15 plans (with or without point of service options)
16 and plans offered by provider-sponsored organi-
17 zations (as defined in section 1855(d)).

18 “(B) COMBINATION OF MSA PLAN AND CON-
19 TRIBUTIONS TO MEDICAREADVANTAGE MSA.—An
20 MSA plan, as defined in section 1859(b)(3), and
21 a contribution into a MedicareAdvantage med-
22 ical savings account (MSA).

23 “(C) PRIVATE FEE-FOR-SERVICE PLANS.—A
24 MedicareAdvantage private fee-for-service plan,
25 as defined in section 1859(b)(2).

1 “(3) *MEDICAREADVANTAGE ELIGIBLE INDIVIDUAL.*—
2

3 “(A) *IN GENERAL.*—Subject to subparagraph (B), in this title, the term
4 ‘*MedicareAdvantage eligible individual*’ means
5 an individual who is entitled to (or enrolled for)
6 benefits under part A, enrolled under part B,
7 and enrolled under part D.
8

9 “(B) *SPECIAL RULE FOR END-STAGE RENAL DISEASE.*—Such term shall not include an individual medically determined to have end-stage renal disease, except that—
10
11
12

13 “(i) an individual who develops end-stage renal disease while enrolled in a
14 Medicare+Choice or a MedicareAdvantage plan may continue to be enrolled in that
15 plan; and
16
17

18 “(ii) in the case of such an individual
19 who is enrolled in a Medicare+Choice plan or a MedicareAdvantage plan under clause
20 (i) (or subsequently under this clause), if the enrollment is discontinued under circumstances described in section
21 1851(e)(4)(A), then the individual will be treated as a ‘MedicareAdvantage eligible in-
22
23
24
25

1 *dividual’ for purposes of electing to con-*
2 *tinue enrollment in another*
3 *MedicareAdvantage plan.*

4 “(b) *SPECIAL RULES.—*

5 “(1) *RESIDENCE REQUIREMENT.—*

6 “(A) *IN GENERAL.—Except as the Secretary*
7 *may otherwise provide and except as provided in*
8 *subparagraph (C), an individual is eligible to*
9 *elect a MedicareAdvantage plan offered by a*
10 *MedicareAdvantage organization only if the plan*
11 *serves the geographic area in which the indi-*
12 *vidual resides.*

13 “(B) *CONTINUATION OF ENROLLMENT PER-*
14 *MITTED.—Pursuant to rules specified by the Sec-*
15 *retary, the Secretary shall provide that a plan*
16 *may offer to all individuals residing in a geo-*
17 *graphic area the option to continue enrollment*
18 *in the plan, notwithstanding that the individual*
19 *no longer resides in the service area of the plan,*
20 *so long as the plan provides that individuals ex-*
21 *ercising this option have, as part of the basic*
22 *benefits described in section 1852(a)(1)(A), rea-*
23 *sonable access within that geographic area to the*
24 *full range of basic benefits, subject to reasonable*
25 *cost-sharing liability in obtaining such benefits.*

“(C) *CONTINUATION OF ENROLLMENT PERMITTED WHERE SERVICE CHANGED.*—*Notwithstanding subparagraph (A) and in addition to subparagraph (B), if a MedicareAdvantage organization eliminates from its service area a MedicareAdvantage payment area that was previously within its service area, the organization may elect to offer individuals residing in all or portions of the affected area who would otherwise be ineligible to continue enrollment the option to continue enrollment in a MedicareAdvantage plan it offers so long as—*

“(i) *the enrollee agrees to receive the full range of basic benefits (excluding emergency and urgently needed care) exclusively at facilities designated by the organization within the plan service area; and*

“(ii) *there is no other MedicareAdvantage plan offered in the area in which the enrollee resides at the time of the organization’s election.*

“(2) *SPECIAL RULE FOR CERTAIN INDIVIDUALS COVERED UNDER FEHBP OR ELIGIBLE FOR VETERANS OR MILITARY HEALTH BENEFITS.*—

1 “(A) *FEHBP*.—An individual who is en-
 2 rolled in a health benefit plan under chapter 89
 3 of title 5, United States Code, is not eligible to
 4 enroll in an MSA plan until such time as the
 5 Director of the Office of Management and Budget
 6 certifies to the Secretary that the Office of Per-
 7 sonnel Management has adopted policies which
 8 will ensure that the enrollment of such individ-
 9 uals in such plans will not result in increased
 10 expenditures for the Federal Government for
 11 health benefit plans under such chapter.

12 “(B) *VA AND DOD*.—The Secretary may
 13 apply rules similar to the rules described in sub-
 14 paragraph (A) in the case of individuals who are
 15 eligible for health care benefits under chapter 55
 16 of title 10, United States Code, or under chapter
 17 17 of title 38 of such Code.

18 “(3) *LIMITATION ON ELIGIBILITY OF QUALIFIED*
 19 *MEDICARE BENEFICIARIES AND OTHER MEDICAID*
 20 *BENEFICIARIES TO ENROLL IN AN MSA PLAN*.—An in-
 21 dividual who is a qualified medicare beneficiary (as
 22 defined in section 1905(p)(1)), a qualified disabled
 23 and working individual (described in section
 24 1905(s)), an individual described in section
 25 1902(a)(10)(E)(iii), or otherwise entitled to medicare

1 *cost-sharing under a State plan under title XIX is*
 2 *not eligible to enroll in an MSA plan.*

3 “(4) *COVERAGE UNDER MSA PLANS ON A DEM-*
 4 *ONSTRATION BASIS.—*

5 “(A) *IN GENERAL.—An individual is not el-*
 6 *igible to enroll in an MSA plan under this*
 7 *part—*

8 “(i) *on or after January 1, 2004, un-*
 9 *less the enrollment is the continuation of*
 10 *such an enrollment in effect as of such date;*
 11 *or*

12 “(ii) *as of any date if the number of*
 13 *such individuals so enrolled as of such date*
 14 *has reached 390,000.*

15 *Under rules established by the Secretary, an in-*
 16 *dividual is not eligible to enroll (or continue en-*
 17 *rollment) in an MSA plan for a year unless the*
 18 *individual provides assurances satisfactory to the*
 19 *Secretary that the individual will reside in the*
 20 *United States for at least 183 days during the*
 21 *year.*

22 “(B) *EVALUATION.—The Secretary shall*
 23 *regularly evaluate the impact of permitting en-*
 24 *rollment in MSA plans under this part on selec-*
 25 *tion (including adverse selection), use of preven-*

1 *tive care, access to care, and the financial status*
 2 *of the Trust Funds under this title.*

3 “(C) *REPORTS.*—*The Secretary shall submit*
 4 *to Congress periodic reports on the numbers of*
 5 *individuals enrolled in such plans and on the*
 6 *evaluation being conducted under subparagraph*
 7 *(B).*

8 “(c) *PROCESS FOR EXERCISING CHOICE.*—

9 “(1) *IN GENERAL.*—*The Secretary shall establish*
 10 *a process through which elections described in sub-*
 11 *section (a) are made and changed, including the form*
 12 *and manner in which such elections are made and*
 13 *changed. Such elections shall be made or changed only*
 14 *during coverage election periods specified under sub-*
 15 *section (e) and shall become effective as provided in*
 16 *subsection (f).*

17 “(2) *COORDINATION THROUGH*
 18 *MEDICAREADVANTAGE ORGANIZATIONS.*—

19 “(A) *ENROLLMENT.*—*Such process shall*
 20 *permit an individual who wishes to elect a*
 21 *MedicareAdvantage plan offered by a*
 22 *MedicareAdvantage organization to make such*
 23 *election through the filing of an appropriate elec-*
 24 *tion form with the organization.*

1 “(B) *DISENROLLMENT*.—Such process shall
 2 permit an individual, who has elected a
 3 *MedicareAdvantage* plan offered by a
 4 *MedicareAdvantage* organization and who wishes
 5 to terminate such election, to terminate such elec-
 6 tion through the filing of an appropriate election
 7 form with the organization.

8 “(3) *DEFAULT*.—

9 “(A) *INITIAL ELECTION*.—

10 “(i) *IN GENERAL*.—Subject to clause
 11 (ii), an individual who fails to make an
 12 election during an initial election period
 13 under subsection (e)(1) is deemed to have
 14 chosen the original medicare fee-for-service
 15 program option.

16 “(ii) *SEAMLESS CONTINUATION OF*
 17 *COVERAGE*.—The Secretary may establish
 18 procedures under which an individual who
 19 is enrolled in a Medicare+Choice plan or
 20 another health plan (other than a
 21 *MedicareAdvantage* plan) offered by a
 22 *MedicareAdvantage* organization at the
 23 time of the initial election period and who
 24 fails to elect to receive coverage other than
 25 through the organization is deemed to have

1 *elected the MedicareAdvantage plan offered*
 2 *by the organization (or, if the organization*
 3 *offers more than 1 such plan, such plan or*
 4 *plans as the Secretary identifies under such*
 5 *procedures).*

6 “(B) CONTINUING PERIODS.—*An individual*
 7 *who has made (or is deemed to have made) an*
 8 *election under this section is considered to have*
 9 *continued to make such election until such time*
 10 *as—*

11 “(i) *the individual changes the election*
 12 *under this section; or*

13 “(ii) *the MedicareAdvantage plan with*
 14 *respect to which such election is in effect is*
 15 *discontinued or, subject to subsection*
 16 *(b)(1)(B), no longer serves the area in*
 17 *which the individual resides.*

18 “(d) PROVIDING INFORMATION TO PROMOTE IN-
 19 FORMED CHOICE.—

20 “(1) IN GENERAL.—*The Secretary shall provide*
 21 *for activities under this subsection to broadly dissemi-*
 22 *nate information to medicare beneficiaries (and pro-*
 23 *spective medicare beneficiaries) on the coverage op-*
 24 *tions provided under this section in order to promote*
 25 *an active, informed selection among such options.*

1 “(2) *PROVISION OF NOTICE.*—

2 “(A) *OPEN SEASON NOTIFICATION.*—*At least*
 3 *15 days before the beginning of each annual, co-*
 4 *ordinated election period (as defined in sub-*
 5 *section (e)(3)(B)), the Secretary shall mail to*
 6 *each MedicareAdvantage eligible individual re-*
 7 *siding in an area the following:*

8 “(i) *GENERAL INFORMATION.*—*The*
 9 *general information described in paragraph*
 10 *(3).*

11 “(ii) *LIST OF PLANS AND COMPARISON*
 12 *OF PLAN OPTIONS.*—*A list identifying the*
 13 *MedicareAdvantage plans that are (or will*
 14 *be) available to residents of the area and in-*
 15 *formation described in paragraph (4) con-*
 16 *cerning such plans. Such information shall*
 17 *be presented in a comparative form.*

18 “(iii) *ADDITIONAL INFORMATION.*—
 19 *Any other information that the Secretary*
 20 *determines will assist the individual in*
 21 *making the election under this section.*

22 *The mailing of such information shall be coordi-*
 23 *nated, to the extent practicable, with the mailing*
 24 *of any annual notice under section 1804.*

1 “(B) *NOTIFICATION TO NEWLY ELIGIBLE*
 2 *MEDICAREADVANTAGE ELIGIBLE INDIVIDUALS.—*
 3 *To the extent practicable, the Secretary shall, not*
 4 *later than 30 days before the beginning of the*
 5 *initial MedicareAdvantage enrollment period for*
 6 *an individual described in subsection (e)(1),*
 7 *mail to the individual the information described*
 8 *in subparagraph (A).*

9 “(C) *FORM.—The information disseminated*
 10 *under this paragraph shall be written and for-*
 11 *matted using language that is easily understand-*
 12 *able by medicare beneficiaries.*

13 “(D) *PERIODIC UPDATING.—The informa-*
 14 *tion described in subparagraph (A) shall be up-*
 15 *dated on at least an annual basis to reflect*
 16 *changes in the availability of MedicareAdvantage*
 17 *plans, the benefits under such plans, and the*
 18 *MedicareAdvantage monthly basic beneficiary*
 19 *premium, MedicareAdvantage monthly bene-*
 20 *ficiary premium for enhanced medical benefits,*
 21 *and MedicareAdvantage monthly beneficiary ob-*
 22 *ligation for qualified prescription drug coverage*
 23 *for such plans.*

24 “(3) *GENERAL INFORMATION.—General informa-*
 25 *tion under this paragraph, with respect to coverage*

1 *under this part during a year, shall include the fol-*
 2 *lowing:*

3 “(A) *BENEFITS UNDER THE ORIGINAL*
 4 *MEDICARE FEE-FOR-SERVICE PROGRAM OP-*
 5 *TION.—A general description of the benefits cov-*
 6 *ered under parts A and B of the original medi-*
 7 *care fee-for-service program, including—*

8 “(i) *covered items and services;*

9 “(ii) *beneficiary cost-sharing, such as*
 10 *deductibles, coinsurance, and copayment*
 11 *amounts; and*

12 “(iii) *any beneficiary liability for bal-*
 13 *ance billing.*

14 “(B) *CATASTROPHIC COVERAGE AND COM-*
 15 *BINED DEDUCTIBLE.—A description of the cata-*
 16 *strophic coverage and unified deductible applica-*
 17 *ble under the plan.*

18 “(C) *OUTPATIENT PRESCRIPTION DRUG*
 19 *COVERAGE BENEFITS.—The information required*
 20 *under section 1860D–4 with respect to coverage*
 21 *for prescription drugs under the plan.*

22 “(D) *ELECTION PROCEDURES.—Informa-*
 23 *tion and instructions on how to exercise election*
 24 *options under this section.*

1 “(E) *RIGHTS*.—A general description of
2 *procedural rights (including grievance and ap-*
3 *peals procedures) of beneficiaries under the origi-*
4 *nal medicare fee-for-service program (including*
5 *such rights under part D) and the*
6 *MedicareAdvantage program and the right to be*
7 *protected against discrimination based on health*
8 *status-related factors under section 1852(b).*

9 “(F) *INFORMATION ON MEDIGAP AND MEDI-*
10 *CARE SELECT*.—A general description of the ben-
11 *efits, enrollment rights, and other requirements*
12 *applicable to medicare supplemental policies*
13 *under section 1882 and provisions relating to*
14 *medicare select policies described in section*
15 *1882(t).*

16 “(G) *POTENTIAL FOR CONTRACT TERMI-*
17 *NATION*.—The fact that a MedicareAdvantage or-
18 *ganization may terminate its contract, refuse to*
19 *renew its contract, or reduce the service area in-*
20 *cluded in its contract, under this part, and the*
21 *effect of such a termination, nonrenewal, or serv-*
22 *ice area reduction may have on individuals en-*
23 *rolled with the MedicareAdvantage plan under*
24 *this part.*

1 “(4) *INFORMATION COMPARING PLAN OPTIONS.*—
 2 *Information under this paragraph, with respect to a*
 3 *MedicareAdvantage plan for a year, shall include the*
 4 *following:*

5 “(A) *BENEFITS.*—*The benefits covered*
 6 *under the plan, including the following:*

7 “(i) *Covered items and services beyond*
 8 *those provided under the original medicare*
 9 *fee-for-service program option.*

10 “(ii) *Beneficiary cost-sharing for any*
 11 *items and services described in clause (i)*
 12 *and paragraph (3)(A)(i), including infor-*
 13 *mation on the unified deductible under sec-*
 14 *tion 1852(a)(1)(C).*

15 “(iii) *The maximum limitations on*
 16 *out-of-pocket expenses under section*
 17 *1852(a)(1)(C).*

18 “(iv) *In the case of an MSA plan, dif-*
 19 *ferences in cost-sharing, premiums, and bal-*
 20 *ance billing under such a plan compared to*
 21 *under other MedicareAdvantage plans.*

22 “(v) *In the case of a*
 23 *MedicareAdvantage private fee-for-service*
 24 *plan, differences in cost-sharing, premiums,*
 25 *and balance billing under such a plan com-*

pared to under other MedicareAdvantage plans.

“(vi) *The extent to which an enrollee may obtain benefits through out-of-network health care providers.*

“(vii) *The extent to which an enrollee may select among in-network providers and the types of providers participating in the plan’s network.*

“(viii) *The organization’s coverage of emergency and urgently needed care.*

“(ix) *The comparative information described in section 1860D–4(b)(2) relating to prescription drug coverage under the plan.*

“(B) *PREMIUMS.—*

“(i) *IN GENERAL.—The MedicareAdvantage monthly basic beneficiary premium and MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, if any, for the plan or, in the case of an MSA plan, the MedicareAdvantage monthly MSA premium.*

“(ii) *REDUCTIONS.—The reduction in part B premiums, if any.*

1 “(iii) *NATURE OF THE PREMIUM FOR*
 2 *ENHANCED MEDICAL BENEFITS.*—*Whether*
 3 *the MedicareAdvantage monthly premium*
 4 *for enhanced benefits is optional or manda-*
 5 *tory.*

6 “(C) *SERVICE AREA.*—*The service area of*
 7 *the plan.*

8 “(D) *QUALITY AND PERFORMANCE.*—*Plan*
 9 *quality and performance indicators for the bene-*
 10 *fits under the plan (and how such indicators*
 11 *compare to quality and performance indicators*
 12 *under the original medicare fee-for-service pro-*
 13 *gram under parts A and B and under the vol-*
 14 *untary prescription drug delivery program*
 15 *under part D in the area involved), including—*

16 “(i) *disenrollment rates for medicare*
 17 *enrollees electing to receive benefits through*
 18 *the plan for the previous 2 years (excluding*
 19 *disenrollment due to death or moving out-*
 20 *side the plan’s service area);*

21 “(ii) *information on medicare enrollee*
 22 *satisfaction;*

23 “(iii) *information on health outcomes;*
 24 *and*

1 “(iv) the recent record regarding com-
 2 pliance of the plan with requirements of
 3 this part (as determined by the Secretary).

4 “(5) *MAINTAINING A TOLL-FREE NUMBER AND*
 5 *INTERNET SITE.*—The Secretary shall maintain a
 6 toll-free number for inquiries regarding
 7 MedicareAdvantage options and the operation of this
 8 part in all areas in which MedicareAdvantage plans
 9 are offered and an Internet site through which indi-
 10 viduals may electronically obtain information on
 11 such options and MedicareAdvantage plans.

12 “(6) *USE OF NON-FEDERAL ENTITIES.*—The Sec-
 13 retary may enter into contracts with non-Federal en-
 14 tities to carry out activities under this subsection.

15 “(7) *PROVISION OF INFORMATION.*—A
 16 MedicareAdvantage organization shall provide the
 17 Secretary with such information on the organization
 18 and each MedicareAdvantage plan it offers as may be
 19 required for the preparation of the information re-
 20 ferred to in paragraph (2)(A).

21 “(e) *COVERAGE ELECTION PERIODS.*—

22 “(1) *INITIAL CHOICE UPON ELIGIBILITY TO MAKE*
 23 *ELECTION IF MEDICAREADVANTAGE PLANS AVAILABLE*
 24 *TO INDIVIDUAL.*—If, at the time an individual first
 25 becomes eligible to elect to receive benefits under part

1 *B or D (whichever is later), there is 1 or more*
 2 *MedicareAdvantage plans offered in the area in which*
 3 *the individual resides, the individual shall make the*
 4 *election under this section during a period specified*
 5 *by the Secretary such that if the individual elects a*
 6 *MedicareAdvantage plan during the period, coverage*
 7 *under the plan becomes effective as of the first date*
 8 *on which the individual may receive such coverage.*

9 “(2) *OPEN ENROLLMENT AND DISENROLLMENT*
 10 *OPPORTUNITIES.—Subject to paragraph (5), the fol-*
 11 *lowing rules shall apply:*

12 “(A) *CONTINUOUS OPEN ENROLLMENT AND*
 13 *DISENROLLMENT THROUGH 2005.—At any time*
 14 *during the period beginning January 1, 1998,*
 15 *and ending on December 31, 2005, a*
 16 *Medicare+Choice eligible individual may change*
 17 *the election under subsection (a)(1).*

18 “(B) *CONTINUOUS OPEN ENROLLMENT AND*
 19 *DISENROLLMENT FOR FIRST 6 MONTHS DURING*
 20 *2006.—*

21 “(i) *IN GENERAL.—Subject to clause*
 22 *(ii) and subparagraph (D), at any time*
 23 *during the first 6 months of 2006, or, if the*
 24 *individual first becomes a*
 25 *MedicareAdvantage eligible individual dur-*

ing 2006, during the first 6 months during
 2006 in which the individual is a
 MedicareAdvantage eligible individual, a
 MedicareAdvantage eligible individual may
 change the election under subsection (a)(1).

“(ii) *LIMITATION OF 1 CHANGE.*—An
 individual may exercise the right under
 clause (i) only once. The limitation under
 this clause shall not apply to changes in
 elections effected during an annual, coordi-
 nated election period under paragraph (3)
 or during a special enrollment period under
 the first sentence of paragraph (4).

“(C) *CONTINUOUS OPEN ENROLLMENT AND
 DISENROLLMENT FOR FIRST 3 MONTHS IN SUB-
 SEQUENT YEARS.*—

“(i) *IN GENERAL.*—Subject to clause
 (ii) and subparagraph (D), at any time
 during the first 3 months of 2007 and each
 subsequent year, or, if the individual first
 becomes a MedicareAdvantage eligible indi-
 vidual during 2007 or any subsequent year,
 during the first 3 months of such year in
 which the individual is a
 MedicareAdvantage eligible individual, a

1 *MedicareAdvantage* eligible individual may
 2 change the election under subsection (a)(1).

3 “(ii) *LIMITATION OF 1 CHANGE DURING*
 4 *OPEN ENROLLMENT PERIOD EACH YEAR.*—
 5 *An individual may exercise the right under*
 6 *clause (i) only once during the applicable 3-*
 7 *month period described in such clause in*
 8 *each year. The limitation under this clause*
 9 *shall not apply to changes in elections ef-*
 10 *fecting during an annual, coordinated elec-*
 11 *tion period under paragraph (3) or during*
 12 *a special enrollment period under para-*
 13 *graph (4).*

14 “(D) *CONTINUOUS OPEN ENROLLMENT FOR*
 15 *INSTITUTIONALIZED INDIVIDUALS.*—*At any time*
 16 *during 2006 or any subsequent year, in the case*
 17 *of a MedicareAdvantage eligible individual who*
 18 *is institutionalized (as defined by the Secretary),*
 19 *the individual may elect under subsection*
 20 *(a)(1)—*

21 “(i) *to enroll in a MedicareAdvantage*
 22 *plan; or*

23 “(ii) *to change the MedicareAdvantage*
 24 *plan in which the individual is enrolled.*

1 “(3) *ANNUAL, COORDINATED ELECTION PE-*
 2 *RIOD.*—

3 “(A) *IN GENERAL.*—*Subject to paragraph*
 4 *(5), each individual who is eligible to make an*
 5 *election under this section may change such elec-*
 6 *tion during an annual, coordinated election pe-*
 7 *riod.*

8 “(B) *ANNUAL, COORDINATED ELECTION PE-*
 9 *RIOD.*—*For purposes of this section, the term*
 10 *‘annual, coordinated election period’ means, with*
 11 *respect to a year before 2003 and after 2006, the*
 12 *month of November before such year and with re-*
 13 *spect to 2003, 2004, 2005, and 2006, the period*
 14 *beginning on November 15 and ending on De-*
 15 *cember 31 of the year before such year.*

16 “(C) *MEDICAREADVANTAGE HEALTH INFOR-*
 17 *MATION FAIRS.*—*During the fall season of each*
 18 *year (beginning with 2006), in conjunction with*
 19 *the annual coordinated election period defined in*
 20 *subparagraph (B), the Secretary shall provide*
 21 *for a nationally coordinated educational and*
 22 *publicity campaign to inform*
 23 *MedicareAdvantage eligible individuals about*
 24 *MedicareAdvantage plans and the election proc-*
 25 *ess provided under this section.*

1 “(D) *SPECIAL INFORMATION CAMPAIGN IN*
 2 *2005.—During the period beginning on November*
 3 *15, 2005, and ending on December 31, 2005, the*
 4 *Secretary shall provide for an educational and*
 5 *publicity campaign to inform*
 6 *MedicareAdvantage eligible individuals about the*
 7 *availability of MedicareAdvantage plans, and el-*
 8 *igible organizations with risk-sharing contracts*
 9 *under section 1876, offered in different areas and*
 10 *the election process provided under this section.*

11 “(4) *SPECIAL ELECTION PERIODS.—Effective on*
 12 *and after January 1, 2006, an individual may dis-*
 13 *continue an election of a MedicareAdvantage plan of-*
 14 *fered by a MedicareAdvantage organization other*
 15 *than during an annual, coordinated election period*
 16 *and make a new election under this section if—*

17 “(A)(i) *the certification of the organization*
 18 *or plan under this part has been terminated, or*
 19 *the organization or plan has notified the indi-*
 20 *vidual of an impending termination of such cer-*
 21 *tification; or*

22 “(ii) *the organization has terminated or*
 23 *otherwise discontinued providing the plan in the*
 24 *area in which the individual resides, or has noti-*

1 *fied the individual of an impending termination*
2 *or discontinuation of such plan;*

3 *“(B) the individual is no longer eligible to*
4 *elect the plan because of a change in the individ-*
5 *ual’s place of residence or other change in cir-*
6 *cumstances (specified by the Secretary, but not*
7 *including termination of the individual’s enroll-*
8 *ment on the basis described in clause (i) or (ii)*
9 *of subsection (g)(3)(B));*

10 *“(C) the individual demonstrates (in ac-*
11 *cordance with guidelines established by the Sec-*
12 *retary) that—*

13 *“(i) the organization offering the plan*
14 *substantially violated a material provision*
15 *of the organization’s contract under this*
16 *part in relation to the individual (includ-*
17 *ing the failure to provide an enrollee on a*
18 *timely basis medically necessary care for*
19 *which benefits are available under the plan*
20 *or the failure to provide such covered care*
21 *in accordance with applicable quality*
22 *standards); or*

23 *“(ii) the organization (or an agent or*
24 *other entity acting on the organization’s be-*
25 *half) materially misrepresented the plan’s*

1 provisions in marketing the plan to the in-
 2 dividual; or

3 “(D) the individual meets such other excep-
 4 tional conditions as the Secretary may provide.

5 *Effective on and after January 1, 2006, an indi-*
 6 *vidual who, upon first becoming eligible for benefits*
 7 *under part A at age 65, enrolls in a*
 8 *MedicareAdvantage plan under this part, the indi-*
 9 *vidual may discontinue the election of such plan, and*
 10 *elect coverage under the original fee-for-service plan,*
 11 *at any time during the 12-month period beginning on*
 12 *the effective date of such enrollment.*

13 “(5) *SPECIAL RULES FOR MSA PLANS.*—*Notwith-*
 14 *standing the preceding provisions of this subsection,*
 15 *an individual—*

16 “(A) *may elect an MSA plan only during—*

17 “*(i) an initial open enrollment period*
 18 *described in paragraph (1);*

19 “*(ii) an annual, coordinated election*
 20 *period described in paragraph (3)(B); or*

21 “*(iii) the month of November 1998;*

22 “(B) *subject to subparagraph (C), may not*
 23 *discontinue an election of an MSA plan except*
 24 *during the periods described in clause (ii) or*

1 *(iii) of subparagraph (A) and under the first*
 2 *sentence of paragraph (4); and*

3 *“(C) who elects an MSA plan during an*
 4 *annual, coordinated election period, and who*
 5 *never previously had elected such a plan, may*
 6 *revoke such election, in a manner determined by*
 7 *the Secretary, by not later than December 15 fol-*
 8 *lowing the date of the election.*

9 *“(6) OPEN ENROLLMENT PERIODS.—Subject to*
 10 *paragraph (5), a MedicareAdvantage organization—*

11 *“(A) shall accept elections or changes to*
 12 *elections during the initial enrollment periods*
 13 *described in paragraph (1), during the period be-*
 14 *ginning on November 15, 2005, and ending on*
 15 *December 31, 2005, and during the annual, co-*
 16 *ordinated election period under paragraph (3)*
 17 *for each subsequent year, and during special*
 18 *election periods described in the first sentence of*
 19 *paragraph (4); and*

20 *“(B) may accept other changes to elections*
 21 *at such other times as the organization provides.*

22 *“(f) EFFECTIVENESS OF ELECTIONS AND CHANGES OF*
 23 *ELECTIONS.—*

24 *“(1) DURING INITIAL COVERAGE ELECTION PE-*
 25 *RIOD.—An election of coverage made during the ini-*

1 *tial coverage election period under subsection*
 2 *(e)(1)(A) shall take effect upon the date the individual*
 3 *becomes entitled to (or enrolled for) benefits under*
 4 *part A, enrolled under part B, and enrolled under*
 5 *part D, except as the Secretary may provide (con-*
 6 *sistent with sections 1838 and 1860D–2)) in order to*
 7 *prevent retroactive coverage.*

8 “(2) *DURING CONTINUOUS OPEN ENROLLMENT*
 9 *PERIODS.—An election or change of coverage made*
 10 *under subsection (e)(2) shall take effect with the first*
 11 *day of the first calendar month following the date on*
 12 *which the election or change is made.*

13 “(3) *ANNUAL, COORDINATED ELECTION PE-*
 14 *RIOD.—An election or change of coverage made dur-*
 15 *ing an annual, coordinated election period (as defined*
 16 *in subsection (e)(3)(B)) in a year shall take effect as*
 17 *of the first day of the following year.*

18 “(4) *OTHER PERIODS.—An election or change of*
 19 *coverage made during any other period under sub-*
 20 *section (e)(4) shall take effect in such manner as the*
 21 *Secretary provides in a manner consistent (to the ex-*
 22 *tent practicable) with protecting continuity of health*
 23 *benefit coverage.*

24 “(g) *GUARANTEED ISSUE AND RENEWAL.—*

1 “(1) *IN GENERAL.*—*Except as provided in this*
 2 *subsection, a MedicareAdvantage organization shall*
 3 *provide that at any time during which elections are*
 4 *accepted under this section with respect to a*
 5 *MedicareAdvantage plan offered by the organization,*
 6 *the organization will accept without restrictions indi-*
 7 *viduals who are eligible to make such election.*

8 “(2) *PRIORITY.*—*If the Secretary determines that*
 9 *a MedicareAdvantage organization, in relation to a*
 10 *MedicareAdvantage plan it offers, has a capacity*
 11 *limit and the number of MedicareAdvantage eligible*
 12 *individuals who elect the plan under this section ex-*
 13 *ceeds the capacity limit, the organization may limit*
 14 *the election of individuals of the plan under this sec-*
 15 *tion but only if priority in election is provided—*

16 “(A) *first to such individuals as have elect-*
 17 *ed the plan at the time of the determination; and*

18 “(B) *then to other such individuals in such*
 19 *a manner that does not discriminate, on a basis*
 20 *described in section 1852(b), among the individ-*
 21 *uals (who seek to elect the plan).*

22 *The preceding sentence shall not apply if it would re-*
 23 *sult in the enrollment of enrollees substantially non-*
 24 *representative, as determined in accordance with reg-*

ulations of the Secretary, of the medicare population
in the service area of the plan.

“(3) *LIMITATION ON TERMINATION OF ELECTION.*—

“(A) *IN GENERAL.*—Subject to subparagraph (B), a MedicareAdvantage organization may not for any reason terminate the election of any individual under this section for a MedicareAdvantage plan it offers.

“(B) *BASIS FOR TERMINATION OF ELECTION.*—A MedicareAdvantage organization may terminate an individual’s election under this section with respect to a MedicareAdvantage plan it offers if—

“(i) any MedicareAdvantage monthly basic beneficiary premium, MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage, or MedicareAdvantage monthly beneficiary premium for required or optional enhanced medical benefits required with respect to such plan are not paid on a timely basis (consistent with standards under section 1856 that provide for a grace period for late payment of such premiums);

1 “(ii) the individual has engaged in
2 disruptive behavior (as specified in such
3 standards); or

4 “(iii) the plan is terminated with re-
5 spect to all individuals under this part in
6 the area in which the individual resides.

7 “(C) CONSEQUENCE OF TERMINATION.—

8 “(i) TERMINATIONS FOR CAUSE.—Any
9 individual whose election is terminated
10 under clause (i) or (ii) of subparagraph (B)
11 is deemed to have elected to receive benefits
12 under the original medicare fee-for-service
13 program option.

14 “(ii) TERMINATION BASED ON PLAN
15 TERMINATION OR SERVICE AREA REDUC-
16 TION.—Any individual whose election is
17 terminated under subparagraph (B)(iii)
18 shall have a special election period under
19 subsection (e)(4)(A) in which to change cov-
20 erage to coverage under another
21 MedicareAdvantage plan. Such an indi-
22 vidual who fails to make an election during
23 such period is deemed to have chosen to
24 change coverage to the original medicare
25 fee-for-service program option.

1 “(D) ORGANIZATION OBLIGATION WITH RE-
 2 SPECT TO ELECTION FORMS.—Pursuant to a
 3 contract under section 1857858., each
 4 MedicareAdvantage organization receiving an
 5 election form under subsection (c)(2) shall trans-
 6 mit to the Secretary (at such time and in such
 7 manner as the Secretary may specify) a copy of
 8 such form or such other information respecting
 9 the election as the Secretary may specify.

10 “(h) APPROVAL OF MARKETING MATERIAL AND APPLI-
 11 CATION FORMS.—

12 “(1) SUBMISSION.—No marketing material or
 13 application form may be distributed by a
 14 MedicareAdvantage organization to (or for the use of)
 15 MedicareAdvantage eligible individuals unless—

16 “(A) at least 45 days (or 10 days in the
 17 case described in paragraph (5)) before the date
 18 of distribution the organization has submitted
 19 the material or form to the Secretary for review;
 20 and

21 “(B) the Secretary has not disapproved the
 22 distribution of such material or form.

23 “(2) REVIEW.—The standards established under
 24 section 1856 shall include guidelines for the review of
 25 any material or form submitted and under such

1 *guidelines the Secretary shall disapprove (or later re-*
 2 *quire the correction of) such material or form if the*
 3 *material or form is materially inaccurate or mis-*
 4 *leading or otherwise makes a material misrepresenta-*
 5 *tion.*

6 “(3) *DEEMED APPROVAL (1-STOP SHOPPING).*—
 7 *In the case of material or form that is submitted*
 8 *under paragraph (1)(A) to the Secretary or a re-*
 9 *gional office of the Department of Health and Human*
 10 *Services and the Secretary or the office has not dis-*
 11 *approved the distribution of marketing material or*
 12 *form under paragraph (1)(B) with respect to a*
 13 *MedicareAdvantage plan in an area, the Secretary is*
 14 *deemed not to have disapproved such distribution in*
 15 *all other areas covered by the plan and organization*
 16 *except with regard to that portion of such material or*
 17 *form that is specific only to an area involved.*

18 “(4) *PROHIBITION OF CERTAIN MARKETING*
 19 *PRACTICES.*—*Each MedicareAdvantage organization*
 20 *shall conform to fair marketing standards, in relation*
 21 *to MedicareAdvantage plans offered under this part,*
 22 *included in the standards established under section*
 23 *1856. Such standards—*

24 “(A) *shall not permit a MedicareAdvantage*
 25 *organization to provide for cash or other mone-*

tary rebates as an inducement for enrollment or otherwise (other than as an additional benefit described in section 1854(g)(1)(C)(i)); and

“(B) may include a prohibition against a MedicareAdvantage organization (or agent of such an organization) completing any portion of any election form used to carry out elections under this section on behalf of any individual.

“(5) SPECIAL TREATMENT OF MARKETING MATERIAL FOLLOWING MODEL MARKETING LANGUAGE.—In the case of marketing material of an organization that uses, without modification, proposed model language specified by the Secretary, the period specified in paragraph (1)(A) shall be reduced from 45 days to 10 days.

“(i) EFFECT OF ELECTION OF MEDICAREADVANTAGE PLAN OPTION.—

“(1) PAYMENTS TO ORGANIZATIONS.—Subject to sections 1852(a)(5), 1853(h), 1853(i), 1886(d)(11), and 1886(h)(3)(D), payments under a contract with a MedicareAdvantage organization under section 1853(a) with respect to an individual electing a MedicareAdvantage plan offered by the organization shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under

1 *parts A, B, and D for items and services furnished*
 2 *to the individual.*

3 “(2) *ONLY ORGANIZATION ENTITLED TO PAY-*
 4 *MENT.—Subject to sections 1853(f), 1853(h), 1853(i),*
 5 *1857(f)(2), 1886(d)(11), and 1886(h)(3)(D), only the*
 6 *MedicareAdvantage organization shall be entitled to*
 7 *receive payments from the Secretary under this title*
 8 *for services furnished to the individual.”.*

9 **SEC. 202. BENEFITS AND BENEFICIARY PROTECTIONS.**

10 *Section 1852 (42 U.S.C. 1395w–22) is amended to*
 11 *read as follows:*

12 “*BENEFITS AND BENEFICIARY PROTECTIONS*

13 “*SEC. 1852. (a) BASIC BENEFITS.—*

14 “(1) *IN GENERAL.—Except as provided in sec-*
 15 *tion 1859(b)(3) for MSA plans, each*
 16 *MedicareAdvantage plan shall provide to members en-*
 17 *rolled under this part, through providers and other*
 18 *persons that meet the applicable requirements of this*
 19 *title and part A of title XI—*

20 “(A) *those items and services (other than*
 21 *hospice care) for which benefits are available*
 22 *under parts A and B to individuals residing in*
 23 *the area served by the plan;*

24 “(B) *except as provided in paragraph*
 25 *(2)(D), qualified prescription drug coverage*

1 *under part D to individuals residing in the area*
 2 *served by the plan;*

3 “(C) *a maximum limitation on out-of-pocket*
 4 *expenses and a unified deductible; and*

5 “(D) *additional benefits required under sec-*
 6 *tion 1854(d)(1).*

7 “(2) *SATISFACTION OF REQUIREMENT.—*

8 “(A) *IN GENERAL.—A MedicareAdvantage*
 9 *plan (other than an MSA plan) offered by a*
 10 *MedicareAdvantage organization satisfies para-*
 11 *graph (1)(A), with respect to benefits for items*
 12 *and services furnished other than through a pro-*
 13 *vider or other person that has a contract with*
 14 *the organization offering the plan, if the plan*
 15 *provides payment in an amount so that—*

16 “(i) *the sum of such payment amount*
 17 *and any cost-sharing provided for under the*
 18 *plan; is equal to at least*

19 “(ii) *the total dollar amount of pay-*
 20 *ment for such items and services as would*
 21 *otherwise be authorized under parts A and*
 22 *B (including any balance billing permitted*
 23 *under such parts).*

24 “(B) *REFERENCE TO RELATED PROVI-*
 25 *SIONS.—For provisions relating to—*

1 “(i) *limitations on balance billing*
 2 *against MedicareAdvantage organizations*
 3 *for noncontract providers, see sections*
 4 *1852(k) and 1866(a)(1)(O); and*

5 “(ii) *limiting actuarial value of en-*
 6 *rollee liability for covered benefits, see sec-*
 7 *tion 1854(f).*

8 “(C) *ELECTION OF UNIFORM COVERAGE*
 9 *POLICY.—In the case of a MedicareAdvantage or-*
 10 *ganization that offers a MedicareAdvantage plan*
 11 *in an area in which more than 1 local coverage*
 12 *policy is applied with respect to different parts*
 13 *of the area, the organization may elect to have*
 14 *the local coverage policy for the part of the area*
 15 *that is most beneficial to MedicareAdvantage en-*
 16 *rollees (as identified by the Secretary) apply*
 17 *with respect to all MedicareAdvantage enrollees*
 18 *enrolled in the plan.*

19 “(D) *SPECIAL RULE FOR PRIVATE FEE-FOR-*
 20 *SERVICE PLANS.—*

21 “(i) *IN GENERAL.—A private fee-for-*
 22 *service plan may elect not to provide quali-*
 23 *fied prescription drug coverage under part*
 24 *D to individuals residing in the area served*
 25 *by the plan.*

1 “(ii) *AVAILABILITY OF DRUG COV-*
 2 *ERAGE FOR ENROLLEES.*—*If a beneficiary*
 3 *enrolls in a plan making the election de-*
 4 *scribed in clause (i), the beneficiary may*
 5 *enroll for drug coverage under part D with*
 6 *an eligible entity under such part.*

7 “(3) *ENHANCED MEDICAL BENEFITS.*—

8 “(A) *BENEFITS INCLUDED SUBJECT TO SEC-*
 9 *RETARY’S APPROVAL.*—*Each MedicareAdvantage*
 10 *organization may provide to individuals enrolled*
 11 *under this part, other than under an MSA plan*
 12 *(without affording those individuals an option to*
 13 *decline the coverage), enhanced medical benefits*
 14 *that the Secretary may approve. The Secretary*
 15 *shall approve any such enhanced medical bene-*
 16 *fits unless the Secretary determines that includ-*
 17 *ing such enhanced medical benefits would sub-*
 18 *stantially discourage enrollment by*
 19 *MedicareAdvantage eligible individuals with the*
 20 *organization.*

21 “(B) *AT ENROLLEES’ OPTION.*—*A*
 22 *MedicareAdvantage organization may not pro-*
 23 *vide, under an MSA plan, enhanced medical*
 24 *benefits that cover the deductible described in sec-*
 25 *tion 1859(b)(2)(B). In applying the previous*

1 *sentence, health benefits described in section*
 2 *1882(u)(2)(B) shall not be treated as covering*
 3 *such deductible.*

4 *“(C) APPLICATION TO MEDICAREADVANTAGE*
 5 *PRIVATE FEE-FOR-SERVICE PLANS.—Nothing in*
 6 *this paragraph shall be construed as preventing*
 7 *a MedicareAdvantage private fee-for-service plan*
 8 *from offering enhanced medical benefits that in-*
 9 *clude payment for some or all of the balance bill-*
 10 *ing amounts permitted consistent with section*
 11 *1852(k) and coverage of additional services that*
 12 *the plan finds to be medically necessary.*

13 *“(D) RULE FOR APPROVAL OF MEDICAL AND*
 14 *PRESCRIPTION DRUG BENEFITS.—Notwith-*
 15 *standing the preceding provisions of this para-*
 16 *graph, the Secretary may not approve any en-*
 17 *hanced medical benefit that provides for the cov-*
 18 *erage of any prescription drug (other than that*
 19 *relating to prescription drugs covered under the*
 20 *original medicare fee-for-service program op-*
 21 *tion).*

22 *“(4) ORGANIZATION AS SECONDARY PAYER.—*
 23 *Notwithstanding any other provision of law, a*
 24 *MedicareAdvantage organization may (in the case of*
 25 *the provision of items and services to an individual*

1 *under a MedicareAdvantage plan under cir-*
 2 *cumstances in which payment under this title is*
 3 *made secondary pursuant to section 1862(b)(2))*
 4 *charge or authorize the provider of such services to*
 5 *charge, in accordance with the charges allowed under*
 6 *a law, plan, or policy described in such section—*

7 *“(A) the insurance carrier, employer, or*
 8 *other entity which under such law, plan, or pol-*
 9 *icy is to pay for the provision of such services;*
 10 *or*

11 *“(B) such individual to the extent that the*
 12 *individual has been paid under such law, plan,*
 13 *or policy for such services.*

14 *“(5) NATIONAL COVERAGE DETERMINATIONS AND*
 15 *LEGISLATIVE CHANGES IN BENEFITS.—If there is a*
 16 *national coverage determination or legislative change*
 17 *in benefits required to be provided under this part*
 18 *made in the period beginning on the date of an an-*
 19 *nouncement under section 1853(b) and ending on the*
 20 *date of the next announcement under such section and*
 21 *the Secretary projects that the determination will re-*
 22 *sult in a significant change in the costs to a*
 23 *MedicareAdvantage organization of providing the*
 24 *benefits that are the subject of such national coverage*
 25 *determination and that such change in costs was not*

1 *incorporated in the determination of the benchmark*
 2 *amount announced under section 1853(b)(1)(A) at the*
 3 *beginning of such period, then, unless otherwise re-*
 4 *quired by law—*

5 “(A) such determination or legislative
 6 change in benefits shall not apply to contracts
 7 under this part until the first contract year that
 8 begins after the end of such period; and

9 “(B) if such coverage determination or leg-
 10 islative change provides for coverage of addi-
 11 tional benefits or coverage under additional cir-
 12 cumstances, section 1851(i)(1) shall not apply to
 13 payment for such additional benefits or benefits
 14 provided under such additional circumstances
 15 until the first contract year that begins after the
 16 end of such period.

17 *The projection under the previous sentence shall be*
 18 *based on an analysis by the Secretary of the actuarial*
 19 *costs associated with the coverage determination or*
 20 *legislative change in benefits.*

21 “(6) *AUTHORITY TO PROHIBIT RISK SELEC-*
 22 *TION.—The Secretary shall have the authority to dis-*
 23 *approve any MedicareAdvantage plan that the Sec-*
 24 *retary determines is designed to attract a population*

1 *that is healthier than the average population residing*
 2 *in the service area of the plan.*

3 “(7) *UNIFIED DEDUCTIBLE DEFINED.*—*In this*
 4 *part, the term ‘unified deductible’ means an annual*
 5 *deductible amount that is applied in lieu of the inpa-*
 6 *tient hospital deductible under section 1813(b)(1) and*
 7 *the deductible under section 1833(b). Nothing in this*
 8 *part shall be construed as preventing a*
 9 *MedicareAdvantage organization from requiring coin-*
 10 *surance or a copayment for inpatient hospital serv-*
 11 *ices after the unified deductible is satisfied, subject to*
 12 *the limitation on enrollee liability under section*
 13 *1854(f).*

14 “(b) *ANTIDISCRIMINATION.*—

15 “(1) *BENEFICIARIES.*—

16 “(A) *IN GENERAL.*—*A MedicareAdvantage*
 17 *organization may not deny, limit, or condition*
 18 *the coverage or provision of benefits under this*
 19 *part, for individuals permitted to be enrolled*
 20 *with the organization under this part, based on*
 21 *any health status-related factor described in sec-*
 22 *tion 2702(a)(1) of the Public Health Service Act.*

23 “(B) *CONSTRUCTION.*—*Except as provided*
 24 *under section 1851(a)(3)(B), subparagraph (A)*
 25 *shall not be construed as requiring a*

1 *MedicareAdvantage organization to enroll indi-*
2 *viduals who are determined to have end-stage*
3 *renal disease.*

4 “(2) *PROVIDERS.—A MedicareAdvantage organi-*
5 *zation shall not discriminate with respect to partici-*
6 *pation, reimbursement, or indemnification as to any*
7 *provider who is acting within the scope of the pro-*
8 *vider’s license or certification under applicable State*
9 *law, solely on the basis of such license or certification.*
10 *This paragraph shall not be construed to prohibit a*
11 *plan from including providers only to the extent nec-*
12 *essary to meet the needs of the plan’s enrollees or from*
13 *establishing any measure designed to maintain qual-*
14 *ity and control costs consistent with the responsibil-*
15 *ities of the plan.*

16 “(c) *DISCLOSURE REQUIREMENTS.—*

17 “(1) *DETAILED DESCRIPTION OF PLAN PROVI-*
18 *SIONS.—A MedicareAdvantage organization shall dis-*
19 *close, in clear, accurate, and standardized form to*
20 *each enrollee with a MedicareAdvantage plan offered*
21 *by the organization under this part at the time of en-*
22 *rollment and at least annually thereafter, the fol-*
23 *lowing information regarding such plan:*

24 “(A) *SERVICE AREA.—The plan’s service*
25 *area.*

1 “(B) *BENEFITS.*—*Benefits offered under the*
2 *plan, including information described section*
3 *1852(a)(1) (relating to benefits under the origi-*
4 *nal medicare fee-for-service program option, the*
5 *maximum limitation in out-of-pocket expenses*
6 *and the unified deductible, and qualified pre-*
7 *scription drug coverage under part D, respec-*
8 *tively) and exclusions from coverage and, if it is*
9 *an MSA plan, a comparison of benefits under*
10 *such a plan with benefits under other*
11 *MedicareAdvantage plans.*

12 “(C) *ACCESS.*—*The number, mix, and dis-*
13 *tribution of plan providers, out-of-network cov-*
14 *erage (if any) provided by the plan, and any*
15 *point-of-service option (including the*
16 *MedicareAdvantage monthly beneficiary pre-*
17 *mium for enhanced medical benefits for such op-*
18 *tion).*

19 “(D) *OUT-OF-AREA COVERAGE.*—*Out-of-*
20 *area coverage provided by the plan.*

21 “(E) *EMERGENCY COVERAGE.*—*Coverage of*
22 *emergency services, including—*

23 “(i) *the appropriate use of emergency*
24 *services, including use of the 911 telephone*
25 *system or its local equivalent in emergency*

1 *situations and an explanation of what con-*
 2 *stitutes an emergency situation;*

3 *“(ii) the process and procedures of the*
 4 *plan for obtaining emergency services; and*

5 *“(iii) the locations of—*

6 *“(I) emergency departments; and*

7 *“(II) other settings, in which plan*
 8 *physicians and hospitals provide emer-*
 9 *gency services and post-stabilization*
 10 *care.*

11 *“(F) ENHANCED MEDICAL BENEFITS.—En-*
 12 *hanced medical benefits available from the orga-*
 13 *nization offering the plan, including—*

14 *“(i) whether the enhanced medical ben-*
 15 *efits are optional;*

16 *“(ii) the enhanced medical benefits cov-*
 17 *ered; and*

18 *“(iii) the MedicareAdvantage monthly*
 19 *beneficiary premium for enhanced medical*
 20 *benefits.*

21 *“(G) PRIOR AUTHORIZATION RULES.—*
 22 *Rules regarding prior authorization or other re-*
 23 *view requirements that could result in non-*
 24 *payment.*

1 “(H) *PLAN GRIEVANCE AND APPEALS PRO-*
 2 *CEDURES.—All plan appeal or grievance rights*
 3 *and procedures.*

4 “(I) *QUALITY ASSURANCE PROGRAM.—A de-*
 5 *scription of the organization’s quality assurance*
 6 *program under subsection (e).*

7 “(2) *DISCLOSURE UPON REQUEST.—Upon re-*
 8 *quest of a MedicareAdvantage eligible individual, a*
 9 *MedicareAdvantage organization must provide the fol-*
 10 *lowing information to such individual:*

11 “(A) *The general coverage information and*
 12 *general comparative plan information made*
 13 *available under clauses (i) and (ii) of section*
 14 *1851(d)(2)(A).*

15 “(B) *Information on procedures used by the*
 16 *organization to control utilization of services*
 17 *and expenditures.*

18 “(C) *Information on the number of griev-*
 19 *ances, reconsiderations, and appeals and on the*
 20 *disposition in the aggregate of such matters.*

21 “(D) *An overall summary description as to*
 22 *the method of compensation of participating*
 23 *physicians.*

24 “(E) *The information described in subpara-*
 25 *graphs (A) through (C) in relation to the quali-*

1 *fied prescription drug coverage provided by the*
 2 *organization.*

3 “(d) *ACCESS TO SERVICES.*—

4 “(1) *IN GENERAL.*—A MedicareAdvantage orga-
 5 *nization offering a MedicareAdvantage plan may se-*
 6 *lect the providers from whom the benefits under the*
 7 *plan are provided so long as—*

8 “(A) *the organization makes such benefits*
 9 *available and accessible to each individual elect-*
 10 *ing the plan within the plan service area with*
 11 *reasonable promptness and in a manner which*
 12 *assures continuity in the provision of benefits;*

13 “(B) *when medically necessary the organi-*
 14 *zation makes such benefits available and acces-*
 15 *sible 24 hours a day and 7 days a week;*

16 “(C) *the plan provides for reimbursement*
 17 *with respect to services which are covered under*
 18 *subparagraphs (A) and (B) and which are pro-*
 19 *vided to such an individual other than through*
 20 *the organization, if—*

21 “(i) *the services were not emergency*
 22 *services (as defined in paragraph (3)),*
 23 *but—*

24 “(I) *the services were medically*
 25 *necessary and immediately required*

1 *because of an unforeseen illness, injury,*
2 *or condition; and*

3 “(II) *it was not reasonable given*
4 *the circumstances to obtain the services*
5 *through the organization;*

6 “(ii) *the services were renal dialysis*
7 *services and were provided other than*
8 *through the organization because the indi-*
9 *vidual was temporarily out of the plan’s*
10 *service area; or*

11 “(iii) *the services are maintenance care*
12 *or post-stabilization care covered under the*
13 *guidelines established under paragraph (2);*

14 “(D) *the organization provides access to ap-*
15 *propriate providers, including credentialed spe-*
16 *cialists, for medically necessary treatment and*
17 *services; and*

18 “(E) *coverage is provided for emergency*
19 *services (as defined in paragraph (3)) without*
20 *regard to prior authorization or the emergency*
21 *care provider’s contractual relationship with the*
22 *organization.*

23 “(2) *GUIDELINES RESPECTING COORDINATION OF*
24 *POST-STABILIZATION CARE.—A MedicareAdvantage*
25 *plan shall comply with such guidelines as the Sec-*

retary may prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1867.

“(3) *DEFINITION OF EMERGENCY SERVICES.*—In this subsection—

“(A) *IN GENERAL.*—The term ‘emergency services’ means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

“(i) are furnished by a provider that is qualified to furnish such services under this title; and

“(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (B)).

“(B) *EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.*—The term ‘emergency medical condition’ means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could rea-

sonably expect the absence of immediate medical attention to result in—

“(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

“(ii) serious impairment to bodily functions; or

“(iii) serious dysfunction of any bodily organ or part.

“(4) ASSURING ACCESS TO SERVICES IN MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—In addition to any other requirements under this part, in the case of a MedicareAdvantage private fee-for-service plan, the organization offering the plan must demonstrate to the Secretary that the organization has sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan. The Secretary shall find that an organization has met such requirement with respect to any category of health care professional or provider if, with respect to that category of provider—

1 “(A) the plan has established payment
 2 rates for covered services furnished by that
 3 category of provider that are not less than
 4 the payment rates provided for under part
 5 A, B, or D for such services; or

6 “(B) the plan has contracts or agree-
 7 ments with a sufficient number and range
 8 of providers within such category to provide
 9 covered services under the terms of the plan,
 10 or a combination of both. The previous sentence
 11 shall not be construed as restricting the persons
 12 from whom enrollees under such a plan may ob-
 13 tain covered benefits.

14 “(e) *QUALITY ASSURANCE PROGRAM.*—

15 “(1) *IN GENERAL.*—Each MedicareAdvantage or-
 16 ganization must have arrangements, consistent with
 17 any regulation, for an ongoing quality assurance pro-
 18 gram for health care services it provides to individ-
 19 uals enrolled with MedicareAdvantage plans of the or-
 20 ganization.

21 “(2) *ELEMENTS OF PROGRAM.*—

22 “(A) *IN GENERAL.*—The quality assurance
 23 program of an organization with respect to a
 24 MedicareAdvantage plan (other than a

1 *MedicareAdvantage private fee-for-service plan*
2 *or a nonnetwork MSA plan) it offers shall—*

3 “(i) *stress health outcomes and provide*
4 *for the collection, analysis, and reporting of*
5 *data (in accordance with a quality meas-*
6 *urement system that the Secretary recog-*
7 *nizes) that will permit measurement of out-*
8 *comes and other indices of the quality of*
9 *MedicareAdvantage plans and organiza-*
10 *tions;*

11 “(ii) *monitor and evaluate high vol-*
12 *ume and high risk services and the care of*
13 *acute and chronic conditions;*

14 “(iii) *provide access to disease man-*
15 *agement and chronic care services;*

16 “(iv) *provide access to preventive bene-*
17 *fits and information for enrollees on such*
18 *benefits;*

19 “(v) *evaluate the continuity and co-*
20 *ordination of care that enrollees receive;*

21 “(vi) *be evaluated on an ongoing basis*
22 *as to its effectiveness;*

23 “(vii) *include measures of consumer*
24 *satisfaction;*

1 “(viii) provide the Secretary with such
2 access to information collected as may be
3 appropriate to monitor and ensure the qual-
4 ity of care provided under this part;

5 “(ix) provide review by physicians and
6 other health care professionals of the process
7 followed in the provision of such health care
8 services;

9 “(x) provide for the establishment of
10 written protocols for utilization review,
11 based on current standards of medical prac-
12 tice;

13 “(xi) have mechanisms to detect both
14 underutilization and overutilization of serv-
15 ices;

16 “(xii) after identifying areas for im-
17 provement, establish or alter practice pa-
18 rameters;

19 “(xiii) take action to improve quality
20 and assesses the effectiveness of such action
21 through systematic followup; and

22 “(xiv) make available information on
23 quality and outcomes measures to facilitate
24 beneficiary comparison and choice of health
25 coverage options (in such form and on such

1 *quality and outcomes measures as the Sec-*
 2 *retary determines to be appropriate).*

3 *Such program shall include a separate focus*
 4 *(with respect to all the elements described in this*
 5 *subparagraph) on racial and ethnic minorities.*

6 “(B) *ELEMENTS OF PROGRAM FOR ORGANI-*
 7 *ZATIONS OFFERING MEDICAREADVANTAGE PRI-*
 8 *VATE FEE-FOR-SERVICE PLANS, AND NONNET-*
 9 *WORK MSA PLANS.—The quality assurance pro-*
 10 *gram of an organization with respect to a*
 11 *MedicareAdvantage private fee-for-service plan*
 12 *or a nonnetwork MSA plan it offers shall—*

13 *“(i) meet the requirements of clauses*
 14 *(i) through (viii) of subparagraph (A);*

15 *“(ii) insofar as it provides for the es-*
 16 *tablishment of written protocols for utiliza-*
 17 *tion review, base such protocols on current*
 18 *standards of medical practice; and*

19 *“(iii) have mechanisms to evaluate uti-*
 20 *lization of services and inform providers*
 21 *and enrollees of the results of such evalua-*
 22 *tion.*

23 *Such program shall include a separate focus*
 24 *(with respect to all the elements described in this*
 25 *subparagraph) on racial and ethnic minorities.*

1 “(C) *DEFINITION OF NONNETWORK MSA*
 2 *PLAN.—In this subsection, the term ‘nonnetwork*
 3 *MSA plan’ means an MSA plan offered by a*
 4 *MedicareAdvantage organization that does not*
 5 *provide benefits required to be provided by this*
 6 *part, in whole or in part, through a defined set*
 7 *of providers under contract, or under another ar-*
 8 *rangement, with the organization.*

9 “(3) *EXTERNAL REVIEW.—*

10 “(A) *IN GENERAL.—Each*
 11 *MedicareAdvantage organization shall, for each*
 12 *MedicareAdvantage plan it operates, have an*
 13 *agreement with an independent quality review*
 14 *and improvement organization approved by the*
 15 *Secretary to perform functions of the type de-*
 16 *scribed in paragraphs (4)(B) and (14) of section*
 17 *1154(a) with respect to services furnished by*
 18 *MedicareAdvantage plans for which payment is*
 19 *made under this title. The previous sentence shall*
 20 *not apply to a MedicareAdvantage private fee-*
 21 *for-service plan or a nonnetwork MSA plan that*
 22 *does not employ utilization review.*

23 “(B) *NONDUPLICATION OF ACCREDITA-*
 24 *TION.—Except in the case of the review of qual-*
 25 *ity complaints, and consistent with subpara-*

graph (C), the Secretary shall ensure that the external review activities conducted under subparagraph (A) are not duplicative of review activities conducted as part of the accreditation process.

“(C) *WAIVER AUTHORITY.*—The Secretary may waive the requirement described in subparagraph (A) in the case of an organization if the Secretary determines that the organization has consistently maintained an excellent record of quality assurance and compliance with other requirements under this part.

“(4) *TREATMENT OF ACCREDITATION.*—

“(A) *IN GENERAL.*—The Secretary shall provide that a MedicareAdvantage organization is deemed to meet all the requirements described in any specific clause of subparagraph (B) if the organization is accredited (and periodically re-accredited) by a private accrediting organization under a process that the Secretary has determined assures that the accrediting organization applies and enforces standards that meet or exceed the standards established under section 1856 to carry out the requirements in such clause.

1 “(B) *REQUIREMENTS DESCRIBED.—The*
 2 *provisions described in this subparagraph are*
 3 *the following:*

4 “(i) *Paragraphs (1) and (2) of this*
 5 *subsection (relating to quality assurance*
 6 *programs).*

7 “(ii) *Subsection (b) (relating to anti-*
 8 *discrimination).*

9 “(iii) *Subsection (d) (relating to access*
 10 *to services).*

11 “(iv) *Subsection (h) (relating to con-*
 12 *fidentiality and accuracy of enrollee*
 13 *records).*

14 “(v) *Subsection (i) (relating to infor-*
 15 *mation on advance directives).*

16 “(vi) *Subsection (j) (relating to pro-*
 17 *vider participation rules).*

18 “(C) *TIMELY ACTION ON APPLICATIONS.—*
 19 *The Secretary shall determine, within 210 days*
 20 *after the date the Secretary receives an applica-*
 21 *tion by a private accrediting organization and*
 22 *using the criteria specified in section 1865(b)(2),*
 23 *whether the process of the private accrediting or-*
 24 *ganization meets the requirements with respect*
 25 *to any specific clause in subparagraph (B) with*

1 *respect to which the application is made. The*
 2 *Secretary may not deny such an application on*
 3 *the basis that it seeks to meet the requirements*
 4 *with respect to only one, or more than one, such*
 5 *specific clause.*

6 “(D) CONSTRUCTION.—*Nothing in this*
 7 *paragraph shall be construed as limiting the au-*
 8 *thority of the Secretary under section 1857, in-*
 9 *cluding the authority to terminate contracts with*
 10 *MedicareAdvantage organizations under sub-*
 11 *section (c)(2) of such section.*

12 “(5) REPORT TO CONGRESS.—

13 “(A) IN GENERAL.—*The Secretary shall*
 14 *submit to Congress a biennial report regarding*
 15 *how quality assurance programs conducted*
 16 *under this subsection focus on racial and ethnic*
 17 *minorities.*

18 “(B) CONTENTS OF REPORT.—*Each such re-*
 19 *port shall include the following:*

20 “(i) *A description of the means by*
 21 *which such programs focus on such racial*
 22 *and ethnic minorities.*

23 “(ii) *An evaluation of the impact of*
 24 *such programs on eliminating health dis-*
 25 *parities and on improving health outcomes,*

1 *continuity and coordination of care, man-*
 2 *agement of chronic conditions, and con-*
 3 *sumer satisfaction.*

4 “(iii) *Recommendations on ways to re-*
 5 *duce clinical outcome disparities among ra-*
 6 *cial and ethnic minorities.*

7 “(f) *GRIEVANCE MECHANISM.—Each*
 8 *MedicareAdvantage organization must provide meaningful*
 9 *procedures for hearing and resolving grievances between the*
 10 *organization (including any entity or individual through*
 11 *which the organization provides health care services) and*
 12 *enrollees with MedicareAdvantage plans of the organization*
 13 *under this part.*

14 “(g) *COVERAGE DETERMINATIONS, RECONSIDER-*
 15 *ATIONS, AND APPEALS.—*

16 “(1) *DETERMINATIONS BY ORGANIZATION.—*

17 “(A) *IN GENERAL.—A MedicareAdvantage*
 18 *organization shall have a procedure for making*
 19 *determinations regarding whether an individual*
 20 *enrolled with the plan of the organization under*
 21 *this part is entitled to receive a health service*
 22 *under this section and the amount (if any) that*
 23 *the individual is required to pay with respect to*
 24 *such service. Subject to paragraph (3), such pro-*

1 *cedures shall provide for such determination to*
 2 *be made on a timely basis.*

3 *“(B) EXPLANATION OF DETERMINATION.—*

4 *Such a determination that denies coverage, in*
 5 *whole or in part, shall be in writing and shall*
 6 *include a statement in understandable language*
 7 *of the reasons for the denial and a description of*
 8 *the reconsideration and appeals processes.*

9 *“(2) RECONSIDERATIONS.—*

10 *“(A) IN GENERAL.—The organization shall*
 11 *provide for reconsideration of a determination*
 12 *described in paragraph (1)(B) upon request by*
 13 *the enrollee involved. The reconsideration shall be*
 14 *within a time period specified by the Secretary,*
 15 *but shall be made, subject to paragraph (3), not*
 16 *later than 60 days after the date of the receipt*
 17 *of the request for reconsideration.*

18 *“(B) PHYSICIAN DECISION ON CERTAIN RE-*
 19 *CONSIDERATIONS.—A reconsideration relating to*
 20 *a determination to deny coverage based on a lack*
 21 *of medical necessity shall be made only by a*
 22 *physician with appropriate expertise in the field*
 23 *of medicine which necessitates treatment who is*
 24 *other than a physician involved in the initial de-*
 25 *termination.*

1 “(3) *EXPEDITED DETERMINATIONS AND RECON-*
2 *SIDERATIONS.*—

3 “(A) *RECEIPT OF REQUESTS.*—

4 “(i) *ENROLLEE REQUESTS.*—An en-
5 rollee in a MedicareAdvantage plan may re-
6 quest, either in writing or orally, an expe-
7 dited determination under paragraph (1) or
8 an expedited reconsideration under para-
9 graph (2) by the MedicareAdvantage orga-
10 nization.

11 “(ii) *PHYSICIAN REQUESTS.*—A physi-
12 cian, regardless whether the physician is af-
13 filiated with the organization or not, may
14 request, either in writing or orally, such an
15 expedited determination or reconsideration.

16 “(B) *ORGANIZATION PROCEDURES.*—

17 “(i) *IN GENERAL.*—The
18 MedicareAdvantage organization shall
19 maintain procedures for expediting organi-
20 zation determinations and reconsiderations
21 when, upon request of an enrollee, the orga-
22 nization determines that the application of
23 the normal timeframe for making a deter-
24 mination (or a reconsideration involving a
25 determination) could seriously jeopardize

1 *the life or health of the enrollee or the en-*
2 *rollee's ability to regain maximum function.*

3 “(ii) *EXPEDITION REQUIRED FOR PHY-*
4 *SICIAN REQUESTS.—In the case of a request*
5 *for an expedited determination or reconsid-*
6 *eration made under subparagraph (A)(ii),*
7 *the organization shall expedite the deter-*
8 *mination or reconsideration if the request*
9 *indicates that the application of the normal*
10 *timeframe for making a determination (or a*
11 *reconsideration involving a determination)*
12 *could seriously jeopardize the life or health*
13 *of the enrollee or the enrollee's ability to re-*
14 *gain maximum function.*

15 “(iii) *TIMELY RESPONSE.—In cases de-*
16 *scribed in clauses (i) and (ii), the organiza-*
17 *tion shall notify the enrollee (and the physi-*
18 *cian involved, as appropriate) of the deter-*
19 *mination or reconsideration under time*
20 *limitations established by the Secretary, but*
21 *not later than 72 hours of the time of re-*
22 *ceipt of the request for the determination or*
23 *reconsideration (or receipt of the informa-*
24 *tion necessary to make the determination or*

1 reconsideration), or such longer period as
 2 the Secretary may permit in specified cases.

3 “(4) *INDEPENDENT REVIEW OF CERTAIN COV-*
 4 *ERAGE DENIALS.*—The Secretary shall contract with
 5 an independent, outside entity to review and resolve
 6 in a timely manner reconsiderations that affirm de-
 7 nial of coverage, in whole or in part. The provisions
 8 of section 1869(c)(5) shall apply to independent out-
 9 side entities under contract with the Secretary under
 10 this paragraph.

11 “(5) *APPEALS.*—An enrollee with a
 12 MedicareAdvantage plan of a MedicareAdvantage or-
 13 ganization under this part who is dissatisfied by rea-
 14 son of the enrollee’s failure to receive any health serv-
 15 ice to which the enrollee believes the enrollee is enti-
 16 tled and at no greater charge than the enrollee believes
 17 the enrollee is required to pay is entitled, if the
 18 amount in controversy is \$100 or more, to a hearing
 19 before the Secretary to the same extent as is provided
 20 in section 205(b), and in any such hearing the Sec-
 21 retary shall make the organization a party. If the
 22 amount in controversy is \$1,000 or more, the indi-
 23 vidual or organization shall, upon notifying the other
 24 party, be entitled to judicial review of the Secretary’s
 25 final decision as provided in section 205(g), and both

1 *the individual and the organization shall be entitled*
 2 *to be parties to that judicial review. In applying sub-*
 3 *sections (b) and (g) of section 205 as provided in this*
 4 *paragraph, and in applying section 205(l) thereto,*
 5 *any reference therein to the Commissioner of Social*
 6 *Security or the Social Security Administration shall*
 7 *be considered a reference to the Secretary or the De-*
 8 *partment of Health and Human Services, respec-*
 9 *tively.*

10 “(h) *CONFIDENTIALITY AND ACCURACY OF ENROLLEE*
 11 *RECORDS.—Insofar as a MedicareAdvantage organization*
 12 *maintains medical records or other health information re-*
 13 *garding enrollees under this part, the MedicareAdvantage*
 14 *organization shall establish procedures—*

15 “(1) *to safeguard the privacy of any individ-*
 16 *ually identifiable enrollee information;*

17 “(2) *to maintain such records and information*
 18 *in a manner that is accurate and timely; and*

19 “(3) *to assure timely access of enrollees to such*
 20 *records and information.*

21 “(i) *INFORMATION ON ADVANCE DIRECTIVES.—Each*
 22 *MedicareAdvantage organization shall meet the requirement*
 23 *of section 1866(f) (relating to maintaining written policies*
 24 *and procedures respecting advance directives).*

25 “(j) *RULES REGARDING PROVIDER PARTICIPATION.—*

1 “(1) *PROCEDURES.—Insofar as a*
2 *MedicareAdvantage organization offers benefits under*
3 *a MedicareAdvantage plan through agreements with*
4 *physicians, the organization shall establish reasonable*
5 *procedures relating to the participation (under an*
6 *agreement between a physician and the organization)*
7 *of physicians under such a plan. Such procedures*
8 *shall include—*

9 “(A) *providing notice of the rules regarding*
10 *participation;*

11 “(B) *providing written notice of participa-*
12 *tion decisions that are adverse to physicians;*
13 *and*

14 “(C) *providing a process within the organi-*
15 *zation for appealing such adverse decisions, in-*
16 *cluding the presentation of information and*
17 *views of the physician regarding such decision.*

18 “(2) *CONSULTATION IN MEDICAL POLICIES.—A*
19 *MedicareAdvantage organization shall consult with*
20 *physicians who have entered into participation agree-*
21 *ments with the organization regarding the organiza-*
22 *tion’s medical policy, quality, and medical manage-*
23 *ment procedures.*

24 “(3) *PROHIBITING INTERFERENCE WITH PRO-*
25 *VIDER ADVICE TO ENROLLEES.—*

1 “(A) *IN GENERAL.*—Subject to subpara-
 2 graphs (B) and (C), a MedicareAdvantage orga-
 3 nization (in relation to an individual enrolled
 4 under a MedicareAdvantage plan offered by the
 5 organization under this part) shall not prohibit
 6 or otherwise restrict a covered health care profes-
 7 sional (as defined in subparagraph (D)) from
 8 advising such an individual who is a patient of
 9 the professional about the health status of the in-
 10 dividual or medical care or treatment for the in-
 11 dividual’s condition or disease, regardless of
 12 whether benefits for such care or treatment are
 13 provided under the plan, if the professional is
 14 acting within the lawful scope of practice.

15 “(B) *CONSCIENCE PROTECTION.*—Subpara-
 16 graph (A) shall not be construed as requiring a
 17 MedicareAdvantage plan to provide, reimburse
 18 for, or provide coverage of a counseling or refer-
 19 ral service if the MedicareAdvantage organiza-
 20 tion offering the plan—

21 “(i) objects to the provision of such
 22 service on moral or religious grounds; and

23 “(ii) in the manner and through the
 24 written instrumentalities such
 25 MedicareAdvantage organization deems ap-

1 *appropriate, makes available information on*
 2 *its policies regarding such service to pro-*
 3 *spective enrollees before or during enroll-*
 4 *ment and to enrollees within 90 days after*
 5 *the date that the organization or plan*
 6 *adopts a change in policy regarding such a*
 7 *counseling or referral service.*

8 “(C) *CONSTRUCTION.*—*Nothing in subpara-*
 9 *graph (B) shall be construed to affect disclosure*
 10 *requirements under State law or under the Em-*
 11 *ployee Retirement Income Security Act of 1974.*

12 “(D) *HEALTH CARE PROFESSIONAL DE-*
 13 *FINED.*—*For purposes of this paragraph, the*
 14 *term ‘health care professional’ means a physi-*
 15 *cian (as defined in section 1861(r)) or other*
 16 *health care professional if coverage for the profes-*
 17 *sional’s services is provided under the*
 18 *MedicareAdvantage plan for the services of the*
 19 *professional. Such term includes a podiatrist,*
 20 *optometrist, chiropractor, psychologist, dentist,*
 21 *licensed pharmacist, physician assistant, phys-*
 22 *ical or occupational therapist and therapy as-*
 23 *istant, speech-language pathologist, audiologist,*
 24 *registered or licensed practical nurse (including*
 25 *nurse practitioner, clinical nurse specialist, cer-*

1 *tified registered nurse anesthetist, and certified*
 2 *nurse-midwife), licensed certified social worker,*
 3 *registered respiratory therapist, and certified res-*
 4 *piratory therapy technician.*

5 “(4) *LIMITATIONS ON PHYSICIAN INCENTIVE*
 6 *PLANS.—*

7 “(A) *IN GENERAL.—No MedicareAdvantage*
 8 *organization may operate any physician incen-*
 9 *tive plan (as defined in subparagraph (B)) un-*
 10 *less the following requirements are met:*

11 “(i) *No specific payment is made di-*
 12 *rectly or indirectly under the plan to a phy-*
 13 *sician or physician group as an inducement*
 14 *to reduce or limit medically necessary serv-*
 15 *ices provided with respect to a specific indi-*
 16 *vidual enrolled with the organization.*

17 “(ii) *If the plan places a physician or*
 18 *physician group at substantial financial*
 19 *risk (as determined by the Secretary) for*
 20 *services not provided by the physician or*
 21 *physician group, the organization—*

22 “(I) *provides stop-loss protection*
 23 *for the physician or group that is ade-*
 24 *quate and appropriate, based on stand-*
 25 *ards developed by the Secretary that*

1 *take into account the number of physi-*
 2 *cians placed at such substantial finan-*
 3 *cial risk in the group or under the*
 4 *plan and the number of individuals*
 5 *enrolled with the organization who re-*
 6 *ceive services from the physician or*
 7 *group; and*

8 *“(II) conducts periodic surveys of*
 9 *both individuals enrolled and individ-*
 10 *uals previously enrolled with the orga-*
 11 *nization to determine the degree of ac-*
 12 *cess of such individuals to services pro-*
 13 *vided by the organization and satisfac-*
 14 *tion with the quality of such services.*

15 *“(iii) The organization provides the*
 16 *Secretary with descriptive information re-*
 17 *garding the plan, sufficient to permit the*
 18 *Secretary to determine whether the plan is*
 19 *in compliance with the requirements of this*
 20 *subparagraph.*

21 *“(B) PHYSICIAN INCENTIVE PLAN DE-*
 22 *FINED.—In this paragraph, the term ‘physician*
 23 *incentive plan’ means any compensation ar-*
 24 *rangement between a MedicareAdvantage organi-*
 25 *zation and a physician or physician group that*

1 *may directly or indirectly have the effect of re-*
 2 *ducing or limiting services provided with respect*
 3 *to individuals enrolled with the organization*
 4 *under this part.*

5 “(5) *LIMITATION ON PROVIDER INDEMNIFICA-*
 6 *TION.—A MedicareAdvantage organization may not*
 7 *provide (directly or indirectly) for a health care pro-*
 8 *fessional, provider of services, or other entity pro-*
 9 *viding health care services (or group of such profes-*
 10 *sionals, providers, or entities) to indemnify the orga-*
 11 *nization against any liability resulting from a civil*
 12 *action brought for any damage caused to an enrollee*
 13 *with a MedicareAdvantage plan of the organization*
 14 *under this part by the organization’s denial of medi-*
 15 *cally necessary care.*

16 “(6) *SPECIAL RULES FOR MEDICAREADVANTAGE*
 17 *PRIVATE FEE-FOR-SERVICE PLANS.—For purposes of*
 18 *applying this part (including subsection (k)(1)) and*
 19 *section 1866(a)(1)(O), a hospital (or other provider of*
 20 *services), a physician or other health care profes-*
 21 *sional, or other entity furnishing health care services*
 22 *is treated as having an agreement or contract in effect*
 23 *with a MedicareAdvantage organization (with respect*
 24 *to an individual enrolled in a MedicareAdvantage*
 25 *private fee-for-service plan it offers), if—*

1 “(A) the provider, professional, or other en-
 2 tity furnishes services that are covered under the
 3 plan to such an enrollee; and

4 “(B) before providing such services, the pro-
 5 vider, professional, or other entity —

6 “(i) has been informed of the individ-
 7 ual’s enrollment under the plan; and

8 “(ii) either—

9 “(I) has been informed of the
 10 terms and conditions of payment for
 11 such services under the plan; or

12 “(II) is given a reasonable oppor-
 13 tunity to obtain information con-
 14 cerning such terms and conditions,
 15 in a manner reasonably designed to effect
 16 informed agreement by a provider.

17 The previous sentence shall only apply in the absence
 18 of an explicit agreement between such a provider, pro-
 19 fessional, or other entity and the MedicareAdvantage
 20 organization.

21 “(k) TREATMENT OF SERVICES FURNISHED BY CER-
 22 TAIN PROVIDERS.—

23 “(1) IN GENERAL.—Except as provided in para-
 24 graph (2), a physician or other entity (other than a
 25 provider of services) that does not have a contract es-

1 *tablishing payment amounts for services furnished to*
 2 *an individual enrolled under this part with a*
 3 *MedicareAdvantage organization described in section*
 4 *1851(a)(2)(A) shall accept as payment in full for cov-*
 5 *ered services under this title that are furnished to*
 6 *such an individual the amounts that the physician or*
 7 *other entity could collect if the individual were not so*
 8 *enrolled. Any penalty or other provision of law that*
 9 *applies to such a payment with respect to an indi-*
 10 *vidual entitled to benefits under this title (but not en-*
 11 *rolled with a MedicareAdvantage organization under*
 12 *this part) also applies with respect to an individual*
 13 *so enrolled.*

14 “(2) *APPLICATION TO MEDICAREADVANTAGE PRI-*
 15 *VATE FEE-FOR-SERVICE PLANS.—*

16 “(A) *BALANCE BILLING LIMITS UNDER*
 17 *MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE*
 18 *PLANS IN CASE OF CONTRACT PROVIDERS.—*

19 “(i) *IN GENERAL.—In the case of an*
 20 *individual enrolled in a MedicareAdvantage*
 21 *private fee-for-service plan under this part,*
 22 *a physician, provider of services, or other*
 23 *entity that has a contract (including*
 24 *through the operation of subsection (j)(6))*
 25 *establishing a payment rate for services fur-*

nished to the enrollee shall accept as payment in full for covered services under this title that are furnished to such an individual an amount not to exceed (including any deductibles, coinsurance, copayments, or balance billing otherwise permitted under the plan) an amount equal to 115 percent of such payment rate.

“(ii) *PROCEDURES TO ENFORCE LIMITS.*—The MedicareAdvantage organization that offers such a plan shall establish procedures, similar to the procedures described in section 1848(g)(1)(A), in order to carry out clause (i).

“(iii) *ASSURING ENFORCEMENT.*—If the MedicareAdvantage organization fails to establish and enforce procedures required under clause (ii), the organization is subject to intermediate sanctions under section 1857(g).

“(B) *ENROLLEE LIABILITY FOR NONCONTRACT PROVIDERS.*—For provisions—

“(i) *establishing a minimum payment rate in the case of noncontract providers*

1 under a MedicareAdvantage private fee-for-
2 service plan, see section 1852(a)(2); or

3 “(ii) limiting enrollee liability in the
4 case of covered services furnished by such
5 providers, see paragraph (1) and section
6 1866(a)(1)(O).

7 “(C) INFORMATION ON BENEFICIARY LIABIL-
8 ITY.—

9 “(i) IN GENERAL.—Each
10 MedicareAdvantage organization that offers
11 a MedicareAdvantage private fee-for-service
12 plan shall provide that enrollees under the
13 plan who are furnished services for which
14 payment is sought under the plan are pro-
15 vided an appropriate explanation of bene-
16 fits (consistent with that provided under
17 parts A, B, and D, and, if applicable,
18 under medicare supplemental policies) that
19 includes a clear statement of the amount of
20 the enrollee’s liability (including any liabil-
21 ity for balance billing consistent with this
22 subsection) with respect to payments for
23 such services.

24 “(ii) ADVANCE NOTICE BEFORE RE-
25 CEIPT OF INPATIENT HOSPITAL SERVICES

1 *AND CERTAIN OTHER SERVICES.—In addi-*
 2 *tion, such organization shall, in its terms*
 3 *and conditions of payments to hospitals for*
 4 *inpatient hospital services and for other*
 5 *services identified by the Secretary for*
 6 *which the amount of the balance billing*
 7 *under subparagraph (A) could be substan-*
 8 *tial, require the hospital to provide to the*
 9 *enrollee, before furnishing such services and*
 10 *if the hospital imposes balance billing under*
 11 *subparagraph (A)—*

12 *“(I) notice of the fact that balance*
 13 *billing is permitted under such sub-*
 14 *paragraph for such services; and*

15 *“(II) a good faith estimate of the*
 16 *likely amount of such balance billing*
 17 *(if any), with respect to such services,*
 18 *based upon the presenting condition of*
 19 *the enrollee.*

20 *“(l) RETURN TO HOME SKILLED NURSING FACILITIES*
 21 *FOR COVERED POST-HOSPITAL EXTENDED CARE SERV-*
 22 *ICES.—*

23 *“(1) ENSURING RETURN TO HOME SNF.—*

24 *“(A) IN GENERAL.—In providing coverage*
 25 *of post-hospital extended care services, a*

1 *MedicareAdvantage plan shall provide for such*
 2 *coverage through a home skilled nursing facility*
 3 *if the following conditions are met:*

4 “(i) *ENROLLEE ELECTION.*—*The en-*
 5 *rollee elects to receive such coverage through*
 6 *such facility.*

7 “(ii) *SNF AGREEMENT.*—*The facility*
 8 *has a contract with the MedicareAdvantage*
 9 *organization for the provision of such serv-*
 10 *ices, or the facility agrees to accept substan-*
 11 *tially similar payment under the same*
 12 *terms and conditions that apply to simi-*
 13 *larly situated skilled nursing facilities that*
 14 *are under contract with the*
 15 *MedicareAdvantage organization for the*
 16 *provision of such services and through*
 17 *which the enrollee would otherwise receive*
 18 *such services.*

19 “(B) *MANNER OF PAYMENT TO HOME*
 20 *SNF.*—*The organization shall provide payment*
 21 *to the home skilled nursing facility consistent*
 22 *with the contract or the agreement described in*
 23 *subparagraph (A)(ii), as the case may be.*

24 “(2) *NO LESS FAVORABLE COVERAGE.*—*The cov-*
 25 *erage provided under paragraph (1) (including scope*

1 *of services, cost-sharing, and other criteria of cov-*
 2 *erage) shall be no less favorable to the enrollee than*
 3 *the coverage that would be provided to the enrollee*
 4 *with respect to a skilled nursing facility the post-hos-*
 5 *pital extended care services of which are otherwise*
 6 *covered under the MedicareAdvantage plan.*

7 *“(3) RULE OF CONSTRUCTION.—Nothing in this*
 8 *subsection shall be construed to do the following:*

9 *“(A) To require coverage through a skilled*
 10 *nursing facility that is not otherwise qualified to*
 11 *provide benefits under part A for medicare bene-*
 12 *ficiaries not enrolled in a MedicareAdvantage*
 13 *plan.*

14 *“(B) To prevent a skilled nursing facility*
 15 *from refusing to accept, or imposing conditions*
 16 *upon the acceptance of, an enrollee for the receipt*
 17 *of post-hospital extended care services.*

18 *“(4) DEFINITIONS.—In this subsection:*

19 *“(A) HOME SKILLED NURSING FACILITY.—*
 20 *The term ‘home skilled nursing facility’ means,*
 21 *with respect to an enrollee who is entitled to re-*
 22 *ceive post-hospital extended care services under a*
 23 *MedicareAdvantage plan, any of the following*
 24 *skilled nursing facilities:*

1 “(i) *SNF RESIDENCE AT TIME OF AD-*
2 *MISSION.—The skilled nursing facility in*
3 *which the enrollee resided at the time of ad-*
4 *mission to the hospital preceding the receipt*
5 *of such post-hospital extended care services.*

6 “(ii) *SNF IN CONTINUING CARE RE-*
7 *TIREMENT COMMUNITY.—A skilled nursing*
8 *facility that is providing such services*
9 *through a continuing care retirement com-*
10 *munity (as defined in subparagraph (B))*
11 *which provided residence to the enrollee at*
12 *the time of such admission.*

13 “(iii) *SNF RESIDENCE OF SPOUSE AT*
14 *TIME OF DISCHARGE.—The skilled nursing*
15 *facility in which the spouse of the enrollee*
16 *is residing at the time of discharge from*
17 *such hospital.*

18 “(B) *CONTINUING CARE RETIREMENT COM-*
19 *MUNITY.—The term ‘continuing care retirement*
20 *community’ means, with respect to an enrollee in*
21 *a MedicareAdvantage plan, an arrangement*
22 *under which housing and health-related services*
23 *are provided (or arranged) through an organiza-*
24 *tion for the enrollee under an agreement that is*

1 *effective for the life of the enrollee or for a speci-*
 2 *fied period.”.*

3 **SEC. 203. PAYMENTS TO MEDICAREADVANTAGE ORGANIZA-**
 4 **TIONS.**

5 *Section 1853 (42 U.S.C. 1395w–23) is amended to*
 6 *read as follows:*

7 “PAYMENTS TO MEDICAREADVANTAGE ORGANIZATIONS

8 “SEC. 1853. (a) PAYMENTS TO ORGANIZATIONS.—

9 “(1) MONTHLY PAYMENTS.—

10 “(A) IN GENERAL.—Under a contract under
 11 *section 1857 and subject to subsections (f), (h),*
 12 *and (j) and section 1859(e)(4), the Secretary*
 13 *shall make, to each MedicareAdvantage organiza-*
 14 *tion, with respect to coverage of an individual*
 15 *for a month under this part in a*
 16 *MedicareAdvantage payment area, separate*
 17 *monthly payments with respect to—*

18 “(i) *benefits under the original medi-*
 19 *care fee-for-service program under parts A*
 20 *and B in accordance with subsection (d);*
 21 *and*

22 “(ii) *benefits under the voluntary pre-*
 23 *scription drug program under part D in*
 24 *accordance with section 1858A and the*
 25 *other provisions of this part.*

1 “(B) *SPECIAL RULE FOR END-STAGE RENAL*
2 *DISEASE.—The Secretary shall establish separate*
3 *rates of payment to a MedicareAdvantage orga-*
4 *nization with respect to classes of individuals de-*
5 *termined to have end-stage renal disease and en-*
6 *rolled in a MedicareAdvantage plan of the orga-*
7 *nization. Such rates of payment shall be actuari-*
8 *ally equivalent to rates paid to other enrollees in*
9 *the MedicareAdvantage payment area (or such*
10 *other area as specified by the Secretary). In ac-*
11 *cordance with regulations, the Secretary shall*
12 *provide for the application of the seventh sen-*
13 *tence of section 1881(b)(7) to payments under*
14 *this section covering the provision of renal dialy-*
15 *sis treatment in the same manner as such sen-*
16 *tence applies to composite rate payments de-*
17 *scribed in such sentence. In establishing such*
18 *rates, the Secretary shall provide for appropriate*
19 *adjustments to increase each rate to reflect the*
20 *demonstration rate (including the risk adjust-*
21 *ment methodology associated with such rate) of*
22 *the social health maintenance organization end-*
23 *stage renal disease capitation demonstrations*
24 *(established by section 2355 of the Deficit Reduc-*
25 *tion Act of 1984, as amended by section 13567(b)*

1 *of the Omnibus Budget Reconciliation Act of*
 2 *1993), and shall compute such rates by taking*
 3 *into account such factors as renal treatment mo-*
 4 *dalidity, age, and the underlying cause of the end-*
 5 *stage renal disease.*

6 “(2) *ADJUSTMENT TO REFLECT NUMBER OF EN-*
 7 *ROLLEES.—*

8 “(A) *IN GENERAL.—The amount of pay-*
 9 *ment under this subsection may be retroactively*
 10 *adjusted to take into account any difference be-*
 11 *tween the actual number of individuals enrolled*
 12 *with an organization under this part and the*
 13 *number of such individuals estimated to be so*
 14 *enrolled in determining the amount of the ad-*
 15 *vance payment.*

16 “(B) *SPECIAL RULE FOR CERTAIN ENROLL-*
 17 *EES.—*

18 “(i) *IN GENERAL.—Subject to clause*
 19 *(ii), the Secretary may make retroactive ad-*
 20 *justments under subparagraph (A) to take*
 21 *into account individuals enrolled during the*
 22 *period beginning on the date on which the*
 23 *individual enrolls with a*
 24 *MedicareAdvantage organization under a*
 25 *plan operated, sponsored, or contributed to*

1 *by the individual’s employer or former em-*
2 *ployer (or the employer or former employer*
3 *of the individual’s spouse) and ending on*
4 *the date on which the individual is enrolled*
5 *in the organization under this part, except*
6 *that for purposes of making such retroactive*
7 *adjustments under this subparagraph, such*
8 *period may not exceed 90 days.*

9 “(ii) *EXCEPTION.—No adjustment may*
10 *be made under clause (i) with respect to*
11 *any individual who does not certify that the*
12 *organization provided the individual with*
13 *the disclosure statement described in section*
14 *1852(c) at the time the individual enrolled*
15 *with the organization.*

16 “(C) *EQUALIZATION OF FEDERAL CON-*
17 *TRIBUTION.—In applying subparagraph (A), the*
18 *Secretary shall ensure that the payment to the*
19 *MedicareAdvantage organization for each indi-*
20 *vidual enrolled with the organization shall equal*
21 *the MedicareAdvantage benchmark amount for*
22 *the payment area in which that individual re-*
23 *sides (as determined under paragraph (4)), as*
24 *adjusted—*

1 “(i) by multiplying the benchmark
2 amount for that payment area by the ratio
3 of—

4 “(I) the payment amount deter-
5 mined under subsection (d)(4); to

6 “(II) the weighted service area
7 benchmark amount determined under
8 subsection (d)(2); and

9 “(ii) using such risk adjustment factor
10 as specified by the Secretary under sub-
11 section (b)(1)(B).

12 “(3) COMPREHENSIVE RISK ADJUSTMENT METH-
13 ODOLOGY.—

14 “(A) APPLICATION OF METHODOLOGY.—The
15 Secretary shall apply the comprehensive risk ad-
16 justment methodology described in subparagraph
17 (B) to 100 percent of the amount of payments to
18 plans under subsection (d)(4)(B).

19 “(B) COMPREHENSIVE RISK ADJUSTMENT
20 METHODOLOGY DESCRIBED.—The comprehensive
21 risk adjustment methodology described in this
22 subparagraph is the risk adjustment methodology
23 that would apply with respect to
24 MedicareAdvantage plans offered by
25 MedicareAdvantage organizations in 2005, ex-

cept that if such methodology does not apply to groups of beneficiaries who are aged or disabled and groups of beneficiaries who have end-stage renal disease, the Secretary shall revise such methodology to apply to such groups.

“(C) *UNIFORM APPLICATION TO ALL TYPES OF PLANS.*—Subject to section 1859(e)(4), the comprehensive risk adjustment methodology established under this paragraph shall be applied uniformly without regard to the type of plan.

“(D) *DATA COLLECTION.*—In order to carry out this paragraph, the Secretary shall require MedicareAdvantage organizations to submit such data and other information as the Secretary deems necessary.

“(E) *IMPROVEMENT OF PAYMENT ACCURACY.*—Notwithstanding any other provision of this paragraph, the Secretary may revise the comprehensive risk adjustment methodology described in subparagraph (B) from time to time to improve payment accuracy.

“(4) *ANNUAL CALCULATION OF BENCHMARK AMOUNTS.*—For each year, the Secretary shall calculate a benchmark amount for each MedicareAdvantage payment area for each month for

1 *such year with respect to coverage of the benefits*
 2 *available under the original medicare fee-for-service*
 3 *program option equal to the greater of the following*
 4 *amounts (adjusted as appropriate for the application*
 5 *of the risk adjustment methodology under paragraph*
 6 *(3)):*

7 *“(A) MINIMUM AMOUNT.—^{1/12} of the annual*
 8 *Medicare+Choice capitation rate determined*
 9 *under subsection (c)(1)(B) for the payment area*
 10 *for the year.*

11 *“(B) LOCAL FEE-FOR-SERVICE RATE.—The*
 12 *local fee-for-service rate for such area for the*
 13 *year (as calculated under paragraph (5)).*

14 *“(5) ANNUAL CALCULATION OF LOCAL FEE-FOR-*
 15 *SERVICE RATES.—*

16 *“(A) IN GENERAL.—Subject to subpara-*
 17 *graphs (B) and (C), the term ‘local fee-for-service*
 18 *rate’ means the amount of payment for a month*
 19 *in a MedicareAdvantage payment area for bene-*
 20 *fits under this title and associated claims proc-*
 21 *essing costs for an individual who has elected to*
 22 *receive benefits under the original medicare fee-*
 23 *for-service program option and not enrolled in a*
 24 *MedicareAdvantage plan under this part. The*
 25 *Secretary shall annually calculate such amount*

1 *in a manner similar to the manner in which the*
 2 *Secretary calculated the adjusted average per*
 3 *capita cost under section 1876.*

4 “(B) *REMOVAL OF MEDICAL EDUCATION*
 5 *COSTS FROM CALCULATION OF LOCAL FEE-FOR-*
 6 *SERVICE RATE.—*

7 “(i) *IN GENERAL.—In calculating the*
 8 *local fee-for-service rate under subparagraph*
 9 *(A) for a year, the amount of payment de-*
 10 *scribed in such subparagraph shall be ad-*
 11 *justed to exclude from such payment the*
 12 *payment adjustments described in clause*
 13 *(ii).*

14 “(ii) *PAYMENT ADJUSTMENTS DE-*
 15 *SCRIBED.—*

16 “(I) *IN GENERAL.—Subject to*
 17 *subclause (II), the payment adjust-*
 18 *ments described in this subparagraph*
 19 *are payment adjustments which the*
 20 *Secretary estimates are payable during*
 21 *the year—*

22 “(aa) *for the indirect costs of*
 23 *medical education under section*
 24 *1886(d)(5)(B); and*

1 “(bb) for direct graduate
2 medical education costs under sec-
3 tion 1886(h).

4 “(II) TREATMENT OF PAYMENTS
5 COVERED UNDER STATE HOSPITAL RE-
6 IMBURSEMENT SYSTEM.—To the extent
7 that the Secretary estimates that the
8 amount of the local fee-for-service rates
9 reflects payments to hospitals reim-
10 bursed under section 1814(b)(3), the
11 Secretary shall estimate a payment ad-
12 justment that is comparable to the
13 payment adjustment that would have
14 been made under clause (i) if the hos-
15 pitals had not been reimbursed under
16 such section.

17 “(b) ANNUAL ANNOUNCEMENT OF PAYMENT FAC-
18 TORS.—

19 “(1) ANNUAL ANNOUNCEMENT.—Beginning in
20 2005, at the same time as the Secretary publishes the
21 risk adjusters under section 1860D–11, the Secretary
22 shall annually announce (in a manner intended to
23 provide notice to interested parties) the following pay-
24 ment factors:

1 “(A) The benchmark amount for each
2 MedicareAdvantage payment area (as calculated
3 under subsection (a)(4)) for the year.

4 “(B) The factors to be used for adjusting
5 payments under the comprehensive risk adjust-
6 ment methodology described in subsection
7 (a)(3)(B) with respect to each
8 MedicareAdvantage payment area for the year.

9 “(2) ADVANCE NOTICE OF METHODOLOGICAL
10 CHANGES.—At least 45 days before making the an-
11 nouncement under paragraph (1) for a year, the Sec-
12 retary shall—

13 “(A) provide for notice to
14 MedicareAdvantage organizations of proposed
15 changes to be made in the methodology from the
16 methodology and assumptions used in the pre-
17 vious announcement; and

18 “(B) provide such organizations with an
19 opportunity to comment on such proposed
20 changes.

21 “(3) EXPLANATION OF ASSUMPTIONS.—In each
22 announcement made under paragraph (1), the Sec-
23 retary shall include an explanation of the assump-
24 tions and changes in methodology used in the an-
25 nouncement in sufficient detail so that

1 *MedicareAdvantage organizations can compute each*
 2 *payment factor described in paragraph (1).*

3 “(c) *CALCULATION OF ANNUAL MEDICARE+CHOICE*
 4 *CAPITATION RATES.—*

5 “(1) *IN GENERAL.—For purposes of making pay-*
 6 *ments under this part for years before 2006 and for*
 7 *purposes of calculating the annual Medicare+Choice*
 8 *capitation rates under paragraph (7) beginning with*
 9 *such year, subject to paragraph (6)(C), each annual*
 10 *Medicare+Choice capitation rate, for a*
 11 *Medicare+Choice payment area before 2006 or a*
 12 *MedicareAdvantage payment area beginning with*
 13 *such year for a contract year consisting of a calendar*
 14 *year, is equal to the largest of the amounts specified*
 15 *in the following subparagraph (A), (B), or (C):*

16 “(A) *BLENDED CAPITATION RATE.—The*
 17 *sum of—*

18 “(i) *the area-specific percentage (as*
 19 *specified under paragraph (2) for the year)*
 20 *of the annual area-specific*
 21 *Medicare+Choice capitation rate for the*
 22 *MedicareAdvantage payment area, as deter-*
 23 *mined under paragraph (3) for the year;*
 24 *and*

1 “(ii) *the national percentage (as speci-*
 2 *fied under paragraph (2) for the year) of*
 3 *the input-price-adjusted annual national*
 4 *Medicare+Choice capitation rate, as deter-*
 5 *mined under paragraph (4) for the year,*
 6 *multiplied by the budget neutrality adjustment*
 7 *factor determined under paragraph (5).*

8 “(B) *MINIMUM AMOUNT.—12 multiplied by*
 9 *the following amount:*

10 “(i) *For 1998, \$367 (but not to exceed,*
 11 *in the case of an area outside the 50 States*
 12 *and the District of Columbia, 150 percent of*
 13 *the annual per capita rate of payment for*
 14 *1997 determined under section*
 15 *1876(a)(1)(C) for the area).*

16 “(ii) *For 1999 and 2000, the min-*
 17 *imum amount determined under clause (i)*
 18 *or this clause, respectively, for the preceding*
 19 *year, increased by the national per capita*
 20 *Medicare+Choice growth percentage de-*
 21 *scribed in paragraph (6)(A) applicable to*
 22 *1999 or 2000, respectively.*

23 “(iii)(I) *Subject to subclause (II), for*
 24 *2001, for any area in a Metropolitan Sta-*
 25 *tistical Area with a population of more*

1 *than 250,000, \$525, and for any other area*
2 *\$475.*

3 *“(II) In the case of an area outside the*
4 *50 States and the District of Columbia, the*
5 *amount specified in this clause shall not ex-*
6 *ceed 120 percent of the amount determined*
7 *under clause (ii) for such area for 2000.*

8 *“(iv) For 2002 through 2013, the min-*
9 *imum amount specified in this clause (or*
10 *clause (iii)) for the preceding year increased*
11 *by the national per capita*
12 *Medicare+Choice growth percentage, de-*
13 *scribed in paragraph (6)(A) for that suc-*
14 *ceeding year.*

15 *“(v) For 2014 and each succeeding*
16 *year, the minimum amount specified in this*
17 *clause (or clause (iv)) for the preceding year*
18 *increased by the percentage increase in the*
19 *Consumer Price Index for all urban con-*
20 *sumers (U.S. urban average) for the 12-*
21 *month period ending with June of the pre-*
22 *vious year.*

23 *“(C) MINIMUM PERCENTAGE INCREASE.—*

24 *“(i) For 1998, 102 percent of the an-*
25 *nuual per capita rate of payment for 1997*

determined under section 1876(a)(1)(C) for the Medicare+Choice payment area.

“(ii) For 1999 and 2000, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

“(iii) For 2001, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2000.

“(iv) For 2002 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

“(2) AREA-SPECIFIC AND NATIONAL PERCENTAGES.—For purposes of paragraph (1)(A)—

“(A) for 1998, the ‘area-specific percentage’ is 90 percent and the ‘national percentage’ is 10 percent;

“(B) for 1999, the ‘area-specific percentage’ is 82 percent and the ‘national percentage’ is 18 percent;

“(C) for 2000, the ‘area-specific percentage’ is 74 percent and the ‘national percentage’ is 26 percent;

1 “(D) for 2001, the ‘area-specific percentage’
 2 is 66 percent and the ‘national percentage’ is 34
 3 percent;

4 “(E) for 2002, the ‘area-specific percentage’
 5 is 58 percent and the ‘national percentage’ is 42
 6 percent; and

7 “(F) for a year after 2002, the ‘area-specific
 8 percentage’ is 50 percent and the ‘national per-
 9 centage’ is 50 percent.

10 “(3) ANNUAL AREA-SPECIFIC MEDICARE+CHOICE
 11 CAPITATION RATE.—

12 “(A) IN GENERAL.—For purposes of para-
 13 graph (1)(A), subject to subparagraph (B), the
 14 annual area-specific Medicare+Choice capita-
 15 tion rate for a Medicare+Choice payment
 16 area—

17 “(i) for 1998 is, subject to subpara-
 18 graph (D), the annual per capita rate of
 19 payment for 1997 determined under section
 20 1876(a)(1)(C) for the area, increased by the
 21 national per capita Medicare+Choice
 22 growth percentage for 1998 (described in
 23 paragraph (6)(A)); or

24 “(ii) for a subsequent year is the an-
 25 nual area-specific Medicare+Choice capita-

tion rate for the previous year determined under this paragraph for the area, increased by the national per capita Medicare+Choice growth percentage for such subsequent year.

“(B) REMOVAL OF MEDICAL EDUCATION FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—

“(i) IN GENERAL.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 1998), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to exclude from the rate the applicable percent (specified in clause (ii)) of the payment adjustments described in subparagraph (C).

“(ii) APPLICABLE PERCENT.—For purposes of clause (i), the applicable percent for—

“(I) 1998 is 20 percent;

“(II) 1999 is 40 percent;

“(III) 2000 is 60 percent;

“(IV) 2001 is 80 percent; and

1 “(V) a succeeding year is 100 per-
2 cent.

3 “(C) *PAYMENT ADJUSTMENT.*—

4 “(i) *IN GENERAL.*—Subject to clause
5 (ii), the payment adjustments described in
6 this subparagraph are payment adjustments
7 which the Secretary estimates were payable
8 during 1997—

9 “(I) for the indirect costs of med-
10 ical education under section
11 1886(d)(5)(B); and

12 “(II) for direct graduate medical
13 education costs under section 1886(h).

14 “(ii) *TREATMENT OF PAYMENTS COV-*
15 *ERED UNDER STATE HOSPITAL REIMBURSE-*
16 *MENT SYSTEM.*—To the extent that the Sec-
17 retary estimates that an annual per capita
18 rate of payment for 1997 described in clause
19 (i) reflects payments to hospitals reimbursed
20 under section 1814(b)(3), the Secretary shall
21 estimate a payment adjustment that is com-
22 parable to the payment adjustment that
23 would have been made under clause (i) if
24 the hospitals had not been reimbursed under
25 such section.

1 “(D) *TREATMENT OF AREAS WITH HIGHLY*
 2 *VARIABLE PAYMENT RATES.*—*In the case of a*
 3 *Medicare+Choice payment area for which the*
 4 *annual per capita rate of payment determined*
 5 *under section 1876(a)(1)(C) for 1997 varies by*
 6 *more than 20 percent from such rate for 1996,*
 7 *for purposes of this subsection the Secretary may*
 8 *substitute for such rate for 1997 a rate that is*
 9 *more representative of the costs of the enrollees in*
 10 *the area.*

11 “(4) *INPUT-PRICE-ADJUSTED ANNUAL NATIONAL*
 12 *MEDICARE+CHOICE CAPITATION RATE.*—

13 “(A) *IN GENERAL.*—*For purposes of para-*
 14 *graph (1)(A), the input-price-adjusted annual*
 15 *national Medicare+Choice capitation rate for a*
 16 *Medicare+Choice payment area for a year is*
 17 *equal to the sum, for all the types of medicare*
 18 *services (as classified by the Secretary), of the*
 19 *product (for each such type of service) of—*

20 “(i) *the national standardized annual*
 21 *Medicare+Choice capitation rate (deter-*
 22 *mined under subparagraph (B)) for the*
 23 *year;*

1 “(ii) the proportion of such rate for the
2 year which is attributable to such type of
3 services; and

4 “(iii) an index that reflects (for that
5 year and that type of services) the relative
6 input price of such services in the area com-
7 pared to the national average input price of
8 such services.

9 *In applying clause (iii), the Secretary may, sub-*
10 *ject to subparagraph (C), apply those indices*
11 *under this title that are used in applying (or up-*
12 *dating) national payment rates for specific areas*
13 *and localities.*

14 “(B) NATIONAL STANDARDIZED ANNUAL
15 MEDICARE+CHOICE CAPITATION RATE.—*In sub-*
16 *paragraph (A)(i), the ‘national standardized an-*
17 *nual Medicare+Choice capitation rate’ for a*
18 *year is equal to—*

19 “(i) the sum (for all Medicare+Choice
20 payment areas) of the product of—

21 “(I) the annual area-specific
22 Medicare+Choice capitation rate for
23 that year for the area under paragraph
24 (3); and

1 “(II) the average number of medi-
 2 care beneficiaries residing in that area
 3 in the year, multiplied by the average
 4 of the risk factor weights used to adjust
 5 payments under subsection (a)(1)(A)
 6 for such beneficiaries in such area; di-
 7 vided by

8 “(ii) the sum of the products described
 9 in clause (i)(II) for all areas for that year.

10 “(5) PAYMENT ADJUSTMENT BUDGET NEU-
 11 TRALITY FACTOR.—For purposes of paragraph (1)(A),
 12 for each year, the Secretary shall determine a budget
 13 neutrality adjustment factor so that the aggregate of
 14 the payments under this part (other than those attrib-
 15 utable to subsections (a)(3)(C)(iii) and (i)) shall
 16 equal the aggregate payments that would have been
 17 made under this part if payment were based entirely
 18 on area-specific capitation rates.

19 “(6) NATIONAL PER CAPITA MEDICARE+CHOICE
 20 GROWTH PERCENTAGE DEFINED.—

21 “(A) IN GENERAL.—In this part, the ‘na-
 22 tional per capita Medicare+Choice growth per-
 23 centage’ for a year is the percentage determined
 24 by the Secretary, by March 1st before the begin-
 25 ning of the year involved, to reflect the Sec-

retary's estimate of the projected per capita rate of growth in expenditures under this title for an individual entitled to (or enrolled for) benefits under part A and enrolled under part B, reduced by the number of percentage points specified in subparagraph (B) for the year. Separate determinations may be made for aged enrollees, disabled enrollees, and enrollees with end-stage renal disease.

“(B) *ADJUSTMENT*.—The number of percentage points specified in this subparagraph is—

“(i) for 1998, 0.8 percentage points;

“(ii) for 1999, 0.5 percentage points;

“(iii) for 2000, 0.5 percentage points;

“(iv) for 2001, 0.5 percentage points;

“(v) for 2002, 0.3 percentage points;

and

“(vi) for a year after 2002, 0 percentage points.

“(C) *ADJUSTMENT FOR OVER OR UNDER PROJECTION OF NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE*.—Beginning with rates calculated for 1999, before computing rates for a year as described in para-

graph (1), the Secretary shall adjust all area-specific and national Medicare+Choice capitation rates (and beginning in 2000, the minimum amount) for the previous year for the differences between the projections of the national per capita Medicare+Choice growth percentage for that year and previous years and the current estimate of such percentage for such years.

“(7) *TRANSITION TO MEDICAREADVANTAGE COMPETITION.*—

“(A) *IN GENERAL.*—For each year (beginning with 2006) payments to MedicareAdvantage plans shall not be computed under this subsection, but instead shall be based on the payment amount determined under subsection (d).

“(B) *CONTINUED CALCULATION OF CAPITATION RATES.*—For each year (beginning with 2006) the Secretary shall calculate and publish the annual Medicare+Choice capitation rates under this subsection and shall use the annual Medicare+Choice capitation rate determined under subsection (c)(1) for purposes of determining the benchmark amount under subsection (a)(4).

1 “(d) *SECRETARY’S DETERMINATION OF PAYMENT*
2 *AMOUNT.*—

3 “(1) *REVIEW OF PLAN BIDS.*—*The Secretary*
4 *shall review each plan bid submitted under section*
5 *1854(a) for the coverage of benefits under the original*
6 *medicare fee-for-service program option to ensure that*
7 *such bids are consistent with the requirements under*
8 *this part an are based on the assumptions described*
9 *in section 1854(a)(2)(A)(iii).*

10 “(2) *DETERMINATION OF WEIGHTED SERVICE*
11 *AREA BENCHMARK AMOUNTS.*—*The Secretary shall*
12 *calculate a weighted service area benchmark amount*
13 *for the benefits under the original medicare fee-for-*
14 *service program option for each plan equal to the*
15 *weighted average of the benchmark amounts for bene-*
16 *fits under such original medicare fee-for-service pro-*
17 *gram option for the payment areas included in the*
18 *service area of the plan using the assumptions de-*
19 *scribed in section 1854(a)(2)(A)(iii).*

20 “(3) *COMPARISON TO BENCHMARK.*—*The Sec-*
21 *retary shall determine the difference between each*
22 *plan bid (as adjusted under paragraph (1)) and the*
23 *weighted service area benchmark amount (as deter-*
24 *mined under paragraph (2)) for purposes of deter-*
25 *mining—*

1 “(A) *the payment amount under paragraph*
 2 *(4); and*

3 “(B) *the additional benefits required and*
 4 *MedicareAdvantage monthly basic beneficiary*
 5 *premiums.*

6 “(4) *DETERMINATION OF PAYMENT AMOUNT FOR*
 7 *ORIGINAL MEDICARE FEE-FOR-SERVICE BENEFITS.—*

8 “(A) *IN GENERAL.—Subject to subpara-*
 9 *graph (B), the Secretary shall determine the*
 10 *payment amount for MedicareAdvantage plans*
 11 *for the benefits under the original medicare fee-*
 12 *for-service program option as follows:*

13 “(i) *BIDS THAT EQUAL OR EXCEED*
 14 *THE BENCHMARK.—In the case of a plan*
 15 *bid that equals or exceeds the weighted serv-*
 16 *ice area benchmark amount, the amount of*
 17 *each monthly payment to a*
 18 *MedicareAdvantage organization with re-*
 19 *spect to each individual enrolled in a plan*
 20 *shall be the weighted service area benchmark*
 21 *amount.*

22 “(ii) *BIDS BELOW THE BENCHMARK.—*
 23 *In the case of a plan bid that is less than*
 24 *the weighted service area benchmark*
 25 *amount, the amount of each monthly pay-*

ment to a MedicareAdvantage organization with respect to each individual enrolled in a plan shall be the weighted service area benchmark amount reduced by the amount of any premium reduction elected by the plan under section 1854(d)(1)(A)(i).

“(B) APPLICATION OF COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.—The Secretary shall adjust the amounts determined under subparagraph (A) using the comprehensive risk adjustment methodology applicable under subsection (a)(3).

“(6) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If the Secretary makes a determination with respect to coverage under this title or there is a change in benefits required to be provided under this part that the Secretary projects will result in a significant increase in the costs to MedicareAdvantage organizations of providing benefits under contracts under this part (for periods after any period described in section 1852(a)(5)), the Secretary shall appropriately adjust the benchmark amounts or payment amounts (as determined by the Secretary). Such projection and adjustment shall be based on an anal-

1 *ysis by the Secretary of the actuarial costs associated*
 2 *with the new benefits.*

3 “(7) *BENEFITS UNDER THE ORIGINAL MEDICARE*
 4 *FEE-FOR-SERVICE PROGRAM OPTION DEFINED.*—*For*
 5 *purposes of this part, the term ‘benefits under the*
 6 *original medicare fee-for-service program option’*
 7 *means those items and services (other than hospice*
 8 *care) for which benefits are available under parts A*
 9 *and B to individuals entitled to, or enrolled for, bene-*
 10 *fits under part A and enrolled under part B, with*
 11 *cost-sharing for those services as required under parts*
 12 *A and B or an actuarially equivalent level of cost-*
 13 *sharing as determined in this part.*

14 “(e) *MEDICAREADVANTAGE PAYMENT AREA DE-*
 15 *FINED.*—

16 “(1) *IN GENERAL.*—*In this part, except as pro-*
 17 *vided in paragraph (3), the term ‘MedicareAdvantage*
 18 *payment area’ means a county, or equivalent area*
 19 *specified by the Secretary.*

20 “(2) *RULE FOR ESRD BENEFICIARIES.*—*In the*
 21 *case of individuals who are determined to have end*
 22 *stage renal disease, the MedicareAdvantage payment*
 23 *area shall be a State or such other payment area as*
 24 *the Secretary specifies.*

25 “(3) *GEOGRAPHIC ADJUSTMENT.*—

1 “(A) *IN GENERAL.*—Upon written request of
 2 the chief executive officer of a State for a con-
 3 tract year (beginning after 2005) made by not
 4 later than February 1 of the previous year, the
 5 Secretary shall make a geographic adjustment to
 6 a MedicareAdvantage payment area in the State
 7 otherwise determined under paragraph (1)—

8 “(i) to a single statewide
 9 MedicareAdvantage payment area;

10 “(ii) to the metropolitan based system
 11 described in subparagraph (C); or

12 “(iii) to consolidating into a single
 13 MedicareAdvantage payment area non-
 14 contiguous counties (or equivalent areas de-
 15 scribed in paragraph (1)) within a State.

16 Such adjustment shall be effective for payments
 17 for months beginning with January of the year
 18 following the year in which the request is re-
 19 ceived.

20 “(B) *BUDGET NEUTRALITY ADJUSTMENT.*—
 21 In the case of a State requesting an adjustment
 22 under this paragraph, the Secretary shall ini-
 23 tially (and annually thereafter) adjust the pay-
 24 ment rates otherwise established under this sec-
 25 tion for MedicareAdvantage payment areas in

1 *the State in a manner so that the aggregate of*
 2 *the payments under this section in the State*
 3 *shall not exceed the aggregate payments that*
 4 *would have been made under this section for*
 5 *MedicareAdvantage payment areas in the State*
 6 *in the absence of the adjustment under this para-*
 7 *graph.*

8 *“(C) METROPOLITAN BASED SYSTEM.—The*
 9 *metropolitan based system described in this sub-*
 10 *paragraph is one in which—*

11 *“(i) all the portions of each metropoli-*
 12 *tan statistical area in the State or in the*
 13 *case of a consolidated metropolitan statis-*
 14 *tical area, all of the portions of each pri-*
 15 *mary metropolitan statistical area within*
 16 *the consolidated area within the State, are*
 17 *treated as a single MedicareAdvantage pay-*
 18 *ment area; and*

19 *“(ii) all areas in the State that do not*
 20 *fall within a metropolitan statistical area*
 21 *are treated as a single MedicareAdvantage*
 22 *payment area.*

23 *“(D) AREAS.—In subparagraph (C), the*
 24 *terms ‘metropolitan statistical area’, ‘consoli-*
 25 *dated metropolitan statistical area’, and ‘pri-*

1 *mary metropolitan statistical area’ mean any*
 2 *area designated as such by the Secretary of Com-*
 3 *merce.*

4 “(f) *SPECIAL RULES FOR INDIVIDUALS ELECTING*
 5 *MSA PLANS.*—

6 “(1) *IN GENERAL.*—*If the amount of the*
 7 *MedicareAdvantage monthly MSA premium (as de-*
 8 *finied in section 1854(b)(2)(D)) for an MSA plan for*
 9 *a year is less than $\frac{1}{12}$ of the annual*
 10 *Medicare+Choice capitation rate applied under this*
 11 *section for the area and year involved, the Secretary*
 12 *shall deposit an amount equal to 100 percent of such*
 13 *difference in a MedicareAdvantage MSA established*
 14 *(and, if applicable, designated) by the individual*
 15 *under paragraph (2).*

16 “(2) *ESTABLISHMENT AND DESIGNATION OF*
 17 *MEDICAREADVANTAGE MEDICAL SAVINGS ACCOUNT AS*
 18 *REQUIREMENT FOR PAYMENT OF CONTRIBUTION.*—*In*
 19 *the case of an individual who has elected coverage*
 20 *under an MSA plan, no payment shall be made under*
 21 *paragraph (1) on behalf of an individual for a month*
 22 *unless the individual—*

23 “(A) *has established before the beginning of*
 24 *the month (or by such other deadline as the Sec-*
 25 *retary may specify) a MedicareAdvantage MSA*

1 *(as defined in section 138(b)(2) of the Internal*
 2 *Revenue Code of 1986); and*

3 *“(B) if the individual has established more*
 4 *than 1 such MedicareAdvantage MSA, has des-*
 5 *ignated 1 of such accounts as the individual’s*
 6 *MedicareAdvantage MSA for purposes of this*
 7 *part.*

8 *Under rules under this section, such an individual*
 9 *may change the designation of such account under*
 10 *subparagraph (B) for purposes of this part.*

11 *“(3) LUMP-SUM DEPOSIT OF MEDICAL SAVINGS*
 12 *ACCOUNT CONTRIBUTION.—In the case of an indi-*
 13 *vidual electing an MSA plan effective beginning with*
 14 *a month in a year, the amount of the contribution to*
 15 *the MedicareAdvantage MSA on behalf of the indi-*
 16 *vidual for that month and all successive months in*
 17 *the year shall be deposited during that first month. In*
 18 *the case of a termination of such an election as of a*
 19 *month before the end of a year, the Secretary shall*
 20 *provide for a procedure for the recovery of deposits at-*
 21 *tributable to the remaining months in the year.*

22 *“(g) PAYMENTS FROM TRUST FUNDS.—Except as pro-*
 23 *vided in section 1858A(c) (relating to payments for quali-*
 24 *fied prescription drug coverage), the payment to a*
 25 *MedicareAdvantage organization under this section for in-*

1 *dividuals enrolled under this part with the organization*
 2 *and payments to a MedicareAdvantage MSA under sub-*
 3 *section (e)(1) shall be made from the Federal Hospital In-*
 4 *surance Trust Fund and the Federal Supplementary Med-*
 5 *ical Insurance Trust Fund in such proportion as the Sec-*
 6 *retary determines reflects the relative weight that benefits*
 7 *under part A and under part B represents of the actuarial*
 8 *value of the total benefits under this title. Monthly pay-*
 9 *ments otherwise payable under this section for October 2000*
 10 *shall be paid on the first business day of such month.*
 11 *Monthly payments otherwise payable under this section for*
 12 *October 2001 shall be paid on the last business day of Sep-*
 13 *tember 2001. Monthly payments otherwise payable under*
 14 *this section for October 2006 shall be paid on the first busi-*
 15 *ness day of October 2006.*

16 “(h) *SPECIAL RULE FOR CERTAIN INPATIENT HOS-*
 17 *PITAL STAYS.—In the case of an individual who is receiv-*
 18 *ing inpatient hospital services from a subsection (d) hos-*
 19 *pital (as defined in section 1886(d)(1)(B)) as of the effective*
 20 *date of the individual’s—*

21 “(1) *election under this part of a*
 22 *MedicareAdvantage plan offered by a*
 23 *MedicareAdvantage organization—*

24 “(A) *payment for such services until the*
 25 *date of the individual’s discharge shall be made*

1 *under this title through the MedicareAdvantage*
2 *plan or the original medicare fee-for-service pro-*
3 *gram option (as the case may be) elected before*
4 *the election with such organization,*

5 *“(B) the elected organization shall not be fi-*
6 *nancially responsible for payment for such serv-*
7 *ices until the date after the date of the individ-*
8 *ual’s discharge; and*

9 *“(C) the organization shall nonetheless be*
10 *paid the full amount otherwise payable to the or-*
11 *ganization under this part; or*

12 *“(2) termination of election with respect to a*
13 *MedicareAdvantage organization under this part—*

14 *“(A) the organization shall be financially*
15 *responsible for payment for such services after*
16 *such date and until the date of the individual’s*
17 *discharge;*

18 *“(B) payment for such services during the*
19 *stay shall not be made under section 1886(d) or*
20 *by any succeeding MedicareAdvantage organiza-*
21 *tion; and*

22 *“(C) the terminated organization shall not*
23 *receive any payment with respect to the indi-*
24 *vidual under this part during the period the in-*
25 *dividual is not enrolled.*

1 “(i) *SPECIAL RULE FOR HOSPICE CARE.*—

2 “(1) *INFORMATION.*—A contract under this part
3 shall require the MedicareAdvantage organization to
4 inform each individual enrolled under this part with
5 a MedicareAdvantage plan offered by the organization
6 about the availability of hospice care if—

7 “(A) a hospice program participating under
8 this title is located within the organization’s
9 service area; or

10 “(B) it is common practice to refer patients
11 to hospice programs outside such service area.

12 “(2) *PAYMENT.*—If an individual who is enrolled
13 with a MedicareAdvantage organization under this
14 part makes an election under section 1812(d)(1) to re-
15 ceive hospice care from a particular hospice pro-
16 gram—

17 “(A) payment for the hospice care furnished
18 to the individual shall be made to the hospice
19 program elected by the individual by the Sec-
20 retary;

21 “(B) payment for other services for which
22 the individual is eligible notwithstanding the in-
23 dividual’s election of hospice care under section
24 1812(d)(1), including services not related to the
25 individual’s terminal illness, shall be made by

the Secretary to the MedicareAdvantage organization or the provider or supplier of the service instead of payments calculated under subsection (a); and

“(C) the Secretary shall continue to make monthly payments to the MedicareAdvantage organization in an amount equal to the value of the additional benefits required under section 1854(f)(1)(A).”.

SEC. 204. SUBMISSION OF BIDS; PREMIUMS.

Section 1854 (42 U.S.C. 1395w–24) is amended to read as follows:

“SUBMISSION OF BIDS; PREMIUMS

“SEC. 1854. (a) SUBMISSION OF BIDS BY MEDICAREADVANTAGE ORGANIZATIONS.—

“(1) IN GENERAL.—Not later than the second Monday in September and except as provided in paragraph (3), each MedicareAdvantage organization shall submit to the Secretary, in such form and manner as the Secretary may specify, for each MedicareAdvantage plan that the organization intends to offer in a service area in the following year—

“(A) notice of such intent and information on the service area of the plan;

“(B) the plan type for each plan;

1 “(C) if the MedicareAdvantage plan is a co-
 2 ordinated care plan (as described in section
 3 1851(a)(2)(A)) or a private fee-for-service plan
 4 (as described in section 1851(a)(2)(C)), the infor-
 5 mation described in paragraph (2) with respect
 6 to each payment area;

7 “(D) the enrollment capacity (if any) in re-
 8 lation to the plan and each payment area;

9 “(E) the expected mix, by health status, of
 10 enrolled individuals; and

11 “(F) such other information as the Sec-
 12 retary may specify.

13 “(2) INFORMATION REQUIRED FOR COORDINATED
 14 CARE PLANS AND PRIVATE FEE-FOR-SERVICE
 15 PLANS.—For a MedicareAdvantage plan that is a co-
 16 ordinated care plan (as described in section
 17 1851(a)(2)(A)) or a private fee-for-service plan (as
 18 described in section 1851(a)(2)(C)), the information
 19 described in this paragraph is as follows:

20 “(A) INFORMATION REQUIRED WITH RE-
 21 SPECT TO BENEFITS UNDER THE ORIGINAL
 22 MEDICARE FEE-FOR-SERVICE PROGRAM OP-
 23 TION.—Information relating to the coverage of
 24 benefits under the original medicare fee-for-serv-
 25 ice program option as follows:

1 “(i) *The plan bid, which shall consist*
2 *of a dollar amount that represents the total*
3 *amount that the plan is willing to accept*
4 *(not taking into account the application of*
5 *the comprehensive risk adjustment method-*
6 *ology under section 1853(a)(3)) for pro-*
7 *viding coverage of the benefits under the*
8 *original medicare fee-for-service program*
9 *option to an individual enrolled in the plan*
10 *that resides in the service area of the plan*
11 *for a month.*

12 “(ii) *For the enhanced medical benefits*
13 *package offered—*

14 “(I) *the adjusted community rate*
15 *(as defined in subsection (g)(3)) of the*
16 *package;*

17 “(II) *the portion of the actuarial*
18 *value of such benefits package (if any)*
19 *that will be applied toward satisfying*
20 *the requirement for additional benefits*
21 *under subsection (g);*

22 “(III) *the MedicareAdvantage*
23 *monthly beneficiary premium for en-*
24 *hanced medical benefits (as defined in*
25 *subsection (b)(2)(C));*

1 “(IV) a description of any cost-
2 sharing;

3 “(V) a description of whether the
4 amount of the unified deductible has
5 been lowered or the maximum limita-
6 tions on out-of-pocket expenses have
7 been decreased (relative to the levels
8 used in calculating the plan bid);

9 “(VI) such other information as
10 the Secretary considers necessary.

11 “(iii) The assumptions that the
12 MedicareAdvantage organization used in
13 preparing the plan bid with respect to num-
14 bers, in each payment area, of enrolled in-
15 dividuals and the mix, by health status, of
16 such individuals.

17 “(B) INFORMATION REQUIRED WITH RE-
18 SPECT TO PART D.—The information required to
19 be submitted by an eligible entity under section
20 1860D–12, including the monthly premiums for
21 standard coverage and any other qualified pre-
22 scription drug coverage available to individuals
23 enrolled under part D.

24 “(C) DETERMINING PLAN COSTS INCLUDED
25 IN PLAN BID.—For purposes of submitting its

1 *plan bid under subparagraph (A)(i) a*
 2 *MedicareAdvantage plan offered by a*
 3 *MedicareAdvantage organization satisfies sub-*
 4 *paragraphs (A) and (C) of section 1852(a)(1) if*
 5 *the actuarial value of the deductibles, coinsur-*
 6 *ance, and copayments applicable on average to*
 7 *individuals enrolled in such plan under this part*
 8 *with respect to benefits under the original medi-*
 9 *care fee-for-service program option on which that*
 10 *bid is based (ignoring any reduction in cost-*
 11 *sharing offered by such plan as enhanced med-*
 12 *ical benefits under paragraph (2)(A)(ii) or re-*
 13 *quired under clause (ii) or (iii) of subsection*
 14 *(g)(1)(C)) equals the amount specified in sub-*
 15 *section (f)(1)(B).*

16 “(3) *REQUIREMENTS FOR MSA PLANS.*—*For an*
 17 *MSA plan described in section 1851(a)(2)(B), the in-*
 18 *formation described in this paragraph is the informa-*
 19 *tion that such a plan would have been required to*
 20 *submit under this part if the Prescription Drug and*
 21 *Medicare Improvements Act of 2003 had not been en-*
 22 *acted.*

23 “(4) *REVIEW.*—

24 “(A) *IN GENERAL.*—*Subject to subpara-*
 25 *graph (B), the Secretary shall review the ad-*

1 *justed community rates (as defined in section*
 2 *1854(g)(3)), the amounts of the*
 3 *MedicareAdvantage monthly basic premium and*
 4 *the MedicareAdvantage monthly beneficiary pre-*
 5 *mium for enhanced medical benefits filed under*
 6 *this subsection and shall approve or disapprove*
 7 *such rates and amounts so submitted. The Sec-*
 8 *retary shall review the actuarial assumptions*
 9 *and data used by the MedicareAdvantage organi-*
 10 *zation with respect to such rates and amounts so*
 11 *submitted to determine the appropriateness of*
 12 *such assumptions and data.*

13 *“(B) MSA EXCEPTION.—The Secretary*
 14 *shall not review, approve, or disapprove the*
 15 *amounts submitted under paragraph (3).*

16 *“(C) CLARIFICATION OF AUTHORITY RE-*
 17 *GARDING DISAPPROVAL OF UNREASONABLE BEN-*
 18 *EFICIARY COST-SHARING.—Under the authority*
 19 *under subparagraph (A), the Secretary may dis-*
 20 *approve the bid if the Secretary determines that*
 21 *the deductibles, coinsurance, or copayments ap-*
 22 *plicable under the plan discourage access to cov-*
 23 *ered services or are likely to result in favorable*
 24 *selection of MedicareAdvantage eligible individ-*
 25 *uals.*

1 “(5) *APPLICATION OF FEHBP STANDARD; PROHI-*
 2 *BITION ON PRICE GOUGING.—Each bid amount sub-*
 3 *mitted under paragraph (1) for a MedicareAdvantage*
 4 *plan must reasonably and equitably reflect the cost of*
 5 *benefits provided under that plan.*

6 “(b) *MONTHLY PREMIUMS CHARGED.—*

7 “(1) *IN GENERAL.—*

8 “(A) *COORDINATED CARE AND PRIVATE*
 9 *FEE-FOR-SERVICE PLANS.—The monthly amount*
 10 *of the premium charged to an individual en-*
 11 *rolled in a MedicareAdvantage plan (other than*
 12 *an MSA plan) offered by a MedicareAdvantage*
 13 *organization shall be equal to the sum of the fol-*
 14 *lowing:*

15 “(i) *The MedicareAdvantage monthly*
 16 *basic beneficiary premium (if any).*

17 “(ii) *The MedicareAdvantage monthly*
 18 *beneficiary premium for enhanced medical*
 19 *benefits (if any).*

20 “(iii) *The MedicareAdvantage monthly*
 21 *obligation for qualified prescription drug*
 22 *coverage (if any).*

23 “(B) *MSA PLANS.—The rules under this*
 24 *section that would have applied with respect to*
 25 *an MSA plan if the Prescription Drug and*

1 *Medicare Improvements Act of 2003 had not*
 2 *been enacted shall continue to apply to MSA*
 3 *plans after the date of enactment of such Act.*

4 “(2) *PREMIUM TERMINOLOGY.*—For purposes of
 5 *this part:*

6 “(A) *MEDICAREADVANTAGE MONTHLY BASIC*
 7 *BENEFICIARY PREMIUM.*—The term
 8 ‘*MedicareAdvantage monthly basic beneficiary*
 9 *premium*’ means, with respect to a
 10 *MedicareAdvantage plan, the amount required to*
 11 *be charged under subsection (d)(2) for the plan.*

12 “(B) *MEDICAREADVANTAGE MONTHLY BEN-*
 13 *EFICIARY OBLIGATION FOR QUALIFIED PRESCRIP-*
 14 *TION DRUG COVERAGE.*—The term
 15 ‘*MedicareAdvantage monthly beneficiary obliga-*
 16 *tion for qualified prescription drug coverage*’
 17 means, with respect to a *MedicareAdvantage*
 18 *plan, the amount determined under section*
 19 *1858A(d).*

20 “(C) *MEDICAREADVANTAGE MONTHLY BEN-*
 21 *EFICIARY PREMIUM FOR ENHANCED MEDICAL*
 22 *BENEFITS.*—The term ‘*MedicareAdvantage*
 23 *monthly beneficiary premium for enhanced med-*
 24 *ical benefits*’ means, with respect to a
 25 *MedicareAdvantage plan, the amount required to*

1 *be charged under subsection (f)(2) for the plan,*
 2 *or, in the case of an MSA plan, the amount filed*
 3 *under subsection (a)(3).*

4 “(D) *MEDICAREADVANTAGE MONTHLY MSA*
 5 *PREMIUM.—The term ‘MedicareAdvantage*
 6 *monthly MSA premium’ means, with respect to*
 7 *a MedicareAdvantage plan, the amount of such*
 8 *premium filed under subsection (a)(3) for the*
 9 *plan.*

10 “(c) *UNIFORM PREMIUM.—The MedicareAdvantage*
 11 *monthly basic beneficiary premium, the MedicareAdvantage*
 12 *monthly beneficiary obligation for qualified prescription*
 13 *drug coverage, the MedicareAdvantage monthly beneficiary*
 14 *premium for enhanced medical benefits, and the*
 15 *MedicareAdvantage monthly MSA premium charged under*
 16 *subsection (b) of a MedicareAdvantage organization under*
 17 *this part may not vary among individuals enrolled in the*
 18 *plan.*

19 “(d) *DETERMINATION OF PREMIUM REDUCTIONS, RE-*
 20 *DUCE COST-SHARING, ADDITIONAL BENEFITS, AND BENE-*
 21 *FICIARY PREMIUMS.—*

22 “(1) *BIDS BELOW THE BENCHMARK.—If the Sec-*
 23 *retary determines under section 1853(d)(3) that the*
 24 *weighted service area benchmark amount exceeds the*
 25 *plan bid, the Secretary shall require the plan to pro-*

1 *vide additional benefits in accordance with subsection*
 2 *(g).*

3 “(2) *BIDS ABOVE THE BENCHMARK.*—*If the Sec-*
 4 *retary determines under section 1853(d)(3) that the*
 5 *plan bid exceeds the weighted service area benchmark*
 6 *amount (determined under section 1853(d)(2)), the*
 7 *amount of such excess shall be the MedicareAdvantage*
 8 *monthly basic beneficiary premium (as defined in*
 9 *section 1854(b)(2)(A)).*

10 “(e) *TERMS AND CONDITIONS OF IMPOSING PRE-*
 11 *MIUMS.*—*Each MedicareAdvantage organization shall per-*
 12 *mit the payment of any MedicareAdvantage monthly basic*
 13 *premium, the MedicareAdvantage monthly beneficiary obli-*
 14 *gation for qualified prescription drug coverage, and the*
 15 *MedicareAdvantage monthly beneficiary premium for en-*
 16 *hanced medical benefits on a monthly basis, may terminate*
 17 *election of individuals for a MedicareAdvantage plan for*
 18 *failure to make premium payments only in accordance with*
 19 *section 1851(g)(3)(B)(i), and may not provide for cash or*
 20 *other monetary rebates as an inducement for enrollment or*
 21 *otherwise (other than as an additional benefit described in*
 22 *subsection (g)(1)(C)(i)).*

23 “(f) *LIMITATION ON ENROLLEE LIABILITY.*—

1 “(1) *FOR BENEFITS UNDER THE ORIGINAL MEDI-*
2 *CARE FEE-FOR-SERVICE PROGRAM OPTION.—The sum*
3 *of—*

4 “(A) *the MedicareAdvantage monthly basic*
5 *beneficiary premium (multiplied by 12) and the*
6 *actuarial value of the deductibles, coinsurance,*
7 *and copayments (determined on the same basis*
8 *as used in determining the plan’s bid under*
9 *paragraph (2)(C)) applicable on average to indi-*
10 *viduals enrolled under this part with a*
11 *MedicareAdvantage plan described in subpara-*
12 *graph (A) or (C) of section 1851(a)(2) of an or-*
13 *ganization with respect to required benefits de-*
14 *scribed in section 1852(a)(1)(A); must equal*

15 “(B) *the actuarial value of the deductibles,*
16 *coinsurance, and copayments that would be ap-*
17 *plicable on average to individuals who have*
18 *elected to receive benefits under the original*
19 *medicare fee-for-service program option if such*
20 *individuals were not members of a*
21 *MedicareAdvantage organization for the year*
22 *(adjusted as determined appropriate by the Sec-*
23 *retary to account for geographic differences and*
24 *for plan cost and utilization differences).*

1 “(2) *FOR ENHANCED MEDICAL BENEFITS.*—*If the*
2 *MedicareAdvantage organization provides to its mem-*
3 *bers enrolled under this part in a MedicareAdvantage*
4 *plan described in subparagraph (A) or (C) of section*
5 *1851(a)(2) with respect to enhanced medical benefits*
6 *relating to benefits under the original medicare fee-*
7 *for-service program option, the sum of the*
8 *MedicareAdvantage monthly beneficiary premium for*
9 *enhanced medical benefits (multiplied by 12) charged*
10 *and the actuarial value of its deductibles, coinsur-*
11 *ance, and copayments charged with respect to such*
12 *benefits for a year must equal the adjusted commu-*
13 *nity rate (as defined in subsection (g)(3)) for such*
14 *benefits for the year minus the actuarial value of any*
15 *additional benefits pursuant to clause (ii), (iii), or*
16 *(iv) of subsection (g)(2)(C) that the plan specified*
17 *under subsection (a)(2)(i)(II).*

18 “(3) *DETERMINATION ON OTHER BASIS.*—*If the*
19 *Secretary determines that adequate data are not*
20 *available to determine the actuarial value under*
21 *paragraph (1)(A) or (2), the Secretary may determine*
22 *such amount with respect to all individuals in the*
23 *same geographic area, the State, or in the United*
24 *States, eligible to enroll in the MedicareAdvantage*

1 *plan involved under this part or on the basis of other*
 2 *appropriate data.*

3 “(4) *SPECIAL RULE FOR PRIVATE FEE-FOR-SERV-*
 4 *ICE PLANS.*—*With respect to a MedicareAdvantage*
 5 *private fee-for-service plan (other than a plan that is*
 6 *an MSA plan), in no event may—*

7 “(A) *the actuarial value of the deductibles,*
 8 *coinsurance, and copayments applicable on aver-*
 9 *age to individuals enrolled under this part with*
 10 *such a plan of an organization with respect to*
 11 *required benefits described in subparagraphs (A),*
 12 *(C), and (D) of section 1852(a)(1); exceed*

13 “(B) *the actuarial value of the deductibles,*
 14 *coinsurance, and copayments that would be ap-*
 15 *plicable on average to individuals entitled to (or*
 16 *enrolled for) benefits under part A and enrolled*
 17 *under part B if they were not members of a*
 18 *MedicareAdvantage organization for the year.*

19 “(g) *REQUIREMENT FOR ADDITIONAL BENEFITS.*—

20 “(1) *REQUIREMENT.*—

21 “(A) *IN GENERAL.*—*Each*
 22 *MedicareAdvantage organization (in relation to*
 23 *a MedicareAdvantage plan, other than an MSA*
 24 *plan, it offers) shall provide that if there is an*
 25 *excess amount (as defined in subparagraph (B))*

1 for the plan for a contract year, subject to the
 2 succeeding provisions of this subsection, the orga-
 3 nization shall provide to individuals such addi-
 4 tional benefits described in subparagraph (C) as
 5 the organization may specify in a value which
 6 the Secretary determines is at least equal to the
 7 adjusted excess amount (as defined in subpara-
 8 graph (D)).

9 “(B) *EXCESS AMOUNT.*—For purposes of
 10 this paragraph, the term ‘excess amount’ means,
 11 for an organization for a plan, is 100 percent of
 12 the amount (if any) by which the weighted serv-
 13 ice area benchmark amount (determined under
 14 section 1853(d)(2)) exceeds the plan bid (as ad-
 15 justed under section 1853(d)(1)).

16 “(C) *ADDITIONAL BENEFITS DESCRIBED.*—
 17 The additional benefits described in this sub-
 18 paragraph are as follows:

19 “(i) Subject to subparagraph (F), a
 20 monthly part B premium reduction for in-
 21 dividuals enrolled in the plan.

22 “(ii) Lowering the amount of the uni-
 23 fied deductible and decreasing the max-
 24 imum limitations on out-of-pocket expenses
 25 for individuals enrolled in the plan.

1 “(iii) *A reduction in the actuarial*
 2 *value of plan cost-sharing for plan enrollees.*

3 “(iv) *Subject to subparagraph (E),*
 4 *such additional benefits as the organization*
 5 *may specify.*

6 “(v) *Contributing to the stabilization*
 7 *fund under paragraph (2).*

8 “(vi) *Any combination of the reduc-*
 9 *tions and benefits described in clauses (i)*
 10 *through (v).*

11 “(D) *ADJUSTED EXCESS AMOUNT.—For*
 12 *purposes of this paragraph, the term ‘adjusted*
 13 *excess amount’ means, for an organization for a*
 14 *plan, is the excess amount reduced to reflect any*
 15 *amount withheld and reserved for the organiza-*
 16 *tion for the year under paragraph (2).*

17 “(E) *RULE FOR APPROVAL OF MEDICAL AND*
 18 *PRESCRIPTION DRUG BENEFITS.—An organiza-*
 19 *tion may not specify any additional benefit that*
 20 *provides for the coverage of any prescription*
 21 *drug (other than that relating to prescription*
 22 *drugs covered under the original medicare fee-*
 23 *for-service program option).*

24 “(F) *PREMIUM REDUCTIONS.—*

1 “(i) *IN GENERAL.*—Subject to clause
 2 (ii), as part of providing any additional
 3 benefits required under subparagraph (A), a
 4 MedicareAdvantage organization may elect
 5 a reduction in its payments under section
 6 1853(a)(1)(A)(i) with respect to a
 7 MedicareAdvantage plan and the Secretary
 8 shall apply such reduction to reduce the
 9 premium under section 1839 of each en-
 10 rollee in such plan as provided in section
 11 1840(i).

12 “(ii) *AMOUNT OF REDUCTION.*—The
 13 amount of the reduction under clause (i)
 14 with respect to any enrollee in a
 15 MedicareAdvantage plan—

16 “(I) may not exceed 125 percent
 17 of the premium described under section
 18 1839(a)(3); and

19 “(II) shall apply uniformly to
 20 each enrollee of the MedicareAdvantage
 21 plan to which such reduction applies.

22 “(G) *UNIFORM APPLICATION.*—This para-
 23 graph shall be applied uniformly for all enrollees
 24 for a plan.

1 “(H) CONSTRUCTION.—Nothing in this sub-
 2 section shall be construed as preventing a
 3 MedicareAdvantage organization from providing
 4 enhanced medical benefits (described in section
 5 1852(a)(3)) that are in addition to the health
 6 care benefits otherwise required to be provided
 7 under this paragraph and from imposing a pre-
 8 mium for such enhanced medical benefits.

9 “(2) STABILIZATION FUND.—A
 10 MedicareAdvantage organization may provide that a
 11 part of the value of an excess amount described in
 12 paragraph (1) be withheld and reserved in the Fed-
 13 eral Hospital Insurance Trust Fund and in the Fed-
 14 eral Supplementary Medical Insurance Trust Fund
 15 (in such proportions as the Secretary determines to be
 16 appropriate) by the Secretary for subsequent annual
 17 contract periods, to the extent required to prevent
 18 undue fluctuations in the additional benefits offered
 19 in those subsequent periods by the organization in ac-
 20 cordance with such paragraph. Any of such value of
 21 the amount reserved which is not provided as addi-
 22 tional benefits described in paragraph (1)(A) to indi-
 23 viduals electing the MedicareAdvantage plan of the
 24 organization in accordance with such paragraph

1 *prior to the end of such periods, shall revert for the*
 2 *use of such Trust Funds.*

3 “(3) *ADJUSTED COMMUNITY RATE.*—For pur-
 4 *poses of this subsection, subject to paragraph (4), the*
 5 *term ‘adjusted community rate’ for a service or serv-*
 6 *ices means, at the election of a MedicareAdvantage or-*
 7 *ganization, either—*

8 “(A) *the rate of payment for that service or*
 9 *services which the Secretary annually determines*
 10 *would apply to an individual electing a*
 11 *MedicareAdvantage plan under this part if the*
 12 *rate of payment were determined under a ‘com-*
 13 *munity rating system’ (as defined in section*
 14 *1302(8) of the Public Health Service Act, other*
 15 *than subparagraph (C)); or*

16 “(B) *such portion of the weighted aggregate*
 17 *premium, which the Secretary annually esti-*
 18 *mates would apply to such an individual, as the*
 19 *Secretary annually estimates is attributable to*
 20 *that service or services,*

21 *but adjusted for differences between the utilization*
 22 *characteristics of the individuals electing coverage*
 23 *under this part and the utilization characteristics of*
 24 *the other enrollees with the plan (or, if the Secretary*
 25 *finds that adequate data are not available to adjust*

1 *for those differences, the differences between the utili-*
 2 *zation characteristics of individuals selecting other*
 3 *MedicareAdvantage coverage, or MedicareAdvantage*
 4 *eligible individuals in the area, in the State, or in the*
 5 *United States, eligible to elect MedicareAdvantage*
 6 *coverage under this part and the utilization charac-*
 7 *teristics of the rest of the population in the area, in*
 8 *the State, or in the United States, respectively).*

9 “(4) *DETERMINATION BASED ON INSUFFICIENT*
 10 *DATA.—For purposes of this subsection, if the Sec-*
 11 *retary finds that there is insufficient enrollment expe-*
 12 *rience to determine the average amount of payments*
 13 *to be made under this part at the beginning of a con-*
 14 *tract period or to determine (in the case of a newly*
 15 *operated provider-sponsored organization or other*
 16 *new organization) the adjusted community rate for*
 17 *the organization, the Secretary may determine such*
 18 *an average based on the enrollment experience of other*
 19 *contracts entered into under this part and may deter-*
 20 *mine such a rate using data in the general commer-*
 21 *cial marketplace.*

22 “(h) *PROHIBITION OF STATE IMPOSITION OF PREMIUM*
 23 *TAXES.—No State may impose a premium tax or similar*
 24 *tax with respect to payments to MedicareAdvantage organi-*
 25 *zations under section 1853.*

1 “(i) *PERMITTING USE OF SEGMENTS OF SERVICE*
 2 *AREAS.*—*The Secretary shall permit a MedicareAdvantage*
 3 *organization to elect to apply the provisions of this section*
 4 *uniformly to separate segments of a service area (rather*
 5 *than uniformly to an entire service area) as long as such*
 6 *segments are composed of 1 or more MedicareAdvantage*
 7 *payment areas.”.*

8 (b) *STUDY AND REPORT ON CLARIFICATION OF AU-*
 9 *THORITY REGARDING DISAPPROVAL OF UNREASONABLE*
 10 *BENEFICIARY COST-SHARING.*—

11 (1) *STUDY.*—*The Secretary, in consultation with*
 12 *beneficiaries, consumer groups, employers, and*
 13 *Medicare+Choice organizations, shall conduct a study*
 14 *to determine the extent to which the cost-sharing*
 15 *structures under Medicare+Choice plans under part*
 16 *C of title XVIII of the Social Security Act discourage*
 17 *access to covered services or discriminate based on the*
 18 *health status of Medicare+Choice eligible individuals*
 19 *(as defined in section 1851(a)(3) of the Social Secu-*
 20 *urity Act (42 U.S.C. 1395w–21(a)(3))).*

21 (2) *REPORT.*—*Not later than December 31, 2004,*
 22 *the Secretary shall submit a report to Congress on the*
 23 *study conducted under paragraph (1) together with*
 24 *recommendations for such legislation and administra-*
 25 *tive actions as the Secretary considers appropriate.*

1 **SEC. 205. SPECIAL RULES FOR PRESCRIPTION DRUG BENE-**
 2 **FITS.**

3 *Part C of title XVIII (42 U.S.C. 1395w–21 et seq.)*
 4 *is amended by inserting after section 1857 the following*
 5 *new section:*

6 “SPECIAL RULES FOR PRESCRIPTION DRUG BENEFITS

7 “SEC. 1858A. (a) AVAILABILITY.—

8 “(1) PLANS REQUIRED TO PROVIDE QUALIFIED
 9 PRESCRIPTION DRUG COVERAGE TO ENROLLEES.—

10 “(A) IN GENERAL.—Except as provided in
 11 subparagraph (B), on and after January 1,
 12 2006, a MedicareAdvantage organization offering
 13 a MedicareAdvantage plan (except for an MSA
 14 plan) shall make available qualified prescription
 15 drug coverage that meets the requirements for
 16 such coverage under this part and part D to each
 17 enrollee of the plan.

18 “(B) PRIVATE FEE-FOR-SERVICE PLANS
 19 MAY, BUT ARE NOT REQUIRED TO, PROVIDE
 20 QUALIFIED PRESCRIPTION DRUG COVERAGE.—
 21 Pursuant to section 1852(a)(2)(D), a private fee-
 22 for-service plan may elect not to provide quali-
 23 fied prescription drug coverage under part D to
 24 individuals residing in the area served by the
 25 plan.

1 “(2) *REFERENCE TO PROVISION PERMITTING AD-*
2 *DITIONAL PRESCRIPTION DRUG COVERAGE.*—For the
3 provisions of part D, made applicable to this part
4 pursuant to paragraph (1), that permit a plan to
5 make available qualified prescription drug coverage
6 that includes coverage of covered drugs that exceeds
7 the coverage required under paragraph (1) of section
8 1860D–6 in an area, but only if the
9 MedicareAdvantage organization offering the plan
10 also offers a MedicareAdvantage plan in the area that
11 only provides the coverage that is required under such
12 paragraph (1), see paragraph (2) of such section.

13 “(3) *RULE FOR APPROVAL OF MEDICAL AND PRE-*
14 *SCRIPTION DRUG BENEFITS.*—Pursuant to sections
15 1854(g)(1)(F) and 1852(a)(3)(D), a
16 MedicareAdvantage organization offering a
17 MedicareAdvantage plan that provides qualified pre-
18 scription drug coverage may not make available cov-
19 erage of any prescription drugs (other than that relat-
20 ing to prescription drugs covered under the original
21 medicare fee-for-service program option) to an en-
22 rollee as an additional benefit or as an enhanced
23 medical benefit.

24 “(b) *COMPLIANCE WITH ADDITIONAL BENEFICIARY*
25 *PROTECTIONS.*—With respect to the offering of qualified

1 *prescription drug coverage by a MedicareAdvantage organi-*
 2 *zation under a MedicareAdvantage plan, the organization*
 3 *and plan shall meet the requirements of section 1860D–5,*
 4 *including requirements relating to information dissemina-*
 5 *tion and grievance and appeals, and such other require-*
 6 *ments under part D that the Secretary determines appro-*
 7 *priate in the same manner as such requirements apply to*
 8 *an eligible entity and a Medicare Prescription Drug plan*
 9 *under part D. The Secretary shall waive such requirements*
 10 *to the extent the Secretary determines that such require-*
 11 *ments duplicate requirements otherwise applicable to the or-*
 12 *ganization or the plan under this part.*

13 “(c) *PAYMENTS FOR PRESCRIPTION DRUGS.—*

14 “(1) *PAYMENT OF FULL AMOUNT OF PREMIUM TO*
 15 *ORGANIZATIONS FOR QUALIFIED PRESCRIPTION DRUG*
 16 *COVERAGE.—*

17 “(A) *IN GENERAL.—For each year (begin-*
 18 *ning with 2006), the Secretary shall pay to each*
 19 *MedicareAdvantage organization offering a*
 20 *MedicareAdvantage plan that provides qualified*
 21 *prescription drug coverage, an amount equal to*
 22 *the full amount of the monthly premium sub-*
 23 *mitted under section 1854(a)(2)(B) for the year,*
 24 *as adjusted using the risk adjusters that apply to*

1 *the standard prescription drug coverage pub-*
 2 *lished under section 1860D–11.*

3 “(B) *APPLICATION OF PART D RISK COR-*
 4 *RIDOR, STABILIZATION RESERVE FUND, AND AD-*
 5 *MINISTRATIVE EXPENSES PROVISIONS.*—*The pro-*
 6 *visions of subsections (b), (c), and (d) of section*
 7 *1860D–16 shall apply to a MedicareAdvantage*
 8 *organization offering a MedicareAdvantage plan*
 9 *that provides qualified prescription drug cov-*
 10 *erage and payments made to such organization*
 11 *under subparagraph (A) in the same manner as*
 12 *such provisions apply to an eligible entity offer-*
 13 *ing a Medicare Prescription Drug plan and pay-*
 14 *ments made to such entity under subsection (a)*
 15 *of section 1860D–16.*

16 “(2) *PAYMENT FROM PRESCRIPTION DRUG AC-*
 17 *COUNT.*—*Payment made to MedicareAdvantage orga-*
 18 *nizations under this subsection shall be made from the*
 19 *Prescription Drug Account in the Federal Supple-*
 20 *mentary Medical Insurance Trust Fund under section*
 21 *1841.*

22 “(d) *COMPUTATION OF MEDICAREADVANTAGE MONTH-*
 23 *LY BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIP-*
 24 *TION DRUG COVERAGE.*—*In the case of a*
 25 *MedicareAdvantage eligible individual receiving qualified*

1 *prescription drug coverage under a MedicareAdvantage*
 2 *plan during a year after 2005, the MedicareAdvantage*
 3 *monthly beneficiary obligation for qualified prescription*
 4 *drug coverage of such individual in the year shall be deter-*
 5 *mined in the same manner as the monthly beneficiary obli-*
 6 *gation is determined under section 1860D–17 for eligible*
 7 *beneficiaries enrolled in a Medicare Prescription Drug*
 8 *plan, except that, for purposes of this subparagraph, any*
 9 *reference to the monthly plan premium approved by the*
 10 *Secretary under section 1860D–13 shall be treated as a ref-*
 11 *erence to the monthly premium for qualified prescription*
 12 *drug coverage submitted by the MedicareAdvantage organi-*
 13 *zation offering the plan under section 1854(a)(2)(A) and*
 14 *approved by the Secretary.*

15 “(e) *COLLECTION OF MEDICAREADVANTAGE MONTHLY*
 16 *BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION*
 17 *DRUG COVERAGE.—The provisions of section 1860D–18,*
 18 *including subsection (b) of such section, shall apply to the*
 19 *amount of the MedicareAdvantage monthly beneficiary obli-*
 20 *gation for qualified prescription drug coverage (as deter-*
 21 *mined under subsection (d)) required to be paid by a*
 22 *MedicareAdvantage eligible individual enrolled in a*
 23 *MedicareAdvantage plan in the same manner as such provi-*
 24 *sions apply to the amount of the monthly beneficiary obli-*
 25 *gation required to be paid by an eligible beneficiary en-*

1 rolled in a Medicare Prescription Drug plan under part
2 D.

3 “(f) AVAILABILITY OF PREMIUM SUBSIDY AND COST-
4 SHARING REDUCTIONS FOR LOW-INCOME ENROLLEES AND
5 REINSURANCE PAYMENTS.—For provisions—

6 “(1) providing premium subsidies and cost-shar-
7 ing reductions for low-income individuals receiving
8 qualified prescription drug coverage through a
9 MedicareAdvantage plan, see section 1860D–19; and
10 “(2) providing a MedicareAdvantage organiza-
11 tion with reinsurance payments for certain expenses
12 incurred in providing qualified prescription drug cov-
13 erage through a MedicareAdvantage plan, see section
14 1860D–20.”.

15 (b) TREATMENT OF REDUCTION FOR PURPOSES OF
16 DETERMINING GOVERNMENT CONTRIBUTION UNDER PART
17 B.—Section 1844(c) (42 U.S.C. 1395w) is amended by
18 striking “section 1854(f)(1)(E)” and inserting “section
19 1854(d)(1)(A)(i)”.

20 **SEC. 206. FACILITATING EMPLOYER PARTICIPATION.**

21 Section 1858(h) (as added by section 211) is amended
22 by inserting “(including subsection (i) of such section)”
23 after “section 1857”.

1 **SEC. 207. ADMINISTRATION BY THE CENTER FOR MEDICARE**
 2 **CHOICES.**

3 *On and after January 1, 2006, the MedicareAdvantage*
 4 *program under part C of title XVIII of the Social Security*
 5 *Act shall be administered by the Center for Medicare*
 6 *Choices established under section 1808 such title (as added*
 7 *by section 301), and each reference to the Secretary made*
 8 *in such part shall be deemed to be a reference to the Admin-*
 9 *istrator of the Center for Medicare Choices.*

10 **SEC. 208. CONFORMING AMENDMENTS.**

11 *(a) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS*
 12 *FOR MEDICAREADVANTAGE ORGANIZATIONS; PROVIDER-*
 13 *SPONSORED ORGANIZATIONS.—Section 1855 (42 U.S.C.*
 14 *1395w–25) is amended—*

15 *(1) in subsection (b), in the matter preceding*
 16 *paragraph (1), by inserting “subparagraphs (A), (B),*
 17 *and (D) of” before “section 1852(A)(1)”; and*

18 *(2) by striking “Medicare+Choice” and insert-*
 19 *ing “MedicareAdvantage” each place it appears.*

20 *(b) ESTABLISHMENT OF PSO STANDARDS.—Section*
 21 *1856 (42 U.S.C. 1395w–26) is amended by striking*
 22 *“Medicare+Choice” and inserting “MedicareAdvantage”*
 23 *each place it appears.*

24 *(c) CONTRACTS WITH MEDICAREADVANTAGE ORGANI-*
 25 *ZATIONS.—Section 1857 (42 U.S.C. 1395w–27) is amend-*
 26 *ed—*

1 (1) in subsection (g)(1)—

2 (A) in subparagraph (B), by striking
3 “amount of the Medicare+Choice monthly basic
4 and supplemental beneficiary premiums” and
5 inserting “amounts of the MedicareAdvantage
6 monthly basic premium and MedicareAdvantage
7 monthly beneficiary premium for enhanced med-
8 ical benefits”;

9 (B) in subparagraph (F), by striking “or”
10 after the semicolon at the end;

11 (C) in subparagraph (G), by adding “or”
12 after the semicolon at the end; and

13 (D) by inserting after subparagraph (G) the
14 following new subparagraph:

15 “(H)(i) charges any individual an amount
16 in excess of the MedicareAdvantage monthly ben-
17 eficiary obligation for qualified prescription
18 drug coverage under section 1858A(d);

19 “(ii) provides coverage for prescription
20 drugs that is not qualified prescription drug cov-
21 erage;

22 “(iii) offers prescription drug coverage, but
23 does not make standard prescription drug cov-
24 erage available; or

1 “(iv) provides coverage for prescription
 2 drugs (other than that relating to prescription
 3 drugs covered under the original medicare fee-
 4 for-service program option described in section
 5 1851(a)(1)(A)(i)) as an enhanced medical benefit
 6 under section 1852(a)(3)(D) or as an additional
 7 benefit under section 1854(g)(1)(F),”; and
 8 (2) by striking “Medicare+Choice” and insert-
 9 ing “MedicareAdvantage” each place it appears.

10 (d) *DEFINITIONS; MISCELLANEOUS PROVISIONS.*—Sec-
 11 tion 1859 (42 U.S.C. 1395w–28) is amended—

12 (1) by striking subsection (c) and inserting the
 13 following new subsection:

14 “(c) *OTHER REFERENCES TO OTHER TERMS.*—

15 “(1) *ENHANCED MEDICAL BENEFITS.*—The term
 16 ‘enhanced medical benefits’ is defined in section
 17 1852(a)(3)(E).

18 “(2) *MEDICAREADVANTAGE ELIGIBLE INDIVIDUAL.*—The term ‘MedicareAdvantage eligible indi-
 19 vidual’ is defined in section 1851(a)(3).
 20

21 “(3) *MEDICAREADVANTAGE PAYMENT AREA.*—
 22 The term ‘MedicareAdvantage payment area’ is de-
 23 fined in section 1853(d).

24 “(4) *NATIONAL PER CAPITA MEDICARE+CHOICE*
 25 *GROWTH PERCENTAGE.*—The ‘national per capita

1 *Medicare+Choice growth percentage’ is defined in sec-*
 2 *tion 1853(c)(6).*

3 “(5) *MEDICAREADVANTAGE MONTHLY BASIC BEN-*
 4 *EFICIARY PREMIUM; MEDICAREADVANTAGE MONTHLY*
 5 *BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIP-*
 6 *TION DRUG COVERAGE; MEDICAREADVANTAGE MONTH-*
 7 *LY BENEFICIARY PREMIUM FOR ENHANCED MEDICAL*
 8 *BENEFITS.—The terms ‘MedicareAdvantage monthly*
 9 *basic beneficiary premium’, ‘MedicareAdvantage*
 10 *monthly beneficiary obligation for qualified prescrip-*
 11 *tion drug coverage’, and ‘MedicareAdvantage monthly*
 12 *beneficiary premium for enhanced medical benefits’*
 13 *are defined in section 1854(b)(2).*

14 “(6) *QUALIFIED PRESCRIPTION DRUG COV-*
 15 *ERAGE.—The term ‘qualified prescription drug cov-*
 16 *erage’ has the meaning given such term in section*
 17 *1860D(9).*

18 “(7) *STANDARD PRESCRIPTION DRUG COV-*
 19 *ERAGE.—The term ‘standard prescription drug cov-*
 20 *erage’ has the meaning given such term in section*
 21 *1860D(10).”; and*

22 (2) *by striking “Medicare+Choice” and insert-*
 23 *ing “MedicareAdvantage” each place it appears.*

24 (e) *CONFORMING AMENDMENTS EFFECTIVE BEFORE*
 25 *2006.—*

1 (1) *EXTENSION OF MSAS.*—Section 1851(b)(4)
 2 (42 U.S.C. 1395w–21(b)(4)) is amended by striking
 3 “January 1, 2003” and inserting “January 1, 2004”.

4 (2) *CONTINUOUS OPEN ENROLLMENT AND*
 5 *DISENROLLMENT THROUGH 2005.*—Section 1851(e) of
 6 the Social Security Act (42 U.S.C. 1395w–21(e)) is
 7 amended—

8 (A) in paragraph (2)(A), by striking
 9 “THROUGH 2004” and “December 31, 2004” and
 10 inserting “THROUGH 2005” and “December 31,
 11 2005”, respectively;

12 (B) in the heading of paragraph (2)(B), by
 13 striking “DURING 2005” and inserting “DURING
 14 2006”;

15 (C) in paragraphs (2)(B)(i) and (2)(C)(i),
 16 by striking “2005” and inserting “2006” each
 17 place it appears;

18 (D) in paragraph (2)(D), by striking
 19 “2004” and inserting “2005”; and

20 (E) in paragraph (4), by striking “2005”
 21 and inserting “2006” each place it appears.

22 (3) *EFFECTIVE DATE.*—The amendments made
 23 by this subsection shall take effect on the date of en-
 24 actment of this Act.

25 (e) *OTHER CONFORMING AMENDMENTS.*—

1 (1) *CONFORMING MEDICARE CROSS-REF-*
2 *ERENCES.—*

3 (A) *Section 1839(a)(2) (42 U.S.C.*
4 *1395r(a)(2)) is amended by striking “section*
5 *1854(f)(1)(E)” and inserting “section*
6 *1854(g)(1)(C)(i)”.*

7 (B) *Section 1840(i) (42 U.S.C. 1395s(i)) is*
8 *amended by striking “section 1854(f)(1)(E)” and*
9 *inserting “section 1854(g)(1)(C)(i)”.*

10 (C) *Section 1844(c) (42 U.S.C. 1395w(c)) is*
11 *amended by striking “section 1854(f)(1)(E)” and*
12 *inserting “section 1854(g)(1)(C)(i)”.*

13 (D) *Section 1876(k)(3)(A) (42 U.S.C.*
14 *1395mm(k)(3)(A)) is amended by inserting “(as*
15 *in effect immediately before the enactment of the*
16 *Prescription Drug and Medicare Improvements*
17 *Act of 2003)” after section 1853(a).*

18 (F) *Section 1876(k)(4) (42 U.S.C.*
19 *1395mm(k)(4)(A)) is amended—*

20 (i) *in subparagraph (A), by striking*
21 *“section 1853(a)(3)(B)” and inserting “sec-*
22 *tion 1853(a)(3)(D)”;* *and*

23 (ii) *in subparagraph (B), by striking*
24 *“section 1854(g)” and inserting “section*
25 *1854(h)”.*

1 (G) Section 1876(k)(4)(C) (42 U.S.C.
 2 1395mm(k)(4)(C)) is amended by inserting “(as
 3 in effect immediately before the enactment of the
 4 Prescription Drug and Medicare Improvements
 5 Act of 2003)” after “section 1851(e)(6)”.

6 (H) Section 1894(d) (42 U.S.C. 1395eee(d))
 7 is amended by adding at the end the following
 8 new paragraph:

9 “(3) APPLICATION OF PROVISIONS.—For pur-
 10 poses of paragraphs (1) and (2), the references to sec-
 11 tion 1853 and subsection (a)(2) of such section in
 12 such paragraphs shall be deemed to be references to
 13 those provisions as in effect immediately before the
 14 enactment of the Prescription Drug and Medicare Im-
 15 provements Act of 2003.”.

16 (2) CONFORMING MEDICARE TERMINOLOGY.—
 17 Title XVIII (42 U.S.C. 1395 et seq.), except for part
 18 C of such title (42 U.S.C. 1395w–21 et seq.), and title
 19 XIX (42 U.S.C. 1396 et seq.) are each amended by
 20 striking “Medicare+Choice” and inserting
 21 “MedicareAdvantage” each place it appears.

22 **SEC. 209. EFFECTIVE DATE.**

23 (a) IN GENERAL.—Except as provided in section
 24 208(d)(3) and subsection (b), the amendments made by this

1 *title shall apply with respect to plan years beginning on*
 2 *and after January 1, 2006.*

3 (b) *MEDICAREADVANTAGE MSA PLANS.*—*Notwith-*
 4 *standing any provision of this title, the Secretary shall*
 5 *apply the payment and other rules that apply with respect*
 6 *to an MSA plan described in section 1851(a)(2)(B) of the*
 7 *Social Security Act (42 U.S.C. 1395w–21(a)(2)(B)) as if*
 8 *this title had not been enacted.*

9 ***Subtitle B—Preferred Provider***
 10 ***Organizations***

11 ***SEC. 211. ESTABLISHMENT OF MEDICAREADVANTAGE PRE-***
 12 ***FERRED PROVIDER PROGRAM OPTION.***

13 (a) *ESTABLISHMENT OF PREFERRED PROVIDER PRO-*
 14 *GRAM OPTION.*—*Section 1851(a)(2) is amended by adding*
 15 *at the end the following new subparagraph:*

16 “(D) *PREFERRED PROVIDER ORGANIZATION*
 17 *PLANS.*—*A MedicareAdvantage preferred pro-*
 18 *vider organization plan under the program es-*
 19 *tablished under section 1858.”.*

20 (b) *PROGRAM SPECIFICATIONS.*—*Part C of title XVIII*
 21 *(42 U.S.C. 1395w–21 et seq.) is amended by inserting after*
 22 *section 1857 the following new section:*

23 “*PREFERRED PROVIDER ORGANIZATIONS*

24 “*SEC. 1858. (a) ESTABLISHMENT OF PROGRAM.*—

25 “(1) *IN GENERAL.*—*Beginning on January 1,*
 26 *2006, there is established a preferred provider pro-*

1 *gram under which preferred provider organization*
 2 *plans offered by preferred provider organizations are*
 3 *offered to MedicareAdvantage eligible individuals in*
 4 *preferred provider regions.*

5 “(2) *DEFINITIONS.—*

6 “(A) *PREFERRED PROVIDER ORGANIZA-*
 7 *TION.—The term ‘preferred provider organiza-*
 8 *tion’ means an entity with a contract under sec-*
 9 *tion 1857 that meets the requirements of this sec-*
 10 *tion applicable with respect to preferred provider*
 11 *organizations.*

12 “(B) *PREFERRED PROVIDER ORGANIZATION*
 13 *PLAN.—The term ‘preferred provider organiza-*
 14 *tion plan’ means a MedicareAdvantage plan*
 15 *that—*

16 “(i) *has a network of providers that*
 17 *have agreed to a contractually specified re-*
 18 *imbursement for covered benefits with the*
 19 *organization offering the plan;*

20 “(ii) *provides for reimbursement for all*
 21 *covered benefits regardless of whether such*
 22 *benefits are provided within such network of*
 23 *providers; and*

24 “(iii) *is offered by a preferred provider*
 25 *organization.*

1 “(C) *PREFERRED PROVIDER REGION.*—*The*
2 *term ‘preferred provider region’ means—*

3 “(i) *a region established under para-*
4 *graph (3); and*

5 “(ii) *a region that consists of the entire*
6 *United States.*

7 “(3) *PREFERRED PROVIDER REGIONS.*—*For pur-*
8 *poses of this part the Secretary shall establish pre-*
9 *ferred provider regions as follows:*

10 “(A) *There shall be at least 10 regions.*

11 “(B) *Each region must include at least 1*
12 *State.*

13 “(C) *The Secretary may not divide States*
14 *so that portions of the State are in different re-*
15 *gions.*

16 “(D) *To the extent possible, the Secretary*
17 *shall include multistate metropolitan statistical*
18 *areas in a single region. The Secretary may di-*
19 *vide metropolitan statistical areas where it is*
20 *necessary to establish regions of such size and ge-*
21 *ography as to maximize the participation of pre-*
22 *ferred provider organization plans.*

23 “(E) *The Secretary may conform the pre-*
24 *ferred provider regions to the service areas estab-*
25 *lished under section 1860D–10.*

1 “(b) *ELIGIBILITY, ELECTION, AND ENROLLMENT; BEN-*
2 *EFITS AND BENEFICIARY PROTECTIONS.*—

3 “(1) *IN GENERAL.*—*Except as provided in the*
4 *succeeding provisions of this subsection, the provisions*
5 *of sections 1851 and 1852 that apply with respect to*
6 *coordinated care plans shall apply to preferred pro-*
7 *vider organization plans offered by a preferred pro-*
8 *vider organization.*

9 “(2) *SERVICE AREA.*—*The service area of a pre-*
10 *ferred provider organization plan shall be a preferred*
11 *provider region.*

12 “(3) *AVAILABILITY.*—*Each preferred provider or-*
13 *ganization plan must be offered to each*
14 *MedicareAdvantage eligible individual who resides in*
15 *the service area of the plan.*

16 “(4) *AUTHORITY TO PROHIBIT RISK SELEC-*
17 *TION.*—*The provisions of section 1852(a)(6) shall*
18 *apply to preferred provider organization plans.*

19 “(5) *ASSURING ACCESS TO SERVICES IN PRE-*
20 *FERRED PROVIDER ORGANIZATION PLANS.*—

21 “(A) *IN GENERAL.*—*In addition to any*
22 *other requirements under this section, in the case*
23 *of a preferred provider organization plan, the or-*
24 *ganization offering the plan must demonstrate to*
25 *the Secretary that the organization has sufficient*

number and range of health care professionals and providers willing to provide services under the terms of the plan.

“(B) *DETERMINATION OF SUFFICIENT ACCESS.*—The Secretary shall find that an organization has met the requirement under subparagraph (A) with respect to any category of health care professional or provider if, with respect to that category of provider the plan has contracts or agreements with a sufficient number and range of providers within such category to provide covered services under the terms of the plan.

“(C) *CONSTRUCTION.*—Subparagraph (B) shall not be construed as restricting the persons from whom enrollees under such a plan may obtain covered benefits.

“(c) *PAYMENTS TO PREFERRED PROVIDER ORGANIZATIONS.*—

“(1) *PAYMENTS TO ORGANIZATIONS.*—

“(A) *MONTHLY PAYMENTS.*—

“(i) *IN GENERAL.*—Under a contract under section 1857 and subject to paragraph (5), subsection (e), and section 1859(e)(4), the Secretary shall make, to each preferred provider organization, with

1 *respect to coverage of an individual for a*
 2 *month under this part in a preferred pro-*
 3 *vider region, separate monthly payments*
 4 *with respect to—*

5 “(I) *benefits under the original*
 6 *medicare fee-for-service program under*
 7 *parts A and B in accordance with*
 8 *paragraph (4); and*

9 “(II) *benefits under the voluntary*
 10 *prescription drug program under part*
 11 *D in accordance with section 1858A*
 12 *and the other provisions of this part.*

13 “(ii) *SPECIAL RULE FOR END-STAGE*
 14 *RENAL DISEASE.—The Secretary shall es-*
 15 *tablish separate rates of payment applicable*
 16 *with respect to classes of individuals deter-*
 17 *mined to have end-stage renal disease and*
 18 *enrolled in a preferred provider organiza-*
 19 *tion plan under this clause that are similar*
 20 *to the separate rates of payment described*
 21 *in section 1853(a)(1)(B).*

22 “(B) *ADJUSTMENT TO REFLECT NUMBER OF*
 23 *ENROLLEES.—The Secretary may retroactively*
 24 *adjust the amount of payment under this para-*
 25 *graph in a manner that is similar to the manner*

1 *in which payment amounts may be retroactively*
 2 *adjusted under section 1853(a)(2).*

3 “(C) *COMPREHENSIVE RISK ADJUSTMENT*
 4 *METHODOLOGY.—The Secretary shall apply the*
 5 *comprehensive risk adjustment methodology de-*
 6 *scribed in section 1853(a)(3)(B) to 100 percent*
 7 *of the amount of payments to plans under para-*
 8 *graph (4)(D)(ii).*

9 “(D) *ADJUSTMENT FOR SPENDING VARI-*
 10 *ATIONS WITHIN A REGION.—The Secretary shall*
 11 *establish a methodology for adjusting the amount*
 12 *of payments to plans under paragraph (4)(D)(ii)*
 13 *that achieves the same objective as the adjust-*
 14 *ment described in paragraph 1853(a)(2)(C).*

15 “(2) *ANNUAL CALCULATION OF BENCHMARK*
 16 *AMOUNTS FOR PREFERRED PROVIDER REGIONS.—For*
 17 *each year (beginning in 2006), the Secretary shall*
 18 *calculate a benchmark amount for each preferred pro-*
 19 *vider region for each month for such year with respect*
 20 *to coverage of the benefits available under the original*
 21 *medicare fee-for-service program option equal to the*
 22 *average of each benchmark amount calculated under*
 23 *section 1853(a)(4) for each MedicareAdvantage pay-*
 24 *ment area for the year within such region, weighted*

1 *by the number of MedicareAdvantage eligible individ-*
 2 *uals residing in each such payment area for the year.*

3 “(3) *ANNUAL ANNOUNCEMENT OF PAYMENT FAC-*
 4 *TORS.—*

5 “(A) *ANNUAL ANNOUNCEMENT.—Beginning*
 6 *in 2005, at the same time as the Secretary pub-*
 7 *lishes the risk adjusters under section 1860D–11,*
 8 *the Secretary shall annually announce (in a*
 9 *manner intended to provide notice to interested*
 10 *parties) the following payment factors:*

11 “(i) *The benchmark amount for each*
 12 *preferred provider region (as calculated*
 13 *under paragraph (2)(A)) for the year.*

14 “(ii) *The factors to be used for adjust-*
 15 *ing payments described under—*

16 “(I) *the comprehensive risk ad-*
 17 *justment methodology described in*
 18 *paragraph (1)(C) with respect to each*
 19 *preferred provider region for the year;*
 20 *and*

21 “(II) *the methodology used for ad-*
 22 *justment for geographic variations*
 23 *within such region established under*
 24 *paragraph (1)(D).*

1 “(B) *ADVANCE NOTICE OF METHODO-*
 2 *LOGICAL CHANGES.*—*At least 45 days before*
 3 *making the announcement under subparagraph*
 4 *(A) for a year, the Secretary shall—*

5 “(i) *provide for notice to preferred pro-*
 6 *vider organizations of proposed changes to*
 7 *be made in the methodology from the meth-*
 8 *odology and assumptions used in the pre-*
 9 *vious announcement; and*

10 “(ii) *provide such organizations with*
 11 *an opportunity to comment on such pro-*
 12 *posed changes.*

13 “(C) *EXPLANATION OF ASSUMPTIONS.*—*In*
 14 *each announcement made under subparagraph*
 15 *(A), the Secretary shall include an explanation*
 16 *of the assumptions and changes in methodology*
 17 *used in the announcement in sufficient detail so*
 18 *that preferred provider organizations can com-*
 19 *pute each payment factor described in such sub-*
 20 *paragraph.*

21 “(4) *SECRETARY’S DETERMINATION OF PAYMENT*
 22 *AMOUNT FOR BENEFITS UNDER THE ORIGINAL MEDI-*
 23 *CARE FEE-FOR-SERVICE PROGRAM.*—*The Secretary*
 24 *shall determine the payment amount for plans as fol-*
 25 *lows:*

1 “(A) *REVIEW OF PLAN BIDS.*—The Sec-
 2 retary shall review each plan bid submitted
 3 under subsection (d)(1) for the coverage of bene-
 4 fits under the original medicare fee-for-service
 5 program option to ensure that such bids are con-
 6 sistent with the requirements under this part
 7 and are based on the assumptions described in
 8 section 1854(a)(2)(A)(iii) that the plan used
 9 with respect to numbers of enrolled individuals.

10 “(B) *DETERMINATION OF PREFERRED PRO-*
 11 *VIDER REGIONAL BENCHMARK AMOUNTS.*—The
 12 Secretary shall calculate a preferred provider re-
 13 gional benchmark amount for that plan for the
 14 benefits under the original medicare fee-for-serv-
 15 ice program option for each plan equal to the re-
 16 gional benchmark adjusted by using the assump-
 17 tions described in section 1854(a)(2)(A)(iii) that
 18 the plan used with respect to numbers of enrolled
 19 individuals.

20 “(C) *COMPARISON TO BENCHMARK.*—The
 21 Secretary shall determine the difference between
 22 each plan bid (as adjusted under subparagraph
 23 (A)) and the preferred provider regional bench-
 24 mark amount (as determined under subpara-
 25 graph (B)) for purposes of determining—

1 “(i) the payment amount under sub-
2 paragraph (D); and

3 “(ii) the additional benefits required
4 and MedicareAdvantage monthly basic ben-
5 eficiary premiums.

6 “(D) DETERMINATION OF PAYMENT
7 AMOUNT.—

8 “(i) IN GENERAL.—Subject to clause
9 (ii), the Secretary shall determine the pay-
10 ment amount to a preferred provider orga-
11 nization for a preferred provider organiza-
12 tion plan as follows:

13 “(I) BIDS THAT EQUAL OR EX-
14 CEED THE BENCHMARK.—In the case
15 of a plan bid that equals or exceeds the
16 preferred provider regional benchmark
17 amount, the amount of each monthly
18 payment to the organization with re-
19 spect to each individual enrolled in a
20 plan shall be the preferred provider re-
21 gional benchmark amount.

22 “(II) BIDS BELOW THE BENCH-
23 MARK.—In the case of a plan bid that
24 is less than the preferred provider re-
25 gional benchmark amount, the amount

1 of each monthly payment to the orga-
 2 nization with respect to each indi-
 3 vidual enrolled in a plan shall be the
 4 preferred provider regional benchmark
 5 amount reduced by the amount of any
 6 premium reduction elected by the plan
 7 under section 1854(d)(1)(A)(i).

8 “(ii) APPLICATION OF ADJUSTMENT
 9 METHODOLOGIES.—The Secretary shall ad-
 10 just the amounts determined under subpara-
 11 graph (A) using the factors described in
 12 paragraph (3)(A)(ii).

13 “(E) FACTORS USED IN ADJUSTING BIDS
 14 AND BENCHMARKS FOR PREFERRED PROVIDER
 15 ORGANIZATIONS AND IN DETERMINING ENROLLEE
 16 PREMIUMS.—Subject to subparagraph (F), in
 17 addition to the factors used to adjust payments
 18 to plans described in section 1853(d)(6), the Sec-
 19 retary shall use the adjustment for geographic
 20 variation within the region established under
 21 paragraph (1)(D).

22 “(F) ADJUSTMENT FOR NATIONAL COV-
 23 ERAGE DETERMINATIONS AND LEGISLATIVE
 24 CHANGES IN BENEFITS.—The Secretary shall
 25 provide for adjustments for national coverage de-

1 *terminations and legislative changes in benefits*
 2 *applicable with respect to preferred provider or-*
 3 *ganizations in the same manner as the Secretary*
 4 *provides for adjustments under section*
 5 *1853(d)(7).*

6 “(5) *PAYMENTS FROM TRUST FUND.*—*The pay-*
 7 *ment to a preferred provider organization under this*
 8 *section shall be made from the Federal Hospital In-*
 9 *surance Trust Fund and the Federal Supplementary*
 10 *Medical Insurance Trust Fund in a manner similar*
 11 *to the manner described in section 1853(g).*

12 “(6) *SPECIAL RULE FOR CERTAIN INPATIENT*
 13 *HOSPITAL STAYS.*—*Rules similar to the rules applica-*
 14 *ble under section 1853(h) shall apply with respect*
 15 *preferred provider organizations.*

16 “(7) *SPECIAL RULE FOR HOSPICE CARE.*—*Rules*
 17 *similar to the rules applicable under section 1853(i)*
 18 *shall apply with respect to preferred provider organi-*
 19 *zations.*

20 “(d) *SUBMISSION OF BIDS BY PPOS; PREMIUMS.*—

21 “(1) *SUBMISSION OF BIDS BY PREFERRED PRO-*
 22 *VIDER ORGANIZATIONS.*—

23 “(A) *IN GENERAL.*—*For the requirements*
 24 *on submissions by MedicareAdvantage preferred*

1 *provider organization plans, see section*
 2 *1854(a)(1).*

3 “(B) *UNIFORM PREMIUMS.—Each bid*
 4 *amount submitted under subparagraph (A) for a*
 5 *preferred provider organization plan in a pre-*
 6 *ferred provider region may not vary among*
 7 *MedicareAdvantage eligible individuals residing*
 8 *in such preferred provider region.*

9 “(C) *APPLICATION OF FEHBP STANDARD;*
 10 *PROHIBITION ON PRICE GOUGING.—Each bid*
 11 *amount submitted under subparagraph (A) for a*
 12 *preferred provider organization plan must rea-*
 13 *sonably and equitably reflect the cost of benefits*
 14 *provided under that plan.*

15 “(D) *REVIEW.—The Secretary shall review*
 16 *the adjusted community rates (as defined in sec-*
 17 *tion 1854(g)(3)), the amounts of the*
 18 *MedicareAdvantage monthly basic premium and*
 19 *the MedicareAdvantage monthly beneficiary pre-*
 20 *mium for enhanced medical benefits filed under*
 21 *this paragraph and shall approve or disapprove*
 22 *such rates and amounts so submitted. The Sec-*
 23 *retary shall review the actuarial assumptions*
 24 *and data used by the preferred provider organi-*
 25 *zation with respect to such rates and amounts so*

1 *submitted to determine the appropriateness of*
 2 *such assumptions and data.*

3 “(E) *AUTHORITY TO LIMIT NUMBER OF*
 4 *PLANS IN A REGION.—If there are bids for more*
 5 *than 3 preferred provider organization plans in*
 6 *a preferred provider region, the Secretary shall*
 7 *accept only the 3 lowest-cost credible bids for*
 8 *that region that meet or exceed the quality and*
 9 *minimum standards applicable under this sec-*
 10 *tion.*

11 “(2) *MONTHLY PREMIUMS CHARGED.—The*
 12 *amount of the monthly premium charged to an indi-*
 13 *vidual enrolled in a preferred provider organization*
 14 *plan offered by a preferred provider organization*
 15 *shall be equal to the sum of the following:*

16 “(A) *The MedicareAdvantage monthly basic*
 17 *beneficiary premium, as defined in section*
 18 *1854(b)(2)(A) (if any).*

19 “(B) *The MedicareAdvantage monthly bene-*
 20 *ficiary premium for enhanced medical benefits,*
 21 *as defined in section 1854(b)(2)(C) (if any).*

22 “(C) *The MedicareAdvantage monthly obli-*
 23 *gation for qualified prescription drug coverage,*
 24 *as defined in section 1854(b)(2)(B) (if any).*

1 “(3) *DETERMINATION OF PREMIUM REDUCTIONS,*
 2 *REDUCED COST-SHARING, ADDITIONAL BENEFITS, AND*
 3 *BENEFICIARY PREMIUMS.—The rules for determining*
 4 *premium reductions, reduced cost-sharing, additional*
 5 *benefits, and beneficiary premiums under section*
 6 *1854(d) shall apply with respect to preferred provider*
 7 *organizations.*

8 “(4) *PROHIBITION OF SEGMENTING PREFERRED*
 9 *PROVIDER REGIONS.—The Secretary may not permit*
 10 *a preferred provider organization to elect to apply the*
 11 *provisions of this section uniformly to separate seg-*
 12 *ments of a preferred provider region (rather than uni-*
 13 *formly to an entire preferred provider region).*

14 “(e) *PORTION OF TOTAL PAYMENTS TO AN ORGANIZA-*
 15 *TION SUBJECT TO RISK FOR 2 YEARS.—*

16 “(1) *NOTIFICATION OF SPENDING UNDER THE*
 17 *PLAN.—*

18 “(A) *IN GENERAL.—For 2007 and 2008, the*
 19 *preferred provider organization offering a pre-*
 20 *ferred provider organization plan shall notify the*
 21 *Secretary of the total amount of costs that the or-*
 22 *ganization incurred in providing benefits covered*
 23 *under parts A and B of the original medicare*
 24 *fee-for-service program for all enrollees under the*
 25 *plan in the previous year.*

1 “(B) *CERTAIN EXPENSES NOT INCLUDED.*—

2 *The total amount of costs specified in subpara-*
 3 *graph (A) may not include—*

4 “(i) *subject to subparagraph (C), ad-*
 5 *ministrative expenses incurred in providing*
 6 *the benefits described in such subparagraph;*
 7 *or*

8 “(ii) *amounts expended on providing*
 9 *enhanced medical benefits under section*
 10 *1852(a)(3)(D).*

11 “(C) *ESTABLISHMENT OF ALLOWABLE AD-*
 12 *MINISTRATIVE EXPENSES.*—*For purposes of ap-*
 13 *plying subparagraph (B)(i), the administrative*
 14 *expenses incurred in providing benefits described*
 15 *in subparagraph (A) under a preferred provider*
 16 *organization plan may not exceed an amount de-*
 17 *termined appropriate by the Administrator.*

18 “(2) *ADJUSTMENT OF PAYMENT.*—

19 “(A) *NO ADJUSTMENT IF COSTS WITHIN*
 20 *RISK CORRIDOR.*—*If the total amount of costs*
 21 *specified in paragraph (1)(A) for the plan for*
 22 *the year are not more than the first threshold*
 23 *upper limit of the risk corridor (specified in*
 24 *paragraph (3)(A)(iii)) and are not less than the*
 25 *first threshold lower limit of the risk corridor*

1 *(specified in paragraph (3)(A)(i)) for the plan*
 2 *for the year, then no additional payments shall*
 3 *be made by the Secretary and no reduced pay-*
 4 *ments shall be made to the preferred provider or-*
 5 *ganization offering the plan.*

6 “(B) INCREASE IN PAYMENT IF COSTS
 7 ABOVE UPPER LIMIT OF RISK CORRIDOR.—

8 “(i) IN GENERAL.—*If the total amount*
 9 *of costs specified in paragraph (1)(A) for*
 10 *the plan for the year are more than the first*
 11 *threshold upper limit of the risk corridor for*
 12 *the plan for the year, then the Secretary*
 13 *shall increase the total of the monthly pay-*
 14 *ments made to the preferred provider orga-*
 15 *nization offering the plan for the year*
 16 *under subsection (c)(1)(A) by an amount*
 17 *equal to the sum of—*

18 “(I) 50 percent of the amount of
 19 such total costs which are more than
 20 such first threshold upper limit of the
 21 risk corridor and not more than the
 22 second threshold upper limit of the risk
 23 corridor for the plan for the year (as
 24 specified under paragraph (3)(A)(iv));
 25 and

1 “(II) 10 percent of the amount of
 2 such total costs which are more than
 3 such second threshold upper limit of
 4 the risk corridor.

5 “(C) REDUCTION IN PAYMENT IF COSTS
 6 BELOW LOWER LIMIT OF RISK CORRIDOR.—If the
 7 total amount of costs specified in paragraph
 8 (1)(A) for the plan for the year are less than the
 9 first threshold lower limit of the risk corridor for
 10 the plan for the year, then the Secretary shall re-
 11 duce the total of the monthly payments made to
 12 the preferred provider organization offering the
 13 plan for the year under subsection (c)(1)(A) by
 14 an amount (or otherwise recover from the plan
 15 an amount) equal to—

16 “(i) 50 percent of the amount of such
 17 total costs which are less than such first
 18 threshold lower limit of the risk corridor
 19 and not less than the second threshold lower
 20 limit of the risk corridor for the plan for the
 21 year (as specified under paragraph
 22 (3)(A)(ii)); and

23 “(ii) 10 percent of the amount of such
 24 total costs which are less than such second
 25 threshold lower limit of the risk corridor.

1 “(3) *ESTABLISHMENT OF RISK CORRIDORS.*—

2 “(A) *IN GENERAL.*—For 2006 and 2007, the
3 *Secretary shall establish a risk corridor for each*
4 *preferred provider organization plan. The risk*
5 *corridor for a plan for a year shall be equal to*
6 *a range as follows:*

7 “(i) *FIRST THRESHOLD LOWER*
8 *LIMIT.*—The first threshold lower limit of
9 *such corridor shall be equal to—*

10 “(I) *the target amount described*
11 *in subparagraph (B) for the plan;*
12 *minus*

13 “(II) *an amount equal to 5 per-*
14 *cent of such target amount.*

15 “(ii) *SECOND THRESHOLD LOWER*
16 *LIMIT.*—The second threshold lower limit of
17 *such corridor shall be equal to—*

18 “(I) *the target amount described*
19 *in subparagraph (B) for the plan;*
20 *minus*

21 “(II) *an amount equal to 10 per-*
22 *cent of such target amount.*

23 “(iii) *FIRST THRESHOLD UPPER*
24 *LIMIT.*—The first threshold upper limit of
25 *such corridor shall be equal to the sum of—*

1 “(I) such target amount; and

2 “(II) the amount described in
3 clause (i)(II).

4 “(iv) SECOND THRESHOLD UPPER
5 LIMIT.—The second threshold upper limit of
6 such corridor shall be equal to the sum of—

7 “(I) such target amount; and

8 “(II) the amount described in
9 clause (ii)(II).

10 “(B) TARGET AMOUNT DESCRIBED.—The
11 target amount described in this paragraph is,
12 with respect to a preferred provider organization
13 plan offered by a preferred provider organization
14 in a year, an amount equal to the sum of—

15 “(i) the total monthly payments made
16 to the organization for enrollees in the plan
17 for the year under subsection (c)(1)(A); and

18 “(ii) the total MedicareAdvantage basic
19 beneficiary premiums collected for such en-
20 rollees for the year under subsection
21 (d)(2)(A).

22 “(4) PLANS AT RISK FOR ENTIRE AMOUNT OF
23 ENHANCED MEDICAL BENEFITS.—A preferred provider
24 organization that offers a preferred provider organi-
25 zation plan that provides enhanced medial benefits

1 *under section 1852(a)(3)(D) shall be at full financial*
 2 *risk for the provision of such benefits.*

3 “(5) *NO EFFECT ON ELIGIBLE BENEFICIARIES.*—
 4 *No change in payments made by reason of this sub-*
 5 *section shall affect the amount of the*
 6 *MedicareAdvantage basic beneficiary premium that a*
 7 *beneficiary is otherwise required to pay under the*
 8 *plan for the year under subsection (d)(2)(A).*

9 “(6) *DISCLOSURE OF INFORMATION.*—*The provi-*
 10 *sions of section 1860D–16(b)(7), including subpara-*
 11 *graph (B) of such section, shall apply to a preferred*
 12 *provider organization and a preferred provider orga-*
 13 *nization plan in the same manner as such provisions*
 14 *apply to an eligible entity and a Medicare Prescrip-*
 15 *tion Drug plan under part D.*

16 “(f) *ORGANIZATIONAL AND FINANCIAL REQUIREMENTS*
 17 *FOR PREFERRED PROVIDER ORGANIZATIONS.*—*A preferred*
 18 *provider organization shall be organized and licensed under*
 19 *State law as a risk-bearing entity eligible to offer health*
 20 *insurance or health benefits coverage in each State within*
 21 *the preferred provider region in which it offers a preferred*
 22 *provider organization plan.*

23 “(g) *INAPPLICABILITY OF PROVIDER-SPONSORED OR-*
 24 *GANIZATION SOLVENCY STANDARDS.*—*The requirements of*

1 *section 1856 shall not apply with respect to preferred pro-*
 2 *vider organizations.*

3 “(h) *CONTRACTS WITH PREFERRED PROVIDER ORGA-*
 4 *NIZATIONS.*—*The provisions of section 1857 shall apply to*
 5 *a preferred provider organization plan offered by a pre-*
 6 *ferred provider organization under this section.”.*

7 (c) *PREFERRED PROVIDER TERMINOLOGY DE-*
 8 *FINED.*—*Section 1859(a) is amended by adding at the end*
 9 *the following new paragraph:*

10 “(3) *PREFERRED PROVIDER ORGANIZATION; PRE-*
 11 *ferred provider organization plan; preferred*
 12 *provider region.*—*The terms ‘preferred provider or-*
 13 *ganization’, ‘preferred provider organization plan’,*
 14 *and ‘preferred provider region’ have the meaning*
 15 *given such terms in section 1858(a)(2).”.*

16 ***Subtitle C—Other Managed Care*** 17 ***Reforms***

18 ***SEC. 221. EXTENSION OF REASONABLE COST CONTRACTS.***

19 (a) *FIVE-YEAR EXTENSION.*—*Section 1876(h)(5)(C)*
 20 *(42 U.S.C. 1395mm(h)(5)(C)) is amended by striking*
 21 *“2004” and inserting “2009”.*

22 (b) *APPLICATION OF CERTAIN MEDICARE+CHOICE*
 23 *REQUIREMENTS TO COST CONTRACTS EXTENDED OR RE-*
 24 *NEWED AFTER 2003.*—*Section 1876(h) (42 U.S.C.*

1 1395mm(h)(5)), as amended by subsection (a), is amend-
2 ed—

3 (1) by redesignating paragraph (5) as para-
4 graph (6); and

5 (2) by inserting after paragraph (4) the fol-
6 lowing new paragraph:

7 “(5) Any reasonable cost reimbursement contract with
8 an eligible organization under this subsection that is ex-
9 tended or renewed on or after the date of enactment of the
10 Prescription Drug and Medicare Improvements Act of 2003
11 for plan years beginning on or after January 1, 2004, shall
12 provide that the following provisions of the
13 Medicare+Choice program under part C (and, on and after
14 January 1, 2006, the provisions of the MedicareAdvantage
15 program under such part) shall apply to such organization
16 and such contract in a substantially similar manner as
17 such provisions apply to Medicare+Choice organizations
18 and Medicare+Choice plans (or, on and after January 1,
19 2006, MedicareAdvantage organizations and
20 MedicareAdvantage plans, respectively) under such part:

21 “(A) Paragraph (1) of section 1852(e) (relating
22 to the requirement of having an ongoing quality as-
23 surance program) and paragraph (2)(B) of such sec-
24 tion (relating to the required elements for such a pro-
25 gram).

1 “(B) Section 1852(j)(4) (relating to limitations
2 on physician incentive plans).

3 “(C) Section 1854(c) (relating to the requirement
4 of uniform premiums among individuals enrolled in
5 the plan).

6 “(D) Section 1854(g), or, on and after January
7 1, 2006, section 1854(h) (relating to restrictions on
8 imposition of premium taxes with respect to pay-
9 ments to organizations).

10 “(E) Section 1856(b) (regarding compliance
11 with the standards established by regulation pursuant
12 to such section, including the provisions of paragraph
13 (3) of such section relating to relation to State laws).

14 “(F) Section 1852(a)(3)(A) (regarding the au-
15 thority of organizations to include supplemental
16 health care benefits and, on and after January 1,
17 2006, enhanced medical benefits under the plan sub-
18 ject to the approval of the Secretary).

19 “(G) The provisions of part C relating to
20 timelines for benefit filings, contract renewal, and
21 beneficiary notification.

22 “(H) Section 1854(e), or, on and after January
23 1, 2006, section 1854(f) (relating to proposed cost-
24 sharing under the contract being subject to review by
25 the Secretary).”.

1 (c) *PERMITTING DEDICATED GROUP PRACTICE HEALTH*
 2 *MAINTENANCE ORGANIZATIONS TO PARTICIPATE IN THE*
 3 *MEDICARE COST CONTRACT PROGRAM.*—Section 1876(h)(6)
 4 *of the Social Security Act (42 U.S.C. 1395mm(h)(6)), as*
 5 *redesignated and amended by subsections (a) and (b), is*
 6 *amended—*

7 (1) *in subparagraph (A), by striking “After the*
 8 *date of the enactment” and inserting “Except as pro-*
 9 *vided in subparagraph (C), after the date of the en-*
 10 *actment”;*

11 (2) *in subparagraph (B), by striking “subpara-*
 12 *graph (C)” and inserting “subparagraph (D)”;*

13 (3) *by redesignating subparagraph (C) as sub-*
 14 *paragraph (D); and*

15 (4) *by inserting after subparagraph (B), the fol-*
 16 *lowing new subparagraph:*

17 “(C) *Subject to paragraph (5) and subparagraph (D),*
 18 *the Secretary shall approve an application to enter into a*
 19 *reasonable cost contract under this section if—*

20 “(i) *the application is submitted to the Secretary*
 21 *by a health maintenance organization (as defined in*
 22 *section 1301(a) of the Public Health Service Act)*
 23 *that, as of January 1, 2004, and except as provided*
 24 *in section 1301(b)(3)(B) of such Act, provides at least*
 25 *85 percent of the services of a physician which are*

1 *provided as basic health services through a medical*
 2 *group (or groups), as defined in section 1302(4) of*
 3 *such Act; and*

4 “(ii) the Secretary determines that the organiza-
 5 tion meets the requirements applicable to such organi-
 6 zations and contracts under this section.”.

7 **SEC. 222. SPECIALIZED MEDICARE+CHOICE PLANS FOR SPE-**
 8 **CIAL NEEDS BENEFICIARIES.**

9 (a) *TREATMENT AS COORDINATED CARE PLAN.*—Sec-
 10 tion 1851(a)(2)(A) (42 U.S.C. 1395w-21(a)(2)(A)) is
 11 amended by adding at the end the following new sentence:
 12 “Specialized Medicare+Choice plans for special needs bene-
 13 ficiaries (as defined in section 1859(b)(4)) may be any type
 14 of coordinated care plan.”.

15 (b) *SPECIALIZED MEDICARE+CHOICE PLAN FOR SPE-*
 16 cial Needs Beneficiaries Defined.—Section 1859(b)
 17 (42 U.S.C. 1395w-28(b)) is amended by adding at the end
 18 the following new paragraph:

19 “(4) *SPECIALIZED MEDICARE+CHOICE PLANS*
 20 *FOR SPECIAL NEEDS BENEFICIARIES.*—

21 “(A) *IN GENERAL.*—The term ‘specialized
 22 Medicare+Choice plan for special needs bene-
 23 ficiaries’ means a Medicare+Choice plan that
 24 exclusively serves special needs beneficiaries (as
 25 defined in subparagraph (B)).

1 “(B) *SPECIAL NEEDS BENEFICIARY.*—The
 2 term ‘special needs beneficiary’ means a
 3 Medicare+Choice eligible individual who—

4 “(i) is institutionalized (as defined by
 5 the Secretary);

6 “(ii) is entitled to medical assistance
 7 under a State plan under title XIX; or

8 “(iii) meets such requirements as the
 9 Secretary may determine would benefit
 10 from enrollment in such a specialized
 11 Medicare+Choice plan described in sub-
 12 paragraph (A) for individuals with severe
 13 or disabling chronic conditions.”.

14 (c) *RESTRICTION ON ENROLLMENT PERMITTED.*—Sec-
 15 tion 1859 (42 U.S.C. 1395w–28) is amended by adding at
 16 the end the following new subsection:

17 “(f) *RESTRICTION ON ENROLLMENT FOR SPECIALIZED*
 18 *MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENE-*
 19 *FICIARIES.*—In the case of a specialized Medicare+Choice
 20 plan (as defined in subsection (b)(4)), notwithstanding any
 21 other provision of this part and in accordance with regula-
 22 tions of the Secretary and for periods before January 1,
 23 2008, the plan may restrict the enrollment of individuals
 24 under the plan to individuals who are within 1 or more
 25 classes of special needs beneficiaries.”.

1 (d) *REPORT TO CONGRESS.*—Not later than December
 2 31, 2006, the Secretary shall submit to Congress a report
 3 that assesses the impact of specialized Medicare+Choice
 4 plans for special needs beneficiaries on the cost and quality
 5 of services provided to enrollees. Such report shall include
 6 an assessment of the costs and savings to the medicare pro-
 7 gram as a result of amendments made by subsections (a),
 8 (b), and (c).

9 (e) *EFFECTIVE DATES.*—

10 (1) *IN GENERAL.*—The amendments made by
 11 subsections (a), (b), and (c) shall take effect on the
 12 date of enactment of this Act.

13 (2) *DEADLINE FOR ISSUANCE OF REQUIREMENTS*
 14 *FOR SPECIAL NEEDS BENEFICIARIES; TRANSITION.*—
 15 No later than 1 year after the date of enactment of
 16 this Act, the Secretary shall issue final regulations to
 17 establish requirements for special needs beneficiaries
 18 under section 1859(b)(4)(B)(iii) of the Social Secu-
 19 rity Act, as added by subsection (b).

20 **SEC. 223. PAYMENT BY PACE PROVIDERS FOR MEDICARE**
 21 **AND MEDICAID SERVICES FURNISHED BY**
 22 **NONCONTRACT PROVIDERS.**

23 (a) *MEDICARE SERVICES.*—

1 (1) *MEDICARE SERVICES FURNISHED BY PRO-*
 2 *VIDERS OF SERVICES.*—Section 1866(a)(1)(O) (42
 3 *U.S.C. 1395cc(a)(1)(O)) is amended—*

4 (A) *by striking “part C or” and inserting*
 5 *“part C, with a PACE provider under section*
 6 *1894 or 1934, or”;*

7 (B) *by striking “(i)”;*

8 (C) *by striking “and (ii)”;* and

9 (D) *by striking “members of the organiza-*
 10 *tion” and inserting “members of the organiza-*
 11 *tion or PACE program eligible individuals en-*
 12 *rolled with the PACE provider,”.*

13 (2) *MEDICARE SERVICES FURNISHED BY PHYSI-*
 14 *CANS AND OTHER ENTITIES.*—Section 1894(b) (42
 15 *U.S.C. 1395eee(b)) is amended by adding at the end*
 16 *the following new paragraphs:*

17 “(3) *TREATMENT OF MEDICARE SERVICES FUR-*
 18 *NISHED BY NONCONTRACT PHYSICIANS AND OTHER*
 19 *ENTITIES.—*

20 “(A) *APPLICATION OF MEDICARE+CHOICE*
 21 *REQUIREMENT WITH RESPECT TO MEDICARE*
 22 *SERVICES FURNISHED BY NONCONTRACT PHYSI-*
 23 *CANS AND OTHER ENTITIES.*—Section
 24 *1852(k)(1) (relating to limitations on balance*
 25 *billing against Medicare+Choice organizations*

1 *for noncontract physicians and other entities*
 2 *with respect to services covered under this title)*
 3 *shall apply to PACE providers, PACE program*
 4 *eligible individuals enrolled with such PACE*
 5 *providers, and physicians and other entities that*
 6 *do not have a contract establishing payment*
 7 *amounts for services furnished to such an indi-*
 8 *vidual in the same manner as such section ap-*
 9 *plies to Medicare+Choice organizations, individ-*
 10 *uals enrolled with such organizations, and physi-*
 11 *cians and other entities referred to in such sec-*
 12 *tion.*

13 “(B) *REFERENCE TO RELATED PROVISION*
 14 *FOR NONCONTRACT PROVIDERS OF SERVICES.—*
 15 *For the provision relating to limitations on bal-*
 16 *ance billing against PACE providers for services*
 17 *covered under this title furnished by noncontract*
 18 *providers of services, see section 1866(a)(1)(O).*

19 “(4) *REFERENCE TO RELATED PROVISION*
 20 *FOR SERVICES COVERED UNDER TITLE XIX BUT*
 21 *NOT UNDER THIS TITLE.—For provisions relat-*
 22 *ing to limitations on payments to providers par-*
 23 *ticipating under the State plan under title XIX*
 24 *that do not have a contract with a PACE pro-*
 25 *vider establishing payment amounts for services*

1 *covered under such plan (but not under this*
 2 *title) when such services are furnished to enroll-*
 3 *ees of that PACE provider, see section*
 4 *1902(a)(66).”.*

5 **(b) MEDICAID SERVICES.—**

6 **(1) REQUIREMENT UNDER STATE PLAN.—***Section*
 7 *1902(a) (42 U.S.C. 1396a(a)) is amended—*

8 *(A) in paragraph (64), by striking “and”*
 9 *at the end;*

10 *(B) in paragraph (65), by striking the pe-*
 11 *riod at the end and inserting “; and”; and*

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

14 *“(66) provide, with respect to services cov-*
 15 *ered under the State plan (but not under title*
 16 *XVIII) that are furnished to a PACE program*
 17 *eligible individual enrolled with a PACE pro-*
 18 *vider by a provider participating under the*
 19 *State plan that does not have a contract with the*
 20 *PACE provider that establishes payment*
 21 *amounts for such services, that such partici-*
 22 *pating provider may not require the PACE pro-*
 23 *vider to pay the participating provider an*
 24 *amount greater than the amount that would oth-*
 25 *erwise be payable for the service to the partici-*

1 *pating provider under the State plan for the*
 2 *State where the PACE provider is located (in ac-*
 3 *cordance with regulations issued by the Sec-*
 4 *retary).”.*

5 *(2) REFERENCE IN MEDICAID STATUTE.—Section*
 6 *1934(b) (42 U.S.C. 1396u–4(b)) is amended by add-*
 7 *ing at the end the following new paragraphs:*

8 *“(3) TREATMENT OF MEDICARE SERVICES FUR-*
 9 *NISHED BY NONCONTRACT PHYSICIANS AND OTHER*
 10 *ENTITIES.—*

11 *“(A) APPLICATION OF MEDICARE+CHOICE*
 12 *REQUIREMENT WITH RESPECT TO MEDICARE*
 13 *SERVICES FURNISHED BY NONCONTRACT PHYSI-*
 14 *CIANS AND OTHER ENTITIES.—Section*
 15 *1852(k)(1) (relating to limitations on balance*
 16 *billing against Medicare+Choice organizations*
 17 *for noncontract physicians and other entities*
 18 *with respect to services covered under title*
 19 *XVIII) shall apply to PACE providers, PACE*
 20 *program eligible individuals enrolled with such*
 21 *PACE providers, and physicians and other enti-*
 22 *ties that do not have a contract establishing pay-*
 23 *ment amounts for services furnished to such an*
 24 *individual in the same manner as such section*
 25 *applies to Medicare+Choice organizations, indi-*

viduals enrolled with such organizations, and
physicians and other entities referred to in such
section.

“(B) *REFERENCE TO RELATED PROVISION
FOR NONCONTRACT PROVIDERS OF SERVICES.*—
For the provision relating to limitations on bal-
ance billing against PACE providers for services
covered under title XVIII furnished by noncon-
tract providers of services, see section
1866(a)(1)(O).

“(4) *REFERENCE TO RELATED PROVISION
FOR SERVICES COVERED UNDER THIS TITLE BUT
NOT UNDER TITLE XVIII.*—For provisions relat-
ing to limitations on payments to providers par-
ticipating under the State plan under this title
that do not have a contract with a PACE pro-
vider establishing payment amounts for services
covered under such plan (but not under title
XVIII) when such services are furnished to en-
rollees of that PACE provider, see section
1902(a)(66).”.

(c) *EFFECTIVE DATE.*—The amendments made by this
section shall apply to services furnished on or after January
1, 2004.

1 **SEC. 224. INSTITUTE OF MEDICINE EVALUATION AND RE-**
2 **PORT ON HEALTH CARE PERFORMANCE**
3 **MEASURES.**

4 (a) *EVALUATION.*—

5 (1) *IN GENERAL.*—Not later than the date that
6 is 2 months after the date of enactment of this Act,
7 the Secretary of Health and Human Services shall
8 enter into an arrangement under which the Institute
9 of Medicine of the National Academy of Sciences (in
10 this section referred to as the “Institute”) shall con-
11 duct an evaluation of leading health care performance
12 measures and options to implement policies that align
13 performance with payment under the medicare pro-
14 gram under title XVIII of the Social Security Act (42
15 U.S.C. 1395 *et seq.*).

16 (2) *SPECIFIC MATTERS EVALUATED.*—In con-
17 ducting the evaluation under paragraph (1), the In-
18 stitute shall—

19 (A) catalogue, review, and evaluate the va-
20 lidity of leading health care performance meas-
21 ures;

22 (B) catalogue and evaluate the success and
23 utility of alternative performance incentive pro-
24 grams in public or private sector settings; and

25 (C) identify and prioritize options to imple-
26 ment policies that align performance with pay-

1 *ment under the medicare program that indi-*
 2 *cate—*

3 *(i) the performance measurement set to*
 4 *be used and how that measurement set will*
 5 *be updated;*

6 *(ii) the payment policy that will re-*
 7 *ward performance; and*

8 *(iii) the key implementation issues*
 9 *(such as data and information technology*
 10 *requirements) that must be addressed.*

11 (3) *SCOPE OF HEALTH CARE PERFORMANCE*
 12 *MEASURES.—The health care performance measures*
 13 *described in paragraph (2)(A) shall encompass a va-*
 14 *riety of perspectives, including physicians, hospitals,*
 15 *health plans, purchasers, and consumers.*

16 (4) *CONSULTATION WITH MEDPAC.—In evalu-*
 17 *ating the matters described in paragraph (2)(C), the*
 18 *Institute shall consult with the Medicare Payment*
 19 *Advisory Commission established under section 1805*
 20 *of the Social Security Act (42 U.S.C. 1395b–6).*

21 (b) *REPORT.—Not later than the date that is 18*
 22 *months after the date of enactment of this Act, the Institute*
 23 *shall submit to the Secretary of Health and Human Serv-*
 24 *ices, the Committees on Ways and Means and Energy and*
 25 *Commerce of the House of Representatives, and the Com-*

1 *mittee on Finance of the Senate a report on the evaluation*
 2 *conducted under subsection (a)(1) describing the findings*
 3 *of such evaluation and recommendations for an overall*
 4 *strategy and approach for aligning payment with perform-*
 5 *ance in the original medicare fee-for-service program under*
 6 *parts A and B of title XVIII of the Social Security Act,*
 7 *the Medicare+Choice program under part C of such title,*
 8 *and any other programs under such title XVIII.*

9 (c) *AUTHORIZATION OF APPROPRIATIONS.—There are*
 10 *authorized to be appropriated \$1,000,000 for purposes of*
 11 *conducting the evaluation and preparing the report re-*
 12 *quired by this section.*

13 **SEC. 225. EXPANDING THE WORK OF MEDICARE QUALITY**
 14 **IMPROVEMENT ORGANIZATIONS TO INCLUDE**
 15 **PARTS C AND D.**

16 (a) **APPLICATION TO MEDICARE MANAGED CARE**
 17 **AND PRESCRIPTION DRUG COVERAGE.—**Section
 18 1154(a)(1) (42 U.S.C. 1320c–3(a)(1)) is amended by in-
 19 serting “, Medicare+Choice organizations and
 20 MedicareAdvantage organizations under part C, and pre-
 21 scription drug card sponsors and eligible entities under
 22 part D” after “under section 1876”.

23 (b) **PRESCRIPTION DRUG THERAPY QUALITY IM-**
 24 **PROVEMENT.—**Section 1154(a) (42 U.S.C. 1320c–3(a)) is

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

3 “(17) The organization shall execute its respon-
 4 sibilities under subparagraphs (A) and (B) of para-
 5 graph (1) by offering to providers, practitioners, pre-
 6 scription drug card sponsors and eligible entities
 7 under part D, and Medicare+Choice and
 8 MedicareAdvantage plans under part C quality im-
 9 provement assistance pertaining to prescription drug
 10 therapy. For purposes of this part and title XVIII,
 11 the functions described in this paragraph shall be
 12 treated as a review function.”.

13 (c) EFFECTIVE DATE.—The amendments made by
 14 this section shall apply on and after January 1, 2004.

15 ***TITLE III—CENTER FOR*** 16 ***MEDICARE CHOICES***

17 ***SEC. 301. ESTABLISHMENT OF THE CENTER FOR MEDICARE***
 18 ***CHOICES.***

19 (a) *IN GENERAL.*—*Title XVIII (42 U.S.C. 1395 et*
 20 *seq.), as amended by section 111, is amended by inserting*
 21 *after 1806 the following new section:*

22 ***“ESTABLISHMENT OF THE CENTER FOR MEDICARE***
 23 ***CHOICES***

24 ***“SEC. 1808. (a) ESTABLISHMENT.***—*By not later than*
 25 *March 1, 2004, the Secretary shall establish within the De-*
 26 *partment of Health and Human Services the Center for*

1 *Medicare Choices, which shall be separate from the Centers*
 2 *for Medicare & Medicaid Services.*

3 “(b) ADMINISTRATOR AND DEPUTY ADMINIS-
 4 TRATOR.—

5 “(1) ADMINISTRATOR.—

6 “(A) IN GENERAL.—*The Center for Medi-*
 7 *care Choices shall be headed by an Adminis-*
 8 *trator (in this section referred to as the ‘Admin-*
 9 *istrator’) who shall be appointed by the Presi-*
 10 *dent, by and with the advice and consent of the*
 11 *Senate. The Administrator shall report directly*
 12 *to the Secretary.*

13 “(B) COMPENSATION.—*The Administrator*
 14 *shall be paid at the rate of basic pay payable for*
 15 *level III of the Executive Schedule under section*
 16 *5314 of title 5, United States Code.*

17 “(C) TERM OF OFFICE.—*The Administrator*
 18 *shall be appointed for a term of 5 years. In any*
 19 *case in which a successor does not take office at*
 20 *the end of an Administrator’s term of office, that*
 21 *Administrator may continue in office until the*
 22 *entry upon office of such a successor. An Admin-*
 23 *istrator appointed to a term of office after the*
 24 *commencement of such term may serve under*

1 *such appointment only for the remainder of such*
2 *term.*

3 “(D) *GENERAL AUTHORITY.*—*The Adminis-*
4 *trator shall be responsible for the exercise of all*
5 *powers and the discharge of all duties of the Cen-*
6 *ter for Medicare Choices, and shall have author-*
7 *ity and control over all personnel and activities*
8 *thereof.*

9 “(E) *RULEMAKING AUTHORITY.*—*The Ad-*
10 *ministrator may prescribe such rules and regula-*
11 *tions as the Administrator determines necessary*
12 *or appropriate to carry out the functions of the*
13 *Center for Medicare Choices. The regulations pre-*
14 *scribed by the Administrator shall be subject to*
15 *the rulemaking procedures established under sec-*
16 *tion 553 of title 5, United States Code.*

17 “(F) *AUTHORITY TO ESTABLISH ORGANIZA-*
18 *TIONAL UNITS.*—*The Administrator may estab-*
19 *lish, alter, consolidate, or discontinue such orga-*
20 *nizational units or components within the Cen-*
21 *ter for Medicare Choices as the Administrator*
22 *considers necessary or appropriate, except that*
23 *this subparagraph shall not apply with respect*
24 *to any unit, component, or provision provided*
25 *for by this section.*

1 “(G) *AUTHORITY TO DELEGATE.*—*The Ad-*
 2 *ministrator may assign duties, and delegate, or*
 3 *authorize successive redelegations of, authority to*
 4 *act and to render decisions, to such officers and*
 5 *employees of the Center for Medicare Choices as*
 6 *the Administrator may find necessary. Within*
 7 *the limitations of such delegations, redelegations,*
 8 *or assignments, all official acts and decisions of*
 9 *such officers and employees shall have the same*
 10 *force and effect as though performed or rendered*
 11 *by the Administrator.*

12 “(2) *DEPUTY ADMINISTRATOR.*—

13 “(A) *IN GENERAL.*—*There shall be a Dep-*
 14 *uty Administrator of the Center for Medicare*
 15 *Choices who shall be appointed by the Adminis-*
 16 *trator.*

17 “(B) *COMPENSATION.*—*The Deputy Admin-*
 18 *istrator shall be paid at the rate of basic pay*
 19 *payable for level IV of the Executive Schedule*
 20 *under section 5315 of title 5, United States Code.*

21 “(C) *TERM OF OFFICE.*—*The Deputy Ad-*
 22 *ministrator shall be appointed for a term of 5*
 23 *years. In any case in which a successor does not*
 24 *take office at the end of a Deputy Administra-*
 25 *tor’s term of office, such Deputy Administrator*

1 *may continue in office until the entry upon of-*
 2 *fice of such a successor. A Deputy Administrator*
 3 *appointed to a term of office after the commence-*
 4 *ment of such term may serve under such ap-*
 5 *pointment only for the remainder of such term.*

6 “(D) *DUTIES.*—*The Deputy Administrator*
 7 *shall perform such duties and exercise such pow-*
 8 *ers as the Administrator shall from time to time*
 9 *assign or delegate. The Deputy Administrator*
 10 *shall be the Acting Administrator of the Center*
 11 *for Medicare Choices during the absence or dis-*
 12 *ability of the Administrator and, unless the*
 13 *President designates another officer of the Gov-*
 14 *ernment as Acting Administrator, in the event of*
 15 *a vacancy in the office of the Administrator.*

16 “(3) *SECRETARIAL COORDINATION OF PROGRAM*
 17 *ADMINISTRATION.*—*The Secretary shall ensure appro-*
 18 *priate coordination between the Administrator and*
 19 *the Administrator of the Centers for Medicare & Med-*
 20 *icaid Services in carrying out the programs under*
 21 *this title.*

22 “(c) *DUTIES; ADMINISTRATIVE PROVISIONS.*—

23 “(1) *DUTIES.*—

1 “(A) *GENERAL DUTIES.*—*The Adminis-*
 2 *trator shall carry out parts C and D, includ-*
 3 *ing—*

4 “(i) *negotiating, entering into, and en-*
 5 *forcing, contracts with plans for the offering*
 6 *of MedicareAdvantage plans under part C,*
 7 *including the offering of qualified prescrip-*
 8 *tion drug coverage under such plans; and*

9 “(ii) *negotiating, entering into, and*
 10 *enforcing, contracts with eligible entities for*
 11 *the offering of Medicare Prescription Drug*
 12 *plans under part D.*

13 “(B) *OTHER DUTIES.*—*The Administrator*
 14 *shall carry out any duty provided for under part*
 15 *C or D, including duties relating to—*

16 “(i) *reasonable cost contracts with eli-*
 17 *gible organizations under section 1876(h);*
 18 *and*

19 “(ii) *demonstration projects carried*
 20 *out in part or in whole under such parts,*
 21 *including the demonstration project carried*
 22 *out through a MedicareAdvantage (formerly*
 23 *Medicare+Choice) project that demonstrates*
 24 *the application of capitation payment rates*
 25 *for frail elderly medicare beneficiaries*

1 *through the use of an interdisciplinary*
 2 *team and through the provision of primary*
 3 *care services to such beneficiaries by means*
 4 *of such a team at the nursing facility in-*
 5 *volved.*

6 “(C) *NONINTERFERENCE.*—*In order to pro-*
 7 *mote competition under parts C and D, the Ad-*
 8 *ministrator, in carrying out the duties required*
 9 *under this section, may not, to the extent pos-*
 10 *sible, interfere in any way with negotiations be-*
 11 *tween eligible entities, MedicareAdvantage orga-*
 12 *nizations, hospitals, physicians, other entities or*
 13 *individuals furnishing items and services under*
 14 *this title (including contractors for such items*
 15 *and services), and drug manufacturers, whole-*
 16 *salers, or other suppliers of covered drugs*

17 “(D) *ANNUAL REPORTS.*—*Not later than*
 18 *March 31 of each year, the Administrator shall*
 19 *submit to Congress and the President a report on*
 20 *the administration of the voluntary prescription*
 21 *drug delivery program under this part during*
 22 *the previous fiscal year.*

23 “(2) *MANAGEMENT STAFF.*—

24 “(A) *IN GENERAL.*—*The Administrator,*
 25 *with the approval of the Secretary, may employ,*

1 *such management staff as determined appro-*
 2 *priate. Any such manager shall be required to*
 3 *have demonstrated, by their education and expe-*
 4 *rience (either in the public or private sector), su-*
 5 *perior expertise in the following areas:*

6 *“(i) The review, negotiation, and ad-*
 7 *ministration of health care contracts.*

8 *“(ii) The design of health care benefit*
 9 *plans.*

10 *“(iii) Actuarial sciences.*

11 *“(iv) Compliance with health plan con-*
 12 *tracts.*

13 *“(v) Consumer education and decision*
 14 *making.*

15 *“(B) COMPENSATION.—*

16 *“(i) IN GENERAL.—Subject to clause*
 17 *(ii), the Administrator shall establish the*
 18 *rate of pay for an individual employed*
 19 *under subparagraph (A).*

20 *“(ii) MAXIMUM RATE.—In no case*
 21 *may the rate of compensation determined*
 22 *under clause (i) exceed the highest rate of*
 23 *basic pay for the Senior Executive Service*
 24 *under section 5382(b) of title 5, United*
 25 *States Code.*

1 “(3) *REDELEGATION OF CERTAIN FUNCTIONS OF*
2 *THE CENTERS FOR MEDICARE & MEDICAID SERV-*
3 *ICES.*—

4 “(A) *IN GENERAL.*—*The Secretary, the Ad-*
5 *ministrator of the Center for Medicare Choices,*
6 *and the Administrator of the Centers for Medi-*
7 *care & Medicaid Services shall establish an ap-*
8 *propriate transition of responsibility in order to*
9 *redelegate the administration of part C from the*
10 *Secretary and the Administrator of the Centers*
11 *for Medicare & Medicaid Services to the Admin-*
12 *istrator of the Center for Medicare Choices as is*
13 *appropriate to carry out the purposes of this sec-*
14 *tion.*

15 “(B) *TRANSFER OF DATA AND INFORMA-*
16 *TION.*—*The Secretary shall ensure that the Ad-*
17 *ministrator of the Centers for Medicare & Med-*
18 *icaid Services transfers to the Administrator*
19 *such information and data in the possession of*
20 *the Administrator of the Centers for Medicare &*
21 *Medicaid Services as the Administrator requires*
22 *to carry out the duties described in paragraph*
23 *(1).*

24 “(C) *CONSTRUCTION.*—*Insofar as a respon-*
25 *sibility of the Secretary or the Administrator of*

1 *the Centers for Medicare & Medicaid Services is*
 2 *redelegated to the Administrator under this sec-*
 3 *tion, any reference to the Secretary or the Ad-*
 4 *ministrator of the Centers for Medicare & Med-*
 5 *icaid Services in this title or title XI with re-*
 6 *spect to such responsibility is deemed to be a ref-*
 7 *erence to the Administrator.*

8 *“(d) OFFICE OF BENEFICIARY ASSISTANCE.—*

9 *“(1) ESTABLISHMENT.—The Secretary shall es-*
 10 *tablish within the Center for Medicare Choices an Of-*
 11 *fice of Beneficiary Assistance to carry out functions*
 12 *relating to medicare beneficiaries under this title, in-*
 13 *cluding making determinations of eligibility of indi-*
 14 *viduals for benefits under this title, providing for en-*
 15 *rollment of medicare beneficiaries under this title,*
 16 *and the functions described in paragraph (2). The Of-*
 17 *fice shall be a separate operating division within the*
 18 *Center for Medicare Choices.*

19 *“(2) DISSEMINATION OF INFORMATION ON BENE-*
 20 *FITS AND APPEALS RIGHTS.—*

21 *“(A) DISSEMINATION OF BENEFITS INFOR-*
 22 *MATION.—The Office of Beneficiary Assistance*
 23 *shall disseminate to medicare beneficiaries, by*
 24 *mail, by posting on the Internet site of the Cen-*
 25 *ter for Medicare Choices, and through the toll-*

1 *free telephone number provided for under section*
 2 *1804(b), information with respect to the fol-*
 3 *lowing:*

4 “(i) *Benefits, and limitations on pay-*
 5 *ment (including cost-sharing, stop-loss pro-*
 6 *visions, and formulary restrictions) under*
 7 *parts C and D.*

8 “(ii) *Benefits, and limitations on pay-*
 9 *ment under parts A, and B, including in-*
 10 *formation on medicare supplemental poli-*
 11 *cies under section 1882.*

12 “(iii) *Other areas determined to be ap-*
 13 *propriate by the Administrator.*

14 *Such information shall be presented in a manner*
 15 *so that medicare beneficiaries may compare ben-*
 16 *efits under parts A, B, and D, and medicare*
 17 *supplemental policies with benefits under*
 18 *MedicareAdvantage plans under part C.*

19 “(B) *DISSEMINATION OF APPEALS RIGHTS*
 20 *INFORMATION.—The Office of Beneficiary Assist-*
 21 *ance shall disseminate to medicare beneficiaries*
 22 *in the manner provided under subparagraph (A)*
 23 *a description of procedural rights (including*
 24 *grievance and appeals procedures) of bene-*
 25 *ficiaries under the original medicare fee-for-serv-*

ice program under parts A and B, the MedicareAdvantage program under part C, and the voluntary prescription drug delivery program under part D.

“(3) *MEDICARE OMBUDSMAN.*—

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

“(B) *DUTIES.*—The Medicare Ombudsman shall—

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

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

“(I) assistance in collecting relevant information for such beneficiaries, to seek an appeal of a decision or determination made by a fiscal

1 *intermediary, carrier,*
 2 *MedicareAdvantage organization, an*
 3 *eligible entity under part D, or the*
 4 *Secretary; and*

5 *“(II) assistance to such bene-*
 6 *ficiaries with any problems arising*
 7 *from disenrollment from a*
 8 *MedicareAdvantage plan under part C*
 9 *or a prescription drug plan under part*
 10 *D; and*

11 *“(iii) submit annual reports to Con-*
 12 *gress, the Secretary, and the Medicare Com-*
 13 *petitive Policy Advisory Board describing*
 14 *the activities of the Office, and including*
 15 *such recommendations for improvement in*
 16 *the administration of this title as the Om-*
 17 *budsman determines appropriate.*

18 *“(C) COORDINATION WITH STATE OMBUDS-*
 19 *MAN PROGRAMS AND CONSUMER ORGANIZA-*
 20 *TIONS.—The Medicare Ombudsman shall, to the*
 21 *extent appropriate, coordinate with State med-*
 22 *ical Ombudsman programs, and with State- and*
 23 *community-based consumer organizations, to—*

24 *“(i) provide information about the*
 25 *medicare program; and*

1 “(ii) *conduct outreach to educate medi-*
 2 *care beneficiaries with respect to manners*
 3 *in which problems under the medicare pro-*
 4 *gram may be resolved or avoided.*

5 “(e) *MEDICARE COMPETITIVE POLICY ADVISORY*
 6 *BOARD.—*

7 “(1) *ESTABLISHMENT.—There is established*
 8 *within the Center for Medicare Choices the Medicare*
 9 *Competitive Policy Advisory Board (in this section*
 10 *referred to as the ‘Board’). The Board shall advise,*
 11 *consult with, and make recommendations to the Ad-*
 12 *ministrator with respect to the administration of*
 13 *parts C and D, including the review of payment poli-*
 14 *cies under such parts.*

15 “(2) *REPORTS.—*

16 “(A) *IN GENERAL.—With respect to matters*
 17 *of the administration of parts C and D, the*
 18 *Board shall submit to Congress and to the Ad-*
 19 *ministrator such reports as the Board determines*
 20 *appropriate. Each such report may contain such*
 21 *recommendations as the Board determines ap-*
 22 *propriate for legislative or administrative*
 23 *changes to improve the administration of such*
 24 *parts, including the stability and solvency of the*
 25 *programs under such parts and the topics de-*

1 scribed in subparagraph (B). Each such report
2 shall be published in the Federal Register.

3 “(B) TOPICS DESCRIBED.—Reports required
4 under subparagraph (A) may include the fol-
5 lowing topics:

6 “(i) FOSTERING COMPETITION.—Rec-
7 ommendations or proposals to increase com-
8 petition under parts C and D for services
9 furnished to medicare beneficiaries.

10 “(ii) EDUCATION AND ENROLLMENT.—
11 Recommendations for the improvement of
12 efforts to provide medicare beneficiaries in-
13 formation and education on the program
14 under this title, and specifically parts C
15 and D, and the program for enrollment
16 under the title.

17 “(iii) QUALITY.—Recommendations on
18 ways to improve the quality of benefits pro-
19 vided under plans under parts C and D.

20 “(iv) DISEASE MANAGEMENT PRO-
21 GRAMS.—Recommendations on the incorpo-
22 ration of disease management programs
23 under parts C and D.

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

4 “(C) *MAINTAINING INDEPENDENCE OF*
 5 *BOARD.*—*The Board shall directly submit to*
 6 *Congress reports required under subparagraph*
 7 *(A). No officer or agency of the United States*
 8 *may require the Board to submit to any officer*
 9 *or agency of the United States for approval,*
 10 *comments, or review, prior to the submission to*
 11 *Congress of such reports.*

12 “(3) *DUTY OF ADMINISTRATOR.*—*With respect to*
 13 *any report submitted by the Board under paragraph*
 14 *(2)(A), not later than 90 days after the report is sub-*
 15 *mitted, the Administrator shall submit to Congress*
 16 *and the President an analysis of recommendations*
 17 *made by the Board in such report. Each such anal-*
 18 *ysis shall be published in the Federal Register.*

19 “(4) *MEMBERSHIP.*—

20 “(A) *APPOINTMENT.*—*Subject to the suc-*
 21 *ceeding provisions of this paragraph, the Board*
 22 *shall consist of 7 members to be appointed as fol-*
 23 *lows:*

24 “(i) *Three members shall be appointed*
 25 *by the President.*

1 “(ii) *Two members shall be appointed*
 2 *by the Speaker of the House of Representa-*
 3 *tives, with the advice of the chairman and*
 4 *the ranking minority member of the Com-*
 5 *mittees on Ways and Means and on Energy*
 6 *and Commerce of the House of Representa-*
 7 *tives.*

8 “(iii) *Two members shall be appointed*
 9 *by the President pro tempore of the Senate*
 10 *with the advice of the chairman and the*
 11 *ranking minority member of the Committee*
 12 *on Finance of the Senate.*

13 “(B) *QUALIFICATIONS.—The members shall*
 14 *be chosen on the basis of their integrity, impar-*
 15 *tiality, and good judgment, and shall be individ-*
 16 *uals who are, by reason of their education and*
 17 *experience in health care benefits management,*
 18 *exceptionally qualified to perform the duties of*
 19 *members of the Board.*

20 “(C) *PROHIBITION ON INCLUSION OF FED-*
 21 *ERAL EMPLOYEES.—No officer or employee of the*
 22 *United States may serve as a member of the*
 23 *Board.*

24 “(5) *COMPENSATION.—Members of the Board*
 25 *shall receive, for each day (including travel time) they*

1 *are engaged in the performance of the functions of the*
 2 *Board, compensation at rates not to exceed the daily*
 3 *equivalent to the annual rate in effect for level IV of*
 4 *the Executive Schedule under section 5315 of title 5,*
 5 *United States Code.*

6 “(6) *TERMS OF OFFICE.*—

7 “(A) *IN GENERAL.*—*The term of office of*
 8 *members of the Board shall be 3 years.*

9 “(B) *TERMS OF INITIAL APPOINTEES.*—*As*
 10 *designated by the President at the time of ap-*
 11 *pointment, of the members first appointed—*

12 “(i) *one shall be appointed for a term*
 13 *of 1 year;*

14 “(ii) *three shall be appointed for terms*
 15 *of 2 years; and*

16 “(iii) *three shall be appointed for*
 17 *terms of 3 years.*

18 “(C) *REAPPOINTMENTS.*—*Any person ap-*
 19 *pointed as a member of the Board may not serve*
 20 *for more than 8 years.*

21 “(D) *VACANCY.*—*Any member appointed to*
 22 *fill a vacancy occurring before the expiration of*
 23 *the term for which the member’s predecessor was*
 24 *appointed shall be appointed only for the re-*
 25 *mainder of that term. A member may serve after*

1 *the expiration of that member's term until a suc-*
 2 *cessor has taken office. A vacancy in the Board*
 3 *shall be filled in the manner in which the origi-*
 4 *nal appointment was made.*

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

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

11 “(9) *DIRECTOR AND STAFF.—*

12 “(A) *APPOINTMENT OF DIRECTOR.—The*
 13 *Board shall have a Director who shall be ap-*
 14 *pointed by the Chair.*

15 “(B) *IN GENERAL.—With the approval of*
 16 *the Board, the Director may appoint such addi-*
 17 *tional personnel as the Director considers appro-*
 18 *priate.*

19 “(C) *ASSISTANCE FROM THE ADMINIS-*
 20 *TRATOR.—The Administrator shall make avail-*
 21 *able to the Board such information and other as-*
 22 *sistance as it may require to carry out its func-*
 23 *tions.*

24 “(10) *CONTRACT AUTHORITY.—The Board may*
 25 *contract with and compensate government and pri-*

1 *vate agencies or persons to carry out its duties under*
 2 *this subsection, without regard to section 3709 of the*
 3 *Revised Statutes (41 U.S.C. 5).*

4 “(f) *FUNDING.*—*There is authorized to be appro-*
 5 *priated, in appropriate part from the Federal Hospital In-*
 6 *surance Trust Fund and from the Federal Supplementary*
 7 *Medical Insurance Trust Fund (including the Prescription*
 8 *Drug Account), such sums as are necessary to carry out*
 9 *this section.”.*

10 (b) *USE OF CENTRAL, TOLL-FREE NUMBER (1-800-*
 11 *MEDICARE).*—*Section 1804(b) (42 U.S.C. 1395b-2(b)) is*
 12 *amended by adding at the end the following: “By not later*
 13 *than 1 year after the date of the enactment of the Prescrip-*
 14 *tion Drug and Medicare Improvement Act of 2003, the Sec-*
 15 *retary shall provide, through the toll-free number 1-800-*
 16 *MEDICARE, for a means by which individuals seeking in-*
 17 *formation about, or assistance with, such programs who*
 18 *phone such toll-free number are transferred (without*
 19 *charge) to appropriate entities for the provision of such in-*
 20 *formation or assistance. Such toll-free number shall be the*
 21 *toll-free number listed for general information and assist-*
 22 *ance in the annual notice under subsection (a) instead of*
 23 *the listing of numbers of individual contractors.”.*

1 **SEC. 302. MISCELLANEOUS ADMINISTRATIVE PROVISIONS.**

2 (a) *ADMINISTRATOR AS MEMBER AND CO-SECRETARY*
 3 *OF THE BOARD OF TRUSTEES OF THE MEDICARE TRUST*
 4 *FUNDS.*—*The fifth sentence of sections 1817(b) and 1841(b)*
 5 *(42 U.S.C. 1395i(b), 1395t(b)) are each amended by strik-*
 6 *ing “shall serve as the Secretary” and inserting “and the*
 7 *Administrator of the Center for Medicare Choices shall serve*
 8 *as the Co-Secretaries”.*

9 (b) *INCREASE IN GRADE TO EXECUTIVE LEVEL III*
 10 *FOR THE ADMINISTRATOR OF THE CENTERS FOR MEDI-*
 11 *CARE & MEDICAID SERVICES.*—

12 (1) *IN GENERAL.*—*Section 5314 of title 5,*
 13 *United States Code, is amended by adding at the end*
 14 *the following:*

15 “*Administrator of the Centers for Medicare &*
 16 *Medicaid Services.*”.

17 (2) *CONFORMING AMENDMENT.*—*Section 5315 of*
 18 *such title is amended by striking “Administrator of*
 19 *the Health Care Financing Administration.”.*

20 (3) *EFFECTIVE DATE.*—*The amendments made*
 21 *by this subsection take effect on March 1, 2004.*

1 ***TITLE IV—MEDICARE FEE-FOR-***
2 ***SERVICE IMPROVEMENTS***
3 ***Subtitle A—Provisions Relating to***
4 ***Part A***

5 ***SEC. 401. EQUALIZING URBAN AND RURAL STANDARDIZED***
6 ***PAYMENT AMOUNTS UNDER THE MEDICARE***
7 ***INPATIENT HOSPITAL PROSPECTIVE PAY-***
8 ***MENT SYSTEM.***

9 (a) *IN GENERAL.*—Section 1886(d)(3)(A)(iv) (42
10 *U.S.C. 1395ww(d)(3)(A)(iv)) is amended—*

11 (1) *by striking “(iv) For discharges” and insert-*
12 *ing “(iv)(I) Subject to the succeeding provisions of*
13 *this clause, for discharges”; and*

14 (2) *by adding at the end the following new sub-*
15 *clauses:*

16 “(II) *For discharges occurring during the last 3*
17 *quarters of fiscal year 2004, the operating standard-*
18 *ized amount for hospitals located other than in a*
19 *large urban area shall be increased by 1/2 of the dif-*
20 *ference between the operating standardized amount*
21 *determined under subclause (I) for hospitals located*
22 *in large urban areas for such fiscal year and such*
23 *amount determined (without regard to this subclause)*
24 *for other hospitals for such fiscal year.*

1 “(III) For discharges occurring in a fiscal year
 2 beginning with fiscal year 2005, the Secretary shall
 3 compute an operating standardized amount for hos-
 4 pitals located in any area within the United States
 5 and within each region equal to the operating stand-
 6 ardized amount computed for the previous fiscal year
 7 under this subparagraph for hospitals located in a
 8 large urban area (or, beginning with fiscal year 2006,
 9 applicable for all hospitals in the previous fiscal year)
 10 increased by the applicable percentage increase under
 11 subsection (b)(3)(B)(i) for the fiscal year involved.”.

12 (b) CONFORMING AMENDMENTS.—

13 (1) COMPUTING DRG-SPECIFIC RATES.—Section
 14 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is
 15 amended—

16 (A) in the heading, by striking “IN DIF-
 17 FERENT AREAS”;

18 (B) in the matter preceding clause (i), by
 19 striking “each of which is”;

20 (C) in clause (i)—

21 (i) in the matter preceding subclause
 22 (I), by inserting “for fiscal years before fis-
 23 cal year 2005,” before “for hospitals”; and

24 (ii) in subclause (II), by striking
 25 “and” after the semicolon at the end;

1 (D) in clause (ii)—

2 (i) in the matter preceding subclause
3 (I), by inserting “for fiscal years before fis-
4 cal year 2005,” before “for hospitals”; and

5 (ii) in subclause (II), by striking the
6 period at the end and inserting “; and”;
7 and

8 (E) by adding at the end the following new
9 clause:

10 “(iii) for a fiscal year beginning after fiscal
11 year 2004, for hospitals located in all areas, to
12 the product of—

13 “(I) the applicable operating standard-
14 ized amount (computed under subparagraph
15 (A)), reduced under subparagraph (B), and
16 adjusted or reduced under subparagraph (C)
17 for the fiscal year; and

18 “(II) the weighting factor (determined
19 under paragraph (4)(B)) for that diagnosis-
20 related group.”.

21 (2) *TECHNICAL CONFORMING SUNSET.*—Section
22 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

23 (A) in the matter preceding subparagraph
24 (A), by inserting “, for fiscal years before fiscal

year 1997,” before “a regional adjusted DRG prospective payment rate”; and

(B) in subparagraph (D), in the matter preceding clause (i), by inserting “, for fiscal years before fiscal year 1997,” before “a regional DRG prospective payment rate for each region,”.

SEC. 402. ADJUSTMENT TO THE MEDICARE INPATIENT HOSPITAL PPS WAGE INDEX TO REVISE THE LABOR-RELATED SHARE OF SUCH INDEX.

(a) *IN GENERAL*.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)) is amended—

(1) by striking “WAGE LEVELS.—The Secretary” and inserting “WAGE LEVELS.—

“(i) *IN GENERAL*.—Except as provided in clause (ii), the Secretary”; and

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

“(ii) *ALTERNATIVE PROPORTION TO BE ADJUSTED BEGINNING IN FISCAL YEAR 2005*.—

“(I) *IN GENERAL*.—Except as provided in subclause (II), for discharges occurring on or after October 1, 2004, the Secretary shall substitute the ‘68 percent’ for the proportion described in the first sentence of clause (i).

1 “(II) *HOLD HARMLESS FOR CERTAIN*
 2 *HOSPITALS.*—If the application of subclause
 3 *(I)* would result in lower payments to a hos-
 4 pital than would otherwise be made, then
 5 this subparagraph shall be applied as if this
 6 clause had not been enacted.”.

7 (b) *WAIVING BUDGET NEUTRALITY.*—Section
 8 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)), as amended
 9 by subsection (a), is amended by adding at the end of clause
 10 (i) the following new sentence: “The Secretary shall apply
 11 the previous sentence for any period as if the amendments
 12 made by section 402(a) of the Prescription Drug and Medi-
 13 care Improvement Act of 2003 had not been enacted.”.

14 **SEC. 403. MEDICARE INPATIENT HOSPITAL PAYMENT AD-**
 15 **JUSTMENT FOR LOW-VOLUME HOSPITALS.**

16 Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by
 17 adding at the end the following new paragraph:

18 “(12) *PAYMENT ADJUSTMENT FOR LOW-VOLUME*
 19 *HOSPITALS.*—

20 “(A) *PAYMENT ADJUSTMENT.*—

21 “(i) *IN GENERAL.*—Notwithstanding
 22 any other provision of this section, for each
 23 cost reporting period (beginning with the
 24 cost reporting period that begins in fiscal
 25 year 2005), the Secretary shall provide for

1 *an additional payment amount to each low-*
 2 *volume hospital (as defined in clause (iii))*
 3 *for discharges occurring during that cost re-*
 4 *porting period which is equal to the appli-*
 5 *cable percentage increase (determined under*
 6 *clause (ii)) in the amount paid to such hos-*
 7 *pital under this section for such discharges.*

8 *“(ii) APPLICABLE PERCENTAGE IN-*
 9 *CREASE.—The Secretary shall determine a*
 10 *percentage increase applicable under this*
 11 *paragraph that ensures that—*

12 *“(I) no percentage increase in*
 13 *payments under this paragraph ex-*
 14 *ceeds 25 percent of the amount of pay-*
 15 *ment that would (but for this para-*
 16 *graph) otherwise be made to a low-vol-*
 17 *ume hospital under this section for*
 18 *each discharge ;*

19 *“(II) low-volume hospitals that*
 20 *have the lowest number of discharges*
 21 *during a cost reporting period receive*
 22 *the highest percentage increases in*
 23 *payments due to the application of this*
 24 *paragraph; and*

1 “(III) the percentage increase in
2 payments to any low-volume hospital
3 due to the application of this para-
4 graph is reduced as the number of dis-
5 charges per cost reporting period in-
6 creases.

7 “(iii) *LOW-VOLUME HOSPITAL DE-*
8 *FINED.*—For purposes of this paragraph,
9 the term ‘low-volume hospital’ means, for a
10 cost reporting period, a subsection (d) hos-
11 pital (as defined in paragraph (1)(B)) other
12 than a critical access hospital (as defined in
13 section 1861(mm)(1)) that—

14 “(I) the Secretary determines had
15 an average of less than 2,000 dis-
16 charges (determined with respect to all
17 patients and not just individuals re-
18 ceiving benefits under this title) during
19 the 3 most recent cost reporting periods
20 for which data are available that pre-
21 cede the cost reporting period to which
22 this paragraph applies; and

23 “(II) is located at least 15 miles
24 from a like hospital (or is deemed by
25 the Secretary to be so located by reason

1 of such factors as the Secretary deter-
 2 mines appropriate, including the time
 3 required for an individual to travel to
 4 the nearest alternative source of appro-
 5 priate inpatient care (after taking into
 6 account the location of such alternative
 7 source of inpatient care and any
 8 weather or travel conditions that may
 9 affect such travel time).

10 “(B) *PROHIBITING CERTAIN REDUCTIONS.*—
 11 Notwithstanding subsection (e), the Secretary
 12 shall not reduce the payment amounts under this
 13 section to offset the increase in payments result-
 14 ing from the application of subparagraph (A).”.

15 **SEC. 404. FAIRNESS IN THE MEDICARE DISPROPORTIONATE**
 16 **SHARE HOSPITAL (DSH) ADJUSTMENT FOR**
 17 **RURAL HOSPITALS.**

18 (a) *EQUALIZING DSH PAYMENT AMOUNTS.*—

19 (1) *IN GENERAL.*—Section 1886(d)(5)(F)(vii)
 20 (42 U.S.C. 1395ww(d)(5)(F)(vii)) is amended by in-
 21 serting “, and, after October 1, 2004, for any other
 22 hospital described in clause (iv),” after “clause
 23 (iv)(I)” in the matter preceding subclause (I).

1 (2) CONFORMING AMENDMENTS.—Section
 2 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is
 3 amended—

4 (A) in clause (iv)—

5 (i) in subclause (II)—

6 (I) by inserting “and before Octo-
 7 ber 1, 2004,” after “April 1, 2001,”;
 8 and

9 (II) by inserting “or, for dis-
 10 charges occurring on or after October
 11 1, 2004, is equal to the percent deter-
 12 mined in accordance with the applica-
 13 ble formula described in clause (vii)”
 14 after “clause (xiii)”;

15 (ii) in subclause (III)—

16 (I) by inserting “and before Octo-
 17 ber 1, 2004,” after “April 1, 2001,”;
 18 and

19 (II) by inserting “or, for dis-
 20 charges occurring on or after October
 21 1, 2004, is equal to the percent deter-
 22 mined in accordance with the applica-
 23 ble formula described in clause (vii)”
 24 after “clause (xii)”;

25 (iii) in subclause (IV)—

1 (I) by inserting “and before Octo-
2 ber 1, 2004,” after “April 1, 2001,”;
3 and

4 (II) by inserting “or, for dis-
5 charges occurring on or after October
6 1, 2004, is equal to the percent deter-
7 mined in accordance with the applica-
8 ble formula described in clause (vii)”
9 after “clause (x) or (xi)”;
10 (iv) in subclause (V)—

11 (I) by inserting “and before Octo-
12 ber 1, 2004,” after “April 1, 2001,”;
13 and

14 (II) by inserting “or, for dis-
15 charges occurring on or after October
16 1, 2004, is equal to the percent deter-
17 mined in accordance with the applica-
18 ble formula described in clause (vii)”
19 after “clause (xi)”;
20 (v) in subclause (VI)—

21 (I) by inserting “and before Octo-
22 ber 1, 2004,” after “April 1, 2001,”;
23 and

24 (II) by inserting “or, for dis-
25 charges occurring on or after October

1 1, 2004, is equal to the percent deter-
 2 mined in accordance with the applica-
 3 ble formula described in clause (vii)”
 4 after “clause (x)”;

5 (B) in clause (viii), by striking “The for-
 6 mula” and inserting “For discharges occurring
 7 before October 1, 2004, the formula”; and

8 (C) in each of clauses (x), (xi), (xii), and
 9 (xiii), by striking “For purposes” and inserting
 10 “With respect to discharges occurring before Oc-
 11 tober 1, 2004, for purposes”.

12 (b) *EFFECTIVE DATE.*—The amendments made by this
 13 section shall apply to discharges occurring on or after Octo-
 14 ber 1, 2004.

15 **SEC. 405. CRITICAL ACCESS HOSPITAL (CAH) IMPROVE-**
 16 **MENTS.**

17 (a) *PERMITTING CAHS TO ALLOCATE SWING BEDS*
 18 *AND ACUTE CARE INPATIENT BEDS SUBJECT TO A TOTAL*
 19 *LIMIT OF 25 BEDS.*—

20 (1) *IN GENERAL.*—Section 1820(c)(2)(B)(iii) (42
 21 U.S.C. 1395i–4(c)(2)(B)(iii)) is amended to read as
 22 follows:

23 “(iii) provides not more than a total of
 24 25 extended care service beds (pursuant to
 25 an agreement under subsection (f)) and

1 *acute care inpatient beds (meeting such*
 2 *standards as the Secretary may establish)*
 3 *for providing inpatient care for a period*
 4 *that does not exceed, as determined on an*
 5 *annual, average basis, 96 hours per pa-*
 6 *tient;”.*

7 (2) *CONFORMING AMENDMENT.—Section 1820(f)*
 8 *(42 U.S.C. 1395i–4(f)) is amended by striking “and*
 9 *the number of beds used at any time for acute care*
 10 *inpatient services does not exceed 15 beds”.*

11 (3) *EFFECTIVE DATE.—The amendments made*
 12 *by this subsection shall with respect to designations*
 13 *made on or after October 1, 2004.*

14 (b) *ELIMINATION OF THE ISOLATION TEST FOR COST-*
 15 *BASED CAH AMBULANCE SERVICES.—*

16 (1) *ELIMINATION.—*

17 (A) *IN GENERAL.—Section 1834(l)(8) (42*
 18 *U.S.C. 1395m(l)(8)), as added by section 205(a)*
 19 *of BIPA (114 Stat. 2763A–482), is amended by*
 20 *striking the comma at the end of subparagraph*
 21 *(B) and all that follows and inserting a period.*

22 (B) *EFFECTIVE DATE.—The amendment*
 23 *made by subparagraph (A) shall apply to serv-*
 24 *ices furnished on or after January 1, 2005.*

1 (2) *TECHNICAL CORRECTION.*—Section 1834(l)
 2 (42 U.S.C. 1395m(l)) is amended by redesignating
 3 paragraph (8), as added by section 221(a) of BIPA
 4 (114 Stat. 2763A–486), as paragraph (9).

5 (c) *COVERAGE OF COSTS FOR CERTAIN EMERGENCY*
 6 *ROOM ON-CALL PROVIDERS.*—

7 (1) *IN GENERAL.*—Section 1834(g)(5) (42 U.S.C.
 8 1395m(g)(5)) is amended—

9 (A) in the heading—

10 (i) by inserting “CERTAIN” before
 11 “EMERGENCY”; and

12 (ii) by striking “PHYSICIANS” and in-
 13 serting “PROVIDERS”;

14 (B) by striking “emergency room physicians
 15 who are on-call (as defined by the Secretary)”
 16 and inserting “physicians, physician assistants,
 17 nurse practitioners, and clinical nurse specialists
 18 who are on-call (as defined by the Secretary) to
 19 provide emergency services”; and

20 (C) by striking “physicians’ services” and
 21 inserting “services covered under this title”.

22 (2) *EFFECTIVE DATE.*—The amendments made
 23 by paragraph (1) shall apply to costs incurred for
 24 services provided on or after January 1, 2005.

1 (d) *AUTHORIZATION OF PERIODIC INTERIM PAYMENT*
 2 (*PIP*).—

3 (1) *IN GENERAL*.—Section 1815(e)(2) (42 U.S.C.
 4 1395g(e)(2)) is amended—

5 (A) in subparagraph (C), by striking “and”
 6 after the semicolon at the end;

7 (B) in subparagraph (D), by adding “and”
 8 after the semicolon at the end; and

9 (C) by inserting after subparagraph (D) the
 10 following new subparagraph:

11 “(E) inpatient critical access hospital services;”.

12 (2) *EFFECTIVE DATE*.—The amendments made
 13 by paragraph (1) shall apply to payments for inpa-
 14 tient critical access facility services furnished on or
 15 after January 1, 2005.

16 (e) *EXCLUSION OF NEW CAHS FROM PPS HOSPITAL*
 17 *WAGE INDEX CALCULATION*.—Section 1886(d)(3)(E)(i) (42
 18 U.S.C. 1395ww(d)(3)(E)(i)), as amended by section 402, is
 19 amended by inserting after the first sentence the following
 20 new sentence: “In calculating the hospital wage levels under
 21 the preceding sentence applicable with respect to cost report-
 22 ing periods beginning on or after January 1, 2004, the Sec-
 23 retary shall exclude the wage levels of any facility that be-
 24 came a critical access hospital prior to the cost reporting
 25 period for which such hospital wage levels are calculated.”.

1 (f) *PROVISIONS RELATED TO CERTAIN RURAL*
 2 *GRANTS.*—

3 (1) *SMALL RURAL HOSPITAL IMPROVEMENT PRO-*
 4 *GRAM.*—Section 1820(g) (42 U.S.C. 1395i–4(g)) is
 5 *amended*—

6 (A) *by redesignating paragraph (3)(F) as*
 7 *paragraph (5) and redesignating and indenting*
 8 *appropriately; and*

9 (B) *by inserting after paragraph (3) the fol-*
 10 *lowing new paragraph:*

11 “(4) *SMALL RURAL HOSPITAL IMPROVEMENT*
 12 *PROGRAM.*—

13 “(A) *GRANTS TO HOSPITALS.*—*The Sec-*
 14 *retary may award grants to hospitals that have*
 15 *submitted applications in accordance with sub-*
 16 *paragraph (B) to assist eligible small rural hos-*
 17 *pitals (as defined in paragraph (3)(B)) in meet-*
 18 *ing the costs of reducing medical errors, increas-*
 19 *ing patient safety, protecting patient privacy,*
 20 *and improving hospital quality and perform-*
 21 *ance.*

22 “(B) *APPLICATION.*—*A hospital seeking a*
 23 *grant under this paragraph shall submit an ap-*
 24 *plication to the Secretary on or before such date*

1 *and in such form and manner as the Secretary*
 2 *specifies.*

3 “(C) *AMOUNT OF GRANT.*—*A grant to a*
 4 *hospital under this paragraph may not exceed*
 5 *\$50,000.*

6 “(D) *USE OF FUNDS.*—*A hospital receiving*
 7 *a grant under this paragraph may use the funds*
 8 *for the purchase of computer software and hard-*
 9 *ware, the education and training of hospital*
 10 *staff, and obtaining technical assistance.”.*

11 (2) *AUTHORIZATION FOR APPROPRIATIONS.*—
 12 *Section 1820(j) (42 U.S.C. 1395i–4(j)) is amended to*
 13 *read as follows:*

14 “(j) *AUTHORIZATION OF APPROPRIATIONS.*—

15 “(1) *HI TRUST FUND.*—*There are authorized to*
 16 *be appropriated from the Federal Hospital Insurance*
 17 *Trust Fund for making grants to all States under—*

18 “(A) *subsection (g), \$25,000,000 in each of*
 19 *the fiscal years 1998 through 2002; and*

20 “(B) *paragraphs (1) and (2) of subsection*
 21 *(g), \$40,000,000 in each of the fiscal years 2004*
 22 *through 2008.*

23 “(2) *GENERAL REVENUES.*—*There are authorized*
 24 *to be appropriated from amounts in the Treasury not*
 25 *otherwise appropriated for making grants to all*

1 *States under subsection (g)(4), \$25,000,000 in each of*
 2 *the fiscal years 2004 through 2008.”.*

3 (3) *REQUIREMENT THAT STATES AWARDED*
 4 *GRANTS CONSULT WITH THE STATE HOSPITAL ASSO-*
 5 *CIATION AND RURAL HOSPITALS ON THE MOST APPRO-*
 6 *PRIATE WAYS TO USE SUCH GRANTS.—*

7 (A) *IN GENERAL.—Section 1820(g) (42*
 8 *U.S.C. 1395i–4(g)), as amended by paragraph*
 9 *(1), is amended by adding at the end the fol-*
 10 *lowing new paragraph:*

11 “(6) *REQUIRED CONSULTATION FOR STATES*
 12 *AWARDED GRANTS.—A State awarded a grant under*
 13 *paragraph (1) or (2) shall consult with the hospital*
 14 *association of such State and rural hospitals located*
 15 *in such State on the most appropriate ways to use the*
 16 *funds under such grant.”.*

17 (B) *EFFECTIVE DATE AND APPLICATION.—*
 18 *The amendment made by subparagraph (A) shall*
 19 *take effect on the date of enactment of this Act*
 20 *and shall apply to grants awarded on or after*
 21 *such date and to grants awarded prior to such*
 22 *date to the extent that funds under such grants*
 23 *have not been obligated as of such date.*

1 **SEC. 406. AUTHORIZING USE OF ARRANGEMENTS TO PRO-**
 2 **VIDE CORE HOSPICE SERVICES IN CERTAIN**
 3 **CIRCUMSTANCES.**

4 (a) *IN GENERAL.*—Section 1861(dd)(5) (42 U.S.C.
 5 1395x(dd)(5)) is amended by adding at the end the fol-
 6 lowing:

7 “(D) *In extraordinary, exigent, or other non-routine*
 8 *circumstances, such as unanticipated periods of high pa-*
 9 *tient loads, staffing shortages due to illness or other events,*
 10 *or temporary travel of a patient outside a hospice pro-*
 11 *gram’s service area, a hospice program may enter into ar-*
 12 *rangements with another hospice program for the provision*
 13 *by that other program of services described in paragraph*
 14 *(2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II)*
 15 *shall apply with respect to the services provided under such*
 16 *arrangements.*

17 “(E) *A hospice program may provide services de-*
 18 *scribed in paragraph (1)(A) other than directly by the pro-*
 19 *gram if the services are highly specialized services of a reg-*
 20 *istered professional nurse and are provided non-routinely*
 21 *and so infrequently so that the provision of such services*
 22 *directly would be impracticable and prohibitively expen-*
 23 *sive.”.*

24 (b) *CONFORMING PAYMENT PROVISION.*—Section
 25 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the
 26 end the following new paragraph:

1 “(4) *In the case of hospice care provided by a hospice*
 2 *program under arrangements under section 1861(dd)(5)(D)*
 3 *made by another hospice program, the hospice program that*
 4 *made the arrangements shall bill and be paid for the hospice*
 5 *care.*”.

6 (c) *EFFECTIVE DATE.*—*The amendments made by this*
 7 *section shall apply to hospice care provided on or after Oc-*
 8 *tober 1, 2004.*

9 **SEC. 407. SERVICES PROVIDED TO HOSPICE PATIENTS BY**
 10 **NURSE PRACTITIONERS, CLINICAL NURSE**
 11 **SPECIALISTS, AND PHYSICIAN ASSISTANTS.**

12 (a) *IN GENERAL.*—*Section 1812(d)(2)(A) (42 U.S.C.*
 13 *1395d(d)(2)(A) in the matter following clause (i)(II), is*
 14 *amended—*

15 (1) *by inserting “or services described in section*
 16 *1861(s)(2)(K)” after “except that clause (i) shall not*
 17 *apply to physicians’ services”; and*

18 (2) *by inserting “, or by a physician assistant,*
 19 *nurse practitioner, or clinical nurse specialist whom*
 20 *is not an employee of the hospice program, and who*
 21 *the individual identifies as the health care provider*
 22 *having the most significant role in the determination*
 23 *and delivery of medical care to the individual at the*
 24 *time the individual makes an election to receive hos-*

1 *pice care,” after the “(if not an employee of the hos-*
 2 *pice program)”.*

3 *(b) EFFECTIVE DATE.—The amendments made by sub-*
 4 *section (a) shall apply to hospice care furnished on or after*
 5 *October 1, 2004.*

6 **SEC. 408. AUTHORITY TO INCLUDE COSTS OF TRAINING OF**
 7 **PSYCHOLOGISTS IN PAYMENTS TO HOS-**
 8 **PITALS UNDER MEDICARE.**

9 *Effective for cost reporting periods beginning on or*
 10 *after October 1, 2004, for purposes of payments to hospitals*
 11 *under the medicare program under title XVIII of the Social*
 12 *Security Act for costs of approved educational activities (as*
 13 *defined in section 413.85 of title 42 of the Code of Federal*
 14 *Regulations), such approved educational activities shall in-*
 15 *clude professional educational training programs, recog-*
 16 *nized by the Secretary, for psychologists.*

17 **SEC. 409. REVISION OF FEDERAL RATE FOR HOSPITALS IN**
 18 **PUERTO RICO.**

19 *Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is*
 20 *amended—*

21 *(1) in subparagraph (A)—*

22 *(A) in clause (i), by striking “for discharges*
 23 *beginning on or after October 1, 1997, 50 percent*
 24 *(and for discharges between October 1, 1987, and*
 25 *September 30, 1997, 75 percent)” and inserting*

1 *“the applicable Puerto Rico percentage (specified*
 2 *in subparagraph (E))”*; and

3 *(B) in clause (ii), by striking “for dis-*
 4 *charges beginning in a fiscal year beginning on*
 5 *or after October 1, 1997, 50 percent (and for dis-*
 6 *charges between October 1, 1987, and September*
 7 *30, 1997, 25 percent)” and inserting “the appli-*
 8 *cable Federal percentage (specified in subpara-*
 9 *graph (E))”*; and

10 *(2) by adding at the end the following new sub-*
 11 *paragraph:*

12 *“(E) For purposes of subparagraph (A), for discharges*
 13 *occurring—*

14 *“(i) between October 1, 1987, and September 30,*
 15 *1997, the applicable Puerto Rico percentage is 75 per-*
 16 *cent and the applicable Federal percentage is 25 per-*
 17 *cent;*

18 *“(ii) on or after October 1, 1997, and before Oc-*
 19 *tober 1, 2004, the applicable Puerto Rico percentage*
 20 *is 50 percent and the applicable Federal percentage is*
 21 *50 percent;*

22 *“(iii) on or after October 1, 2004, and before Oc-*
 23 *tober 1, 2009, the applicable Puerto Rico percentage*
 24 *is 0 percent and the applicable Federal percentage is*
 25 *100 percent; and*

1 “(iv) on or after October 1, 2009, the applicable
 2 *Puerto Rico percentage is 50 percent and the applica-*
 3 *ble Federal percentage is 50 percent.”.*

4 **SEC. 410. AUTHORITY REGARDING GERIATRIC FELLOW-**
 5 **SHIPS.**

6 *The Secretary shall have the authority to clarify that*
 7 *geriatric training programs are eligible for 2 years of fel-*
 8 *lowship support for purposes of making payments for direct*
 9 *graduate medical education under subsection (h) of section*
 10 *1886 of the Social Security Act (42 U.S.C. 1395ww) and*
 11 *indirect medical education under subsection (d)(5)(B) of*
 12 *such section on or after October 1, 2004.*

13 **SEC. 411. CLARIFICATION OF CONGRESSIONAL INTENT RE-**
 14 **GARDING THE COUNTING OF RESIDENTS IN A**
 15 **NONPROVIDER SETTING AND A TECHNICAL**
 16 **AMENDMENT REGARDING THE 3-YEAR ROLL-**
 17 **ING AVERAGE AND THE IME RATIO.**

18 *(a) CLARIFICATION OF REQUIREMENTS FOR COUNTING*
 19 *RESIDENTS TRAINING IN NONPROVIDER SETTING.—*

20 *(1) D-GME.—Section 1886(h)(4)(E) (42 U.S.C.*
 21 *1395ww(h)(4)(E)) is amended by adding at the end*
 22 *the following new sentence: For purposes of the pre-*
 23 *ceding sentence time shall only be counted from the ef-*
 24 *fective date of a written agreement between the hos-*
 25 *pital and the entity owning or operating a nonpro-*

1 *vider setting. The effective date of such written agree-*
 2 *ment shall be determined in accordance with gen-*
 3 *erally accepted accounting principles. All, or substan-*
 4 *tially all, of the costs for the training program in*
 5 *that setting shall be defined as the residents' stipends*
 6 *and benefits and other costs, if any, as determined by*
 7 *the parties."*

8 (2) *IME.*—Section 1886(d)(5)(B)(iv) (42 U.S.C.
 9 1395ww(d)(5)(B)(iv)) is amended by adding at the
 10 end the following new sentence: For purposes of the
 11 preceding sentence time shall only be counted from the
 12 effective date of a written agreement between the hos-
 13 pital and the entity owning or operating a nonpro-
 14 vider setting. The effective date of such written agree-
 15 ment shall be determined in accordance with gen-
 16 erally accepted accounting principles. All, or substan-
 17 tially all, of the costs for the training program in
 18 that setting shall be defined as the residents' stipends
 19 and benefits and other costs, if any, as determined by
 20 the parties."

21 (b) *LIMITING ONE-YEAR LAG IN THE INDIRECT MED-*
 22 *ICAL EDUCATION (IME) RATIO AND THREE-YEAR ROLLING*
 23 *AVERAGE IN RESIDENT COUNT FOR IME AND FOR DIRECT*
 24 *GRADUATE MEDICAL EDUCATION (D-GME) TO MEDICAL*
 25 *RESIDENCY PROGRAMS.*—

1 (1) *IME RATIO AND IME ROLLING AVERAGE.*—
 2 *Section 1886(d)(5)(B)(vi) of the Social Security Act*
 3 *(42 U.S.C. 1395ww(d)(5)(B)(vi)) is amended by add-*
 4 *ing at the end the following new sentence: “For cost*
 5 *reporting periods beginning during fiscal years begin-*
 6 *ning on or after October 1, 2004, subclauses (I) and*
 7 *(II) shall be applied only with respect to a hospital’s*
 8 *approved medical residency training programs in the*
 9 *fields of allopathic and osteopathic medicine.”.*

10 (2) *D-GME ROLLING AVERAGE.*—*Section*
 11 *1886(h)(4)(G) of the Social Security Act (42 U.S.C.*
 12 *1395ww(h)(4)(G)) is amended by adding at the end*
 13 *the following new clause:*

14 *“(iv) APPLICATION FOR FISCAL YEAR*
 15 *2004 AND SUBSEQUENT YEARS.—For cost*
 16 *reporting periods beginning during fiscal*
 17 *years beginning on or after October 1, 2004,*
 18 *clauses (i) through (iii) shall be applied*
 19 *only with respect to a hospital’s approved*
 20 *medical residency training program in the*
 21 *fields of allopathic and osteopathic medi-*
 22 *cine.”.*

1 **SEC. 412. LIMITATION ON CHARGES FOR INPATIENT HOS-**
 2 **PITAL CONTRACT HEALTH SERVICES PRO-**
 3 **VIDED TO INDIANS BY MEDICARE PARTICI-**
 4 **PATING HOSPITALS.**

5 (a) *IN GENERAL.*—Section 1866(a)(1) (42 U.S.C.
 6 1395cc(a)(1)) is amended—

7 (1) *in subparagraph (R), by striking “and” at*
 8 *the end;*

9 (2) *in subparagraph (S), by striking the period*
 10 *and inserting “, and”; and*

11 (3) *by adding at the end the following new sub-*
 12 *paragraph:*

13 “(T) *in the case of hospitals which furnish*
 14 *inpatient hospital services for which payment*
 15 *may be made under this title, to be a partici-*
 16 *parting provider of medical care—*

17 “(i) *under the contract health services*
 18 *program funded by the Indian Health Serv-*
 19 *ice and operated by the Indian Health*
 20 *Service, an Indian tribe, or tribal organiza-*
 21 *tion (as those terms are defined in section*
 22 *4 of the Indian Health Care Improvement*
 23 *Act), with respect to items and services that*
 24 *are covered under such program and fur-*
 25 *nished to an individual eligible for such*
 26 *items and services under such program; and*

1 “(ii) under a program funded by the
 2 Indian Health Service and operated by an
 3 urban Indian organization with respect to
 4 the purchase of items and services for an el-
 5 igible urban Indian (as those terms are de-
 6 fined in such section 4),
 7 in accordance with regulations promulgated by
 8 the Secretary regarding admission practices,
 9 payment methodology, and rates of payment (in-
 10 cluding the acceptance of no more than such
 11 payment rate as payment in full for such items
 12 and services).”.

13 (b) *EFFECTIVE DATE.*—The amendments made by this
 14 section shall apply as of a date specified by the Secretary
 15 of Health and Human Services (but in no case later than
 16 6 months after the date of enactment of this Act) to medi-
 17 care participation agreements in effect (or entered into) on
 18 or after such date.

19 **SEC. 413. GAO STUDY AND REPORT ON APPROPRIATENESS**
 20 **OF PAYMENTS UNDER THE PROSPECTIVE**
 21 **PAYMENT SYSTEM FOR INPATIENT HOSPITAL**
 22 **SERVICES.**

23 (a) *STUDY.*—The Comptroller General of the United
 24 States, using the most current data available, shall conduct
 25 a study to determine—

(b) *REPORT.*—Not later than 24 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a) together with such recommendations for legislative and administrative action as the Comptroller General determines appropriate.

19 **SEC. 421. ESTABLISHMENT OF FLOOR ON GEOGRAPHIC AD-**
20 **JUSTMENTS OF PAYMENTS FOR PHYSICIANS'**
21 **SERVICES.**

•S 1 RS

(1) in subparagraph (A), by striking “subparagraphs (B) and (C)” and inserting “subparagraphs (B), (C), (E), and (F)”; and

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

“(E) FLOOR FOR WORK GEOGRAPHIC INDICES.—

“(i) IN GENERAL.—For purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2008, after calculating the work geographic indices in subparagraph (A)(iii), the Secretary shall increase the work geographic index to the work floor index for any locality for which such geographic index is less than the work floor index.

“(ii) WORK FLOOR INDEX.—For purposes of clause (i), the term ‘applicable floor index’ means—

“(I) 0.980 with respect to services furnished during 2004; and

“(II) 1.000 for services furnished during 2005, 2006, and 2007.

“(F) FLOOR FOR PRACTICE EXPENSE AND MALPRACTICE GEOGRAPHIC INDICES.—For pur-

poses of payment for services furnished on or after January 1, 2005, and before January 1, 2008, after calculating the practice expense and malpractice indices in clauses (i) and (ii) of subparagraph (A) and in subparagraph (B), the Secretary shall increase any such index to 1.00 for any locality for which such index is less than 1.00.

SEC. 422. MEDICARE INCENTIVE PAYMENT PROGRAM IMPROVEMENTS.

(a) *PROCEDURES FOR SECRETARY, AND NOT PHYSICIANS, TO DETERMINE WHEN BONUS PAYMENTS UNDER MEDICARE INCENTIVE PAYMENT PROGRAM SHOULD BE MADE.*—Section 1833(m) (42 U.S.C. 1395l(m)) is amended—

(1) by inserting “(1)” after “(m)”; and

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

“(2) The Secretary shall establish procedures under which the Secretary, and not the physician furnishing the service, is responsible for determining when a payment is required to be made under paragraph (1).”.

(b) *EDUCATIONAL PROGRAM REGARDING THE MEDICARE INCENTIVE PAYMENT PROGRAM.*—The Secretary shall establish and implement an ongoing educational program

1 *to provide education to physicians under the medicare pro-*
 2 *gram on the medicare incentive payment program under*
 3 *section 1833(m) of the Social Security Act (42 U.S.C.*
 4 *1395l(m)).*

5 *(c) ONGOING GAO STUDY AND ANNUAL REPORT ON*
 6 *THE MEDICARE INCENTIVE PAYMENT PROGRAM.—*

7 *(1) ONGOING STUDY.—The Comptroller General*
 8 *of the United States shall conduct an ongoing study*
 9 *on the medicare incentive payment program under*
 10 *section 1833(m) of the Social Security Act (42 U.S.C.*
 11 *1395l(m)). Such study shall focus on whether such*
 12 *program increases the access of medicare beneficiaries*
 13 *who reside in an area that is designated (under sec-*
 14 *tion 332(a)(1)(A) of the Public Health Service Act*
 15 *(42 U.S.C. 254e(a)(1)(A))) as a health professional*
 16 *shortage area to physicians' services under the medi-*
 17 *care program.*

18 *(2) ANNUAL REPORTS.—Not later than 1 year*
 19 *after the date of enactment of this Act, and annually*
 20 *thereafter, the Comptroller General of the United*
 21 *States shall submit to Congress a report on the study*
 22 *conducted under paragraph (1), together with rec-*
 23 *ommendations as the Comptroller General considers*
 24 *appropriate.*

1 **SEC. 423. INCREASE IN RENAL DIALYSIS COMPOSITE RATE.**

2 *Notwithstanding any other provision of law, with re-*
 3 *spect to payment under part B of title XVIII of the Social*
 4 *Security Act for renal dialysis services furnished in 2005*
 5 *and 2006, the composite rate for such services shall be in-*
 6 *creased by 1.6 percent under section 1881(b)(12) of such*
 7 *Act (42 U.S.C. 1395rr(b)(7)), as added by section 433(b)(5).*

8 **SEC. 424. EXTENSION OF HOLD HARMLESS PROVISIONS**

9 **FOR SMALL RURAL HOSPITALS AND TREAT-**
 10 **MENT OF CERTAIN SOLE COMMUNITY HOS-**
 11 **PITALS TO LIMIT DECLINE IN PAYMENT**
 12 **UNDER THE OPD PPS.**

13 (a) *SMALL RURAL HOSPITALS.*—Section
 14 1833(t)(7)(D)(i) (42 U.S.C. 1395l(t)(7)(D)(i)) is amended
 15 by inserting “and during 2006” after “2004.”

16 (b) *SOLE COMMUNITY HOSPITALS.*—Section
 17 1833(t)(7)(D) (42 U.S.C. 1395l(t)(7)(D)) is amended by
 18 adding at the end the following:

19 “(i) *TEMPORARY TREATMENT FOR*
 20 *SOLE COMMUNITY HOSPITALS .—In the case*
 21 *of a sole community hospital (as defined in*
 22 *section 1886(d)(5)(D)(iii)) located in a*
 23 *rural area, for covered OPD services fur-*
 24 *nished in 2006, for which the PPS amount*
 25 *is less than the pre-BBA amount, the*
 26 *amount of payment under this subsection*

1 shall be increased by the amount of such
2 difference.”.

3 **SEC. 425. INCREASE IN PAYMENTS FOR CERTAIN SERVICES**
4 **FURNISHED BY SMALL RURAL AND SOLE**
5 **COMMUNITY HOSPITALS UNDER MEDICARE**
6 **PROSPECTIVE PAYMENT SYSTEM FOR HOS-**
7 **PITAL OUTPATIENT DEPARTMENT SERVICES.**

8 (a) *INCREASE.*—

9 (1) *IN GENERAL.*—In the case of an applicable
10 covered OPD service (as defined in paragraph (2))
11 that is furnished by a hospital described in clause (i)
12 or (iii) of paragraph (7)(D) of section 1833(t) of the
13 Social Security Act (42 U.S.C. 1395l(t)), as amended
14 by section 424, on or after January 1, 2005, and be-
15 fore January 1, 2008, the Secretary shall increase the
16 medicare OPD fee schedule amount (as determined
17 under paragraph (4)(A) of such section) that is appli-
18 cable for such service in that year (determined with-
19 out regard to any increase under this section in a
20 previous year) by 5 percent.

21 (2) *APPLICABLE COVERED OPD SERVICES DE-*
22 *FINED.*—For purposes of this section, the term “appli-
23 cable covered OPD service” means a covered clinic or
24 emergency room visit that is classified within the
25 groups of covered OPD services (as defined in para-

1 *graph (1)(B) of section 1833(t) of the Social Security*
 2 *Act (42 U.S.C. 1395l(t))) established under paragraph*
 3 *(2)(B) of such section.*

4 *(b) NO EFFECT ON COPAYMENT AMOUNT.—The Sec-*
 5 *retary shall compute the copayment amount for applicable*
 6 *covered OPD services under section 1833(t)(8)(A) of the So-*
 7 *cial Security Act (42 U.S.C. 1395l(t)(8)(A)) as if this sec-*
 8 *tion had not been enacted.*

9 *(c) NO EFFECT ON INCREASE UNDER HOLD HARM-*
 10 *LESS OR OUTLIER PROVISIONS.—The Secretary shall apply*
 11 *the temporary hold harmless provision under clause (i) and*
 12 *(iii) of paragraph (7)(D) of section 1833(t) of the Social*
 13 *Security Act (42 U.S.C. 1395l(t)) and the outlier provision*
 14 *under paragraph (5) of such section as if this section had*
 15 *not been enacted.*

16 *(d) WAIVING BUDGET NEUTRALITY AND NO REVISION*
 17 *OR ADJUSTMENTS.—The Secretary shall not make any revi-*
 18 *sion or adjustment under subparagraph (A), (B), or (C)*
 19 *of section 1833(t)(9) of the Social Security Act (42 U.S.C.*
 20 *1395l(t)(9)) because of the application of subsection (a)(1).*

21 *(e) NO EFFECT ON PAYMENTS AFTER INCREASE PE-*
 22 *RIOD ENDS.—The Secretary shall not take into account any*
 23 *payment increase provided under subsection (a)(1) in deter-*
 24 *mining payments for covered OPD services (as defined in*
 25 *paragraph (1)(B) of section 1833(t) of the Social Security*

1 *Act (42 U.S.C. 1395l(t)) under such section that are fur-*
 2 *nished after January 1, 2007.*

3 (f) *TECHNICAL AMENDMENT.—Section 1833(t)(2)(B)*
 4 *(42 U.S.C. 1395l(t)(2)(B)) is amended by inserting “(and*
 5 *periodically revise such groups pursuant to paragraph*
 6 *(9)(A))” after “establish groups”.*

7 **SEC. 426. INCREASE FOR GROUND AMBULANCE SERVICES**
 8 **FURNISHED IN A RURAL AREA.**

9 *Section 1834(l) (42 U.S.C. 1395m(l)), as amended by*
 10 *section 405(b)(2), is amended by adding at the end the fol-*
 11 *lowing new paragraph:*

12 “(10) *TEMPORARY INCREASE FOR GROUND AM-*
 13 *BULANCE SERVICES FURNISHED IN A RURAL AREA.—*

14 “(A) *IN GENERAL.—Notwithstanding any*
 15 *other provision of this subsection, in the case of*
 16 *ground ambulance services furnished on or after*
 17 *January 1, 2005, and before January 1, 2008,*
 18 *for which the transportation originates in a*
 19 *rural area described in paragraph (9) or in a*
 20 *rural census tract described in such paragraph,*
 21 *the fee schedule established under this section,*
 22 *with respect to both the payment rate for service*
 23 *and the payment rate for mileage, shall provide*
 24 *that such rates otherwise established, after appli-*

1 *cation of any increase under such paragraph,*
 2 *shall be increased by 5 percent.*

3 “(B) *APPLICATION OF INCREASED PAY-*
 4 *MENTS AFTER 2007.—The increased payments*
 5 *under subparagraph (A) shall not be taken into*
 6 *account in calculating payments for services fur-*
 7 *nished on or after the period specified in such*
 8 *subparagraph.”.*

9 **SEC. 427. ENSURING APPROPRIATE COVERAGE OF AIR AM-**
 10 **BULANCE SERVICES UNDER AMBULANCE FEE**
 11 **SCHEDULE.**

12 (a) *COVERAGE.—Section 1834(l) (42 U.S.C.*
 13 *1395m(l)), as amended by section 426, is amended by add-*
 14 *ing at the end the following new paragraph:*

15 “(11) *ENSURING APPROPRIATE COVERAGE OF*
 16 *AIR AMBULANCE SERVICES.—*

17 “(A) *IN GENERAL.—The regulations de-*
 18 *scribed in section 1861(s)(7) shall ensure that*
 19 *air ambulance services (as defined in subpara-*
 20 *graph (C)) are reimbursed under this subsection*
 21 *at the air ambulance rate if the air ambulance*
 22 *service—*

23 “(i) *is medically necessary based on*
 24 *the health condition of the individual being*

1 *transported at or immediately prior to the*
 2 *time of the transport; and*

3 “(ii) *complies with equipment and*
 4 *crew requirements established by the Sec-*
 5 *retary.*

6 “(B) *MEDICALLY NECESSARY.—An air am-*
 7 *bulance service shall be considered to be medi-*
 8 *cally necessary for purposes of subparagraph*
 9 *(A)(i) if such service is requested—*

10 “(i) *by a physician or a hospital in*
 11 *accordance with the physician’s or hos-*
 12 *pital’s responsibilities under section 1867*
 13 *(commonly known as the Emergency Med-*
 14 *ical Treatment and Active Labor Act);*

15 “(ii) *as a result of a protocol estab-*
 16 *lished by a State or regional emergency*
 17 *medical service (EMS) agency;*

18 “(iii) *by a physician, nurse practi-*
 19 *tioner, physician assistant, registered nurse,*
 20 *or emergency medical responder who rea-*
 21 *sonably determines or certifies that the pa-*
 22 *tient’s condition is such that the time need-*
 23 *ed to transport the individual by land or*
 24 *the lack of an appropriate ground ambu-*

1 lance, significantly increases the medical
2 risks for the individual; or

3 “(iv) by a Federal or State agency to
4 relocate patients following a natural dis-
5 aster, an act of war, or a terrorist attack.

6 “(C) AIR AMBULANCE SERVICES DE-
7 FINED.—For purposes of this paragraph, the
8 term ‘air ambulance service’ means fixed wing
9 and rotary wing air ambulance services.”.

10 (b) CONFORMING AMENDMENT.—Section 1861(s)(7)
11 (42 U.S.C. 1395x(s)(7)) is amended by inserting “, subject
12 to section 1834(l)(11),” after “but”.

13 (c) EFFECTIVE DATE.—The amendments made by this
14 section shall apply to services furnished on or after January
15 1, 2005.

16 **SEC. 428. TREATMENT OF CERTAIN CLINICAL DIAGNOSTIC**
17 **LABORATORY TESTS FURNISHED BY A SOLE**
18 **COMMUNITY HOSPITAL.**

19 Notwithstanding subsections (a), (b), and (h) of section
20 1833 of the Social Security Act (42 U.S.C. 1395l) and sec-
21 tion 1834(d)(1) of such Act (42 U.S.C. 1395m(d)(1)), in
22 the case of a clinical diagnostic laboratory test covered
23 under part B of title XVIII of such Act that is furnished
24 in 2005 or 2006 by a sole community hospital (as defined
25 in section 1886(d)(5)(D)(iii) of such Act (42 U.S.C.

1 1395ww(d)(5)(D)(iii))) as part of services furnished to pa-
 2 tients of the hospital, the following rules shall apply:

3 (1) *PAYMENT BASED ON REASONABLE COSTS.*—

4 The amount of payment for such test shall be 100 per-
 5 cent of the reasonable costs of the hospital in fur-
 6 nishing such test.

7 (2) *NO BENEFICIARY COST-SHARING.*—Notwith-
 8 standing section 432, no coinsurance, deductible, co-
 9 payment, or other cost-sharing otherwise applicable
 10 under such part B shall apply with respect to such
 11 test.

12 **SEC. 429. IMPROVEMENT IN RURAL HEALTH CLINIC REIM-**
 13 **BURSEMENT.**

14 Section 1833(f) (42 U.S.C. 1395l(f)) is amended—

15 (1) in paragraph (1), by striking “, and” at the
 16 end and inserting a semicolon;

17 (2) in paragraph (2)—

18 (A) by striking “in a subsequent year” and
 19 inserting “in 1989 through 2004”; and

20 (B) by striking the period at the end and
 21 inserting a semicolon; and

22 (3) by adding at the end the following new para-
 23 graphs:

24 “(3) in 2005, at \$80 per visit; and

1 “(4) in a subsequent year, at the limit estab-
 2 lished under this subsection for the previous year in-
 3 creased by the percentage increase in the MEI (as so
 4 defined) applicable to primary care services (as so de-
 5 fined) furnished as of the first day of that year.”.

6 **SEC. 430. ELIMINATION OF CONSOLIDATED BILLING FOR**
 7 **CERTAIN SERVICES UNDER THE MEDICARE**
 8 **PPS FOR SKILLED NURSING FACILITY SERV-**
 9 **ICES.**

10 (a) *CERTAIN RURAL HEALTH CLINIC AND FEDERALLY*
 11 *QUALIFIED HEALTH CENTER SERVICES.*—Section 1888(e)
 12 (42 U.S.C. 1395yy(e)) is amended—

13 (1) in paragraph (2)(A)(i)(II), by striking
 14 “clauses (ii) and (iii)” and inserting “clauses (ii),
 15 (iii), and (iv)”; and

16 (2) by adding at the end of paragraph (2)(A) the
 17 following new clause:

18 “(iv) *EXCLUSION OF CERTAIN RURAL*
 19 *HEALTH CLINIC AND FEDERALLY QUALIFIED*
 20 *HEALTH CENTER SERVICES.*—Services de-
 21 scribed in this clause are—

22 “(I) rural health clinic services
 23 (as defined in paragraph (1) of section
 24 1861(aa)); and

1 “(II) *Federally qualified health*
 2 *center services (as defined in para-*
 3 *graph (3) of such section);*
 4 *that would be described in clause (ii) if such*
 5 *services were furnished by a physician or*
 6 *practitioner not affiliated with a rural*
 7 *health clinic or a Federally qualified health*
 8 *center.”.*

9 (b) *CERTAIN SERVICES FURNISHED BY AN ENTITY*
 10 *JOINTLY OWNED BY HOSPITALS AND CRITICAL ACCESS*
 11 *HOSPITALS.—For purposes of applying section 411.15(p)–*
 12 *(3)(iii) of title 42 of the Code of Federal Regulations, the*
 13 *Secretary shall treat an entity that is 100 percent owned*
 14 *as a joint venture by 2 Medicare-participating hospitals or*
 15 *critical access hospitals as a Medicare-participating hos-*
 16 *pital or a critical access hospital.*

17 (c) *TECHNICAL AMENDMENT.—Sections 1842(b)(6)(E)*
 18 *and 1866(a)(1)(H)(ii) (42 U.S.C. 1395u(b)(6)(E);*
 19 *1395cc(a)(1)(H)(ii)) are each amended by striking “section*
 20 *1888(e)(2)(A)(ii)” and inserting “clauses (ii), (iii), and*
 21 *(iv) of section 1888(e)(2)(A)”.*

22 (d) *EFFECTIVE DATE.—The amendments made by this*
 23 *section and the provision of subsection (b) shall apply to*
 24 *services furnished on or after January 1, 2005.*

1 **SEC. 431. FREEZE IN PAYMENTS FOR CERTAIN ITEMS OF**
 2 **DURABLE MEDICAL EQUIPMENT AND CER-**
 3 **TAIN ORTHOTICS; ESTABLISHMENT OF QUAL-**
 4 **ITY STANDARDS AND ACCREDITATION RE-**
 5 **QUIREMENTS FOR DME PROVIDERS.**

6 (a) *FREEZE FOR DME.*—Section 1834(a)(14) (42
 7 U.S.C. 1395m(a)(14)) is amended—

8 (1) in subparagraph (E), by striking “and” at
 9 the end;

10 (2) in subparagraph (F)—

11 (A) by striking “a subsequent year” and in-
 12 serting “2003”; and

13 (B) by striking “the previous year.” and in-
 14 serting “2002;”; and

15 (3) by adding at the end the following new sub-
 16 paragraphs:

17 “(G) for each of the years 2004 through
 18 2010—

19 “(i) in the case of class III medical de-
 20 vices described in section 513(a)(1)(C) of
 21 the Federal Food, Drug, and Cosmetic Act
 22 (21 U.S.C. 360(c)(1)(C)), the percentage in-
 23 crease described in subparagraph (B) for
 24 the year involved; and

1 “(ii) in the case of covered items not
 2 described in clause (i), 0 percentage points;
 3 and
 4 “(H) for a subsequent year, the percentage
 5 increase described in subparagraph (B) for the
 6 year involved.”.

7 (b) *FREEZE FOR OFF-THE-SHELF ORTHOTICS*.—Sec-
 8 tion 1834(h)(4)(A) of the Social Security Act (42 U.S.C.
 9 1395m(h)(4)(A)) is amended—

10 (1) in clause (vii), by striking “and” at the end;
 11 (2) in clause (viii), by striking “a subsequent
 12 year” and inserting “2003”; and
 13 (3) by adding at the end the following new
 14 clauses:

15 “(ix) for each of the years 2004
 16 through 2010—

17 “(I) in the case of orthotics that
 18 have not been custom-fabricated, 0 per-
 19 cent; and

20 “(II) in the case of prosthetics,
 21 prosthetic devices, and custom-fab-
 22 ricated orthotics, the percentage in-
 23 crease described in clause (viii) for the
 24 year involved; and

1 “(x) for 2011 and each subsequent
 2 year, the percentage increase described in
 3 clause (viii) for the year involved;”.

4 (c) *ESTABLISHMENT OF QUALITY STANDARDS AND AC-*
 5 *CREDITATION REQUIREMENTS FOR DURABLE MEDICAL*
 6 *EQUIPMENT PROVIDERS.*—Section 1834(a) (42 U.S.C.
 7 1395m(a)) is amended—

8 (1) by redesignating paragraph (17), as added
 9 by section 4551(c)(1) of the *Balanced Budget Act of*
 10 1997 (111 Stat. 458), as paragraph (19); and

11 (2) by adding at the end the following new para-
 12 graph:

13 “(20) *IDENTIFICATION OF QUALITY STAND-*
 14 *ARDS.*—

15 “(A) *IN GENERAL.*—Subject to subpara-
 16 graph (C), the Secretary shall establish and im-
 17 plement quality standards for providers of dura-
 18 ble medical equipment throughout the United
 19 States that are developed by recognized inde-
 20 pendent accreditation organizations (as des-
 21 ignated under subparagraph (B)(i)) and with
 22 which such providers shall be required to comply
 23 in order to—

24 “(i) participate in the program under
 25 this title;

1 “(ii) *furnish any item or service de-*
 2 *scribed in subparagraph (D) for which pay-*
 3 *ment is made under this part; and*

4 “(iii) *receive or retain a provider or*
 5 *supplier number used to submit claims for*
 6 *reimbursement for any item or service de-*
 7 *scribed in subparagraph (D) for which pay-*
 8 *ment may be made under this title.*

9 “(B) *DESIGNATION OF INDEPENDENT AC-*
 10 *CREDITATION ORGANIZATIONS.—*

11 “(i) *IN GENERAL.—Not later than the*
 12 *date that is 6 months after the date of en-*
 13 *actment of the Prescription Drug and Medi-*
 14 *care Improvement Act of 2003, the Sec-*
 15 *retary shall designate independent accredi-*
 16 *tation organizations for purposes of sub-*
 17 *paragraph (A).*

18 “(ii) *CONSULTATION.—In determining*
 19 *which independent accreditation organiza-*
 20 *tions to designate under clause (i), the Sec-*
 21 *retary shall consult with an expert outside*
 22 *advisory panel composed of an appropriate*
 23 *selection of representatives of physicians,*
 24 *practitioners, suppliers, and manufacturers*
 25 *to review (and advise the Secretary con-*

1 cerning) selection of accrediting organiza-
 2 tions and the quality standards of such or-
 3 ganizations.

4 “(C) *QUALITY STANDARDS.*—The quality
 5 standards described in subparagraph (A) may
 6 not be less stringent than the quality standards
 7 that would otherwise apply if this paragraph did
 8 not apply and shall include consumer services
 9 standards.

10 “(D) *ITEMS AND SERVICES DESCRIBED.*—
 11 The items and services described in this subpara-
 12 graph are covered items (as defined in para-
 13 graph (13)) for which payment may otherwise be
 14 made under this subsection, other than items
 15 used in infusion, and inhalation drugs used in
 16 conjunction with durable medical equipment.

17 “(E) *PHASED-IN IMPLEMENTATION.*—The
 18 application of the quality standards described in
 19 subparagraph (A) shall be phased-in over a pe-
 20 riod that does not exceed 3 years.”.

21 **SEC. 432. APPLICATION OF COINSURANCE AND DEDUCT-**
 22 **IBLE FOR CLINICAL DIAGNOSTIC LABORA-**
 23 **TORY TESTS.**

24 (a) *COINSURANCE.*—

1 (1) *IN GENERAL.*—Section 1833(a) (42 U.S.C.
2 1395l(a)) is amended—

3 (A) in paragraph (1)(D)(i), by striking “(or
4 100 percent, in the case of such tests for which
5 payment is made on an assignment-related
6 basis)”; and

7 (B) in paragraph (2)(D)(i), by striking
8 “(or 100 percent, in the case of such tests for
9 which payment is made on an assignment-re-
10 lated basis or to a provider having an agreement
11 under section 1866)”.

12 (2) *CONFORMING AMENDMENT.*—The third sen-
13 tence of section 1866(a)(2)(A) of the Social Security
14 Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by strik-
15 ing “and with respect to clinical diagnostic labora-
16 tory tests for which payment is made under part B”.

17 (b) *DEDUCTIBLE.*—Section 1833(b) of the Social Secu-
18 rity Act (42 U.S.C. 1395l(b)) is amended—

19 (1) by striking paragraph (3); and

20 (2) by redesignating paragraphs (4), (5), and (6)
21 as paragraphs (3), (4), and (5), respectively.

22 (c) *EFFECTIVE DATE.*—The amendments made by this
23 section shall apply to tests furnished on or after January
24 1, 2004.

1 **SEC. 433. BASING MEDICARE PAYMENTS FOR COVERED**
 2 **OUTPATIENT DRUGS ON MARKET PRICES.**

3 (a) *MEDICARE MARKET BASED PAYMENT AMOUNT.*—

4 *Section 1842(o) (42 U.S.C. 1395u(o)) is amended—*

5 (1) *in paragraph (1), by striking “equal to 95*
 6 *percent of the average wholesale price.” and inserting*
 7 *“equal to—*

8 *“(A) in the case of a drug or biological furnished*
 9 *prior to January 1, 2004, 95 percent of the average*
 10 *wholesale price; and*

11 *“(B) in the case of a drug or biological furnished*
 12 *on or after January 1, 2004, the payment amount*
 13 *specified in—*

14 *“(i) in the case of such a drug or biological*
 15 *that is first available for payment under this*
 16 *part on or before April 1, 2003, paragraph (4);*
 17 *and*

18 *“(ii) in the case of such a drug or biological*
 19 *that is first available for payment under this*
 20 *part after such date, paragraph (5).”;* and

21 (2) *by adding at the end the following new para-*
 22 *graphs:*

23 *“(4)(A) Subject to subparagraph (C), the payment*
 24 *amount specified in this paragraph for a year for a drug*
 25 *or biological is an amount equal to the lesser of—*

1 “(i) the average wholesale price for the drug or
2 biological; or

3 “(ii) the amount determined under subpara-
4 graph (B)

5 “(B)(i) Subject to clause (ii), the amount determined
6 under this subparagraph is an amount equal to—

7 “(I) in the case of a drug or biological furnished
8 in 2004, 85 percent of the average wholesale price for
9 the drug or biological (determined as of April 1,
10 2003); and

11 “(II) in the case of a drug or biological furnished
12 in 2005 or a subsequent year, the amount determined
13 under this subparagraph for the previous year in-
14 creased by the percentage increase in the consumer
15 price index for medical care for the 12-month period
16 ending with June of the previous year.

17 “(ii) In the case of a vaccine described in subpara-
18 graph (A) or (B) of section 1861(s)(10), the amount deter-
19 mined under this subparagraph is an amount equal to the
20 average wholesale price for the drug or biological.

21 “(C)(i) The Secretary shall establish a process under
22 which the Secretary determines, for such drugs or
23 biologicals as the Secretary determines appropriate, wheth-
24 er the widely available market price to physicians or sup-
25 pliers for the drug or biological furnished in a year is dif-

1 *ferent from the payment amount established under subpara-*
2 *graph (B) for the year. Such determination shall be based*
3 *on the information described in clause (ii) as the Secretary*
4 *determines appropriate.*

5 “(ii) *The information described in this clause is the*
6 *following information:*

7 “(I) *Any report on drug or biological market*
8 *prices by the Inspector General of the Department of*
9 *Health and Human Services or the Comptroller Gen-*
10 *eral of the United States that is made available after*
11 *December 31, 1999.*

12 “(II) *A review of drug or biological market*
13 *prices by the Secretary, which may include informa-*
14 *tion on such market prices from insurers, private*
15 *health plans, manufacturers, wholesalers, distributors,*
16 *physician supply houses, specialty pharmacies, group*
17 *purchasing arrangements, physicians, suppliers, or*
18 *any other source the Secretary determines appro-*
19 *priate.*

20 “(III) *Data and information submitted by the*
21 *manufacturer of the drug or biological or by another*
22 *entity.*

23 “(IV) *Other data and information as determined*
24 *appropriate by the Secretary.*

1 “(iii) If the Secretary makes a determination under
2 clause (i) with respect to the widely available market price
3 for a drug or biological for a year, the following provisions
4 shall apply:

5 “(I) Subject to clause (iv), the amount deter-
6 mined under this subparagraph shall be substituted
7 for the amount determined under subparagraph (B)
8 for purposes of applying subparagraph (A)(ii)(I) for
9 the year and all subsequent years.

10 “(II) The Secretary may make subsequent deter-
11 minations under clause (i) with respect to the widely
12 available market price for the drug or biological.

13 “(III) If the Secretary does not make a subse-
14 quent determination under clause (i) with respect to
15 the widely available market price for the drug or bio-
16 logical for a year, the amount determined under this
17 subparagraph shall be an amount equal to the
18 amount determined under this subparagraph for the
19 previous year increased by the percentage increase de-
20 scribed in subparagraph (B)(i)(II) for the year in-
21 volved.

22 “(iv) If the first determination made under clause (i)
23 with respect to the widely available market price for a drug
24 or biological would result in a payment amount in a year
25 that is more than 15 percent less than the amount deter-

1 mined under subparagraph (B) for the drug or biological
 2 for the previous year (or, for 2004, the payment amount
 3 determined under paragraph (1)(A), determined as of April
 4 1, 2003), the Secretary shall provide for a transition to the
 5 amount determined under clause (i) so that the payment
 6 amount is reduced in annual increments equal to 15 per-
 7 cent of the payment amount in such previous year until
 8 the payment amount is equal to the amount determined
 9 under clause (i), as increased each year by the percentage
 10 increase described in subparagraph (B)(i)(II) for the year.
 11 The preceding sentence shall not apply to a drug or biologi-
 12 cal where a generic version of the drug or biological first
 13 enters the market on or after January 1, 2004 (even if the
 14 generic version of the drug or biological is not marketed
 15 under the chemical name of such drug or biological).

16 “(5) In the case of a drug or biological that is first
 17 available for payment under this part after April 1, 2003,
 18 the following rules shall apply:

19 “(A) As a condition of obtaining a code to report
 20 such new drug or biological and to receive payment
 21 under this part, a manufacturer shall provide the
 22 Secretary (in a time, manner, and form approved by
 23 the Secretary) with data and information on prices
 24 at which the manufacturer estimates physicians and
 25 suppliers will be able to routinely obtain the drug or

1 *biological in the market during the first year that the*
2 *drug or biological is available for payment under this*
3 *part and such additional information that the manu-*
4 *facturer determines appropriate.*

5 “(B) *During the year that the drug or biological*
6 *is first available for payment under this part, the*
7 *manufacturer of the drug or biological shall provide*
8 *the Secretary (in a time, manner, and form approved*
9 *by the Secretary) with updated information on the*
10 *actual market prices paid by such physicians or sup-*
11 *pliers for the drug or biological in the year.*

12 “(C) *The amount specified in this paragraph for*
13 *a drug or biological for the year described in subpara-*
14 *graph (B) is equal to an amount determined by the*
15 *Secretary based on the information provided under*
16 *subparagraph (A) and other information that the Sec-*
17 *retary determines appropriate.*

18 “(D) *The amount specified in this paragraph for*
19 *a drug or biological for the year after the year de-*
20 *scribed in subparagraph (B) is equal to an amount*
21 *determined by the Secretary based on the information*
22 *provided under subparagraph (B) and other informa-*
23 *tion that the Secretary determines appropriate.*

24 “(E) *The amount specified in this paragraph for*
25 *a drug or biological for the year beginning after the*

1 year described in subparagraph (D) and each subse-
 2 quent year is equal to the lesser of—

3 “(i) the average wholesale price for the drug
 4 or biological; or

5 “(ii) the amount determined—

6 “(I) by the Secretary under paragraph
 7 (4)(C)(i) with respect to the widely avail-
 8 able market price for the drug or biological
 9 for the year, if such paragraph was applied
 10 by substituting ‘the payment determined
 11 under paragraph (5)(E)(ii)(II) for the year’
 12 for ‘established under subparagraph (B) for
 13 the year’; and

14 “(II) if no determination described in
 15 subclause (I) is made for the drug or bio-
 16 logical for the year, under this subpara-
 17 graph with respect to the drug or biological
 18 for the previous year increased by the per-
 19 centage increase described in paragraph
 20 (4)(B)(i)(II) for the year involved.”.

21 (b) *ADJUSTMENTS TO PAYMENT AMOUNTS FOR ADMIN-*
 22 *ISTRATION OF DRUGS AND BIOLOGICALS.*—

23 (1) *ADJUSTMENT IN PHYSICIAN PRACTICE EX-*
 24 *PENSE RELATIVE VALUE UNITS.*—Section 1848(c)(2)
 25 (42 U.S.C. 1395w-4(c)(2)) is amended—

1 (A) in subparagraph (B)—

2 (i) in clause (ii)(II), by striking “The
3 adjustments” and inserting “Subject to
4 clause (iv), the adjustments”; and

5 (ii) by adding at the end the following
6 new clause:

7 “(iv) *EXEMPTION FROM BUDGET NEU-*
8 *TRALITY IN 2004.—Any additional expendi-*
9 *tures under this part that are attributable*
10 *to subparagraph (H) shall not be taken into*
11 *account in applying clause (ii)(II) for*
12 *2004.”; and*

13 (B) by adding at the end the following new
14 subparagraph:

15 “(H) *ADJUSTMENTS IN PRACTICE EXPENSE*
16 *RELATIVE VALUE UNITS FOR DRUG ADMINISTRA-*
17 *TION SERVICES FOR 2004.—In establishing the*
18 *physician fee schedule under subsection (b) with*
19 *respect to payments for services furnished in*
20 *2004, the Secretary shall, in determining prac-*
21 *tice expense relative value units under this sub-*
22 *section, utilize a survey submitted to the Sec-*
23 *retary as of January 1, 2003, by a physician*
24 *specialty organization pursuant to section 212 of*

1 *the Medicare, Medicaid, and SCHIP Balanced*
 2 *Budget Refinement Act of 1999 if the survey—*

3 *“(i) covers practice expenses for oncol-*
 4 *ogy administration services; and*

5 *“(ii) meets criteria established by the*
 6 *Secretary for acceptance of such surveys.”.*

7 *(2) PAYMENT FOR MULTIPLE CHEMOTHERAPY*
 8 *AGENTS FURNISHED ON A SINGLE DAY THROUGH THE*
 9 *PUSH TECHNIQUE.—*

10 *(A) REVIEW OF POLICY.—The Secretary*
 11 *shall review the policy, as in effect on the date*
 12 *of enactment of this Act, with respect to payment*
 13 *under section 1848 of the Social Security Act (42*
 14 *U.S.C. 1395w-4) for the administration of more*
 15 *than 1 anticancer chemotherapeutic agent to an*
 16 *individual on a single day through the push*
 17 *technique.*

18 *(B) MODIFICATION OF POLICY.—After con-*
 19 *ducting the review under subparagraph (A), the*
 20 *Secretary shall modify such payment policy if*
 21 *the Secretary determines such modification to be*
 22 *appropriate.*

23 *(C) EXEMPTION FROM BUDGET NEUTRALITY*
 24 *UNDER PHYSICIAN FEE SCHEDULE.—If the Sec-*
 25 *retary modifies such payment policy pursuant to*

subparagraph (B), any increased expenditures under title XVIII of the Social Security Act resulting from such modification shall be treated as additional expenditures attributable to subparagraph (H) of section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w-4(c)(2)), as added by paragraph (1)(B), for purposes of applying the exemption to budget neutrality under subparagraph (B)(iv) of such section, as added by paragraph (1)(A).

(3) *TREATMENT OF OTHER SERVICES CURRENTLY IN THE NONPHYSICIAN WORK POOL.*—The Secretary shall make adjustments to the nonphysician work pool methodology (as such term is used in the final rule promulgated by the Secretary in the Federal Register on December 31, 2002 (67 Fed. Reg. 251)), for the determination of practice expense relative value units under the physician fee schedule under section 1848(c)(2)(C)(ii) of the Social Security Act (42 U.S.C. 1395w-4(c)(2)(C)(ii)), so that the practice expense relative value units for services determined under such methodology are not disproportionately reduced relative to the practice expense relative value units of services not determined under such

1 *methodology, as a result of the amendments to such*
2 *Act made by paragraph (1).*

3 (4) *ADMINISTRATION OF BLOOD CLOTTING FAC-*
4 *TORS.—Section 1842(o) (42 U.S.C. 1395u(o)), as*
5 *amended by subsection (a)(2), is amended by adding*
6 *at the end the following new paragraph:*

7 “(6)(A) *Subject to subparagraph (B), in the case of*
8 *clotting factors furnished on or after January 1, 2004, the*
9 *Secretary shall, after reviewing the January 2003 report*
10 *to Congress by the Comptroller General of the United States*
11 *entitled ‘Payment for Blood Clotting Factor Exceeds Pro-*
12 *viders Acquisition Cost’ (GAO–03–184), provide for a sepa-*
13 *rate payment for the administration of such blood clotting*
14 *factors in an amount that the Secretary determines to be*
15 *appropriate.*

16 “(B) *In determining the separate payment amount*
17 *under subparagraph (A) for blood clotting factors furnished*
18 *in 2004, the Secretary shall ensure that the total amount*
19 *of payments under this part (as estimated by the Secretary)*
20 *for such factors under paragraphs (4) and (5) and such sep-*
21 *arate payments for such factors does not exceed the total*
22 *amount of payments that would have been made for such*
23 *factors under this part (as estimated by the Secretary) if*
24 *the amendments made by section 433 of the Prescription*

1 *Drug and Medicare Improvement Act of 2003 had not been*
 2 *enacted.*

3 “(C) *The separate payment amount under this sub-*
 4 *paragraph for blood clotting factors furnished in 2005 or*
 5 *a subsequent year shall be equal to the separate payment*
 6 *amount determined under this paragraph for the previous*
 7 *year increased by the percentage increase described in para-*
 8 *graph (4)(B)(i)(II) for the year involved.”.*

9 (5) *INCREASE IN COMPOSITE RATE FOR END*
 10 *STAGE RENAL DISEASE FACILITIES.—Section 1881(b)*
 11 *(42 U.S.C. 1395rr(b) is amended—*

12 (A) *in paragraph (7), by adding at the end*
 13 *the following new sentence: “In the case of dialy-*
 14 *sis services furnished in 2004 or a subsequent*
 15 *year, the composite rate for such services shall be*
 16 *determined under paragraph (12).”;* and

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

19 “(12)(A) *In the case of dialysis services furnished dur-*
 20 *ing 2004, the composite rate for such services shall be the*
 21 *composite rate that would otherwise apply under paragraph*
 22 *(7) for the year increased by an amount to ensure (as esti-*
 23 *mated by the Secretary) that—*

24 “(i) *the sum of the total amount of—*

1 “(I) the composite rate payments for such
2 services for the year, as increased under this
3 paragraph; and

4 “(II) the payments for drugs and biologicals
5 (other than erythropoetin) furnished in connec-
6 tion with the furnishing of renal dialysis services
7 and separately billed by renal dialysis facilities
8 under paragraphs (4) and (5) of section 1842(o)
9 for the year; is equal to

10 “(ii) the sum of the total amount of the com-
11 posite rate payments under paragraph (7) for the
12 year and the payments for the separately billed drugs
13 and biologicals described in clause (i)(II) that would
14 have been made if the amendments made by section
15 433 of the Prescription Drug and Medicare Improve-
16 ment Act of 2003 had not been enacted.

17 “(B) Subject to subparagraph (E), in the case of dialy-
18 sis services furnished in 2005, the composite rate for such
19 services shall be an amount equal to the composite rate es-
20 tablished under subparagraph (A), increased by 0.05 per-
21 cent and further increased pursuant to section 423 of the
22 Prescription Drug and Medicare Improvement Act of 2003.

23 “(C) Subject to subparagraph (E), in the case of dialy-
24 sis services furnished in 2006, the composite rate for such
25 services shall be an amount equal to the composite rate es-

1 *tablished under subparagraph (B), increased by 0.05 per-*
2 *cent.*

3 “(D) *Subject to subparagraph (E), in the case of dialy-*
4 *sis services furnished in 2007 or a subsequent year, the com-*
5 *posite rate for such services shall be an amount equal to*
6 *the composite rate established under this paragraph for the*
7 *previous year (determined as if such section 423 had not*
8 *been enacted), increased by 0.05 percent.*

9 “(E) *If the Secretary implements a reduction in*
10 *the payment amount under paragraph (4)(C) or (5)*
11 *for a drug or biological described in subparagraph*
12 *(A)(i)(II) for a year after 2004, the Secretary shall,*
13 *as estimated by the Secretary—*

14 “(i) *increase the composite rate for dialysis*
15 *services furnished in such year in the same man-*
16 *ner that the composite rate for such services for*
17 *2004 was increased under subparagraph (A);*
18 *and*

19 “(ii) *increase the percentage increase under*
20 *subparagraph (C) or (D) (as applicable) for*
21 *years after the year described in clause (i) to en-*
22 *sure that such increased percentage would result*
23 *in expenditures equal to the sum of the total*
24 *composite rate payments for such services for*
25 *such years and the total payments for drugs and*

1 *biologicals described in subparagraph (A)(i)(II)*
 2 *is equal to the sum of the total amount of the*
 3 *composite rate payments under this paragraph*
 4 *for such years and the payments for the drugs*
 5 *and biologicals described in subparagraph*
 6 *(A)(i)(II) that would have been made if the re-*
 7 *duction in payment amount described in sub-*
 8 *paragraph had not been made.*

9 “(F) *There shall be no administrative or judicial re-*
 10 *view under section 1869, section 1878, or otherwise, of de-*
 11 *terminations of payment amounts, methods, or adjustments*
 12 *under this paragraph.”.*

13 (6) *HOME INFUSION DRUGS.—Section 1842(o)*
 14 *(42 U.S.C. 1395u(o)), as amended by subsection*
 15 *(a)(2) and paragraph (4), is amended by adding at*
 16 *the end the following new paragraph:*

17 “(7)(A) *Subject to subparagraph (B), in the case of*
 18 *infusion drugs and biologicals furnished through an item*
 19 *of durable medical equipment covered under section 1861(n)*
 20 *on or after January 1, 2004, the Secretary may make sepa-*
 21 *rate payments for furnishing such drugs and biologicals in*
 22 *an amount determined by the Secretary if the Secretary de-*
 23 *termines such separate payment to be appropriate.*

24 “(B) *In determining the amount of any separate pay-*
 25 *ment under subparagraph (A) for a year, the Secretary*

1 *shall ensure that the total amount of payments under this*
 2 *part for such infusion drugs and biologicals for the year*
 3 *and such separate payments for the year does not exceed*
 4 *the total amount of payments that would have been made*
 5 *under this part for the year for such infusion drugs and*
 6 *biologicals if section 433 of the Prescription Drug and*
 7 *Medicare Improvement Act of 2003 had not been enacted.”.*

8 (7) *INHALATION DRUGS.*—Section 1842(o) (42
 9 U.S.C. 1395u(o)), as amended by subsection (a)(2)
 10 and paragraphs (4) and (6), is amended by adding
 11 at the end the following new paragraph:

12 “(8)(A) Subject to subparagraph (B), in the case of
 13 inhalation drugs and biologicals furnished through durable
 14 medical equipment covered under section 1861(n) on or
 15 after January 1, 2004, the Secretary may increase pay-
 16 ments for such equipment under section 1834(a) and may
 17 make separate payments for furnishing such drugs and
 18 biologicals if the Secretary determines such increased or
 19 separate payments are necessary to appropriately furnish
 20 such equipment and drugs and biologicals to beneficiaries.

21 “(B) The total amount of any increased payments and
 22 separate payments under subparagraph (A) for a year may
 23 not exceed an amount equal to 10 percent of the amount
 24 (as estimated by the Secretary) by which—

1 “(i) the total amount of payments that would
 2 have been made for such drugs and biologicals for the
 3 year if section 433 of the Prescription Drug and
 4 Medicare Improvement Act of 2003 had not been en-
 5 acted; exceeds

6 “(ii) the total amount of payments for such
 7 drugs and biologicals under paragraphs (4) and (5).”.

8 (8) *PHARMACY DISPENSING FEE FOR CERTAIN*
 9 *DRUGS AND BIOLOGICALS.*—Section 1842(o)(2) (42
 10 U.S.C. 1395u(o)(2)) is amended to read as follows:

11 “(2) If payment for a drug or biological is made to
 12 a licensed pharmacy approved to dispense drugs or
 13 biologicals under this part, the Secretary—

14 “(A) in the case of an immunosuppressive drug
 15 described in subparagraph (J) of section 1861(s)(2)
 16 and an oral drug described in subparagraph (Q) or
 17 (T) of such section, shall pay a dispensing fee deter-
 18 mined appropriate by the Secretary (less the applica-
 19 ble deductible and coinsurance amounts) to the phar-
 20 macy; and

21 “(B) in the case of a drug or biological not de-
 22 scribed in subparagraph (A), may pay a dispensing
 23 fee determined appropriate by the Secretary (less the
 24 applicable deductible and coinsurance amounts) to the
 25 pharmacy.”.

1 (9) *PAYMENT FOR CHEMOTHERAPY DRUGS PUR-*
 2 *CHASED BUT NOT ADMINISTERED BY PHYSICIANS.—*
 3 *Section 1842(o) (42 U.S.C. 1395u(o)), as amended by*
 4 *subsection (a)(2) and paragraphs (4), (6) and (7), is*
 5 *amended by adding at the end the following new*
 6 *paragraph:*

7 “(9)(A) *Subject to subparagraph (B), the Sec-*
 8 *retary may increase (in an amount determined ap-*
 9 *propriate) the amount of payments to physicians for*
 10 *anticancer chemotherapeutic drugs or biologicals that*
 11 *would otherwise be made under this part in order to*
 12 *compensate such physicians for anticancer*
 13 *chemotherapeutic drugs or biologicals that are pur-*
 14 *chased by physicians with a reasonable intent to ad-*
 15 *minister to an individual enrolled under this part but*
 16 *which cannot be administered to such individual de-*
 17 *spite the reasonable efforts of the physician.*

18 (B) *The total amount of increased payments*
 19 *made under subparagraph (A) in a year (as esti-*
 20 *mated by the Secretary) may not exceed an amount*
 21 *equal to 1 percent of the total amount of payments*
 22 *made under paragraphs (4) and (5) for such*
 23 *anticancer chemotherapeutic drugs or biologicals fur-*
 24 *nished by physicians in such year (as estimated by*
 25 *the Secretary).”.*

1 (c) *LINKAGE OF REVISED DRUG PAYMENTS AND IN-*
 2 *CREASES FOR DRUG ADMINISTRATION.*—*The Secretary*
 3 *shall not implement the revisions in payment amounts for*
 4 *a category of drug or biological as a result of the amend-*
 5 *ments made by subsection (a) unless the Secretary concur-*
 6 *rently implements the adjustments to payment amounts for*
 7 *administration of such category of drug or biological for*
 8 *which the Secretary is required to make an adjustment, as*
 9 *specified in the amendments made by, and provisions of,*
 10 *subsection (b).*

11 (d) *PROHIBITION OF ADMINISTRATIVE AND JUDICIAL*
 12 *REVIEW.*—

13 (1) *DRUGS.*—*Section 1842(o) (42 U.S.C.*
 14 *1395u(o)), as amended by subsection (a)(2) and para-*
 15 *graphs (4), (6), (7), and (9) of subsection (b), is*
 16 *amended by adding at the end the following new*
 17 *paragraph:*

18 “(10) *There shall be no administrative or judicial re-*
 19 *view under section 1869, section 1878, or otherwise, of de-*
 20 *terminations of payment amounts, methods, or adjustments*
 21 *under paragraph (2) or paragraphs (4) through (9).”.*

22 (2) *PHYSICIAN FEE SCHEDULE.*—*Section*
 23 *1848(i)(1) (42 U.S.C. 1395w-4(i)(1)) is amended—*
 24 (A) *in subparagraph (D), by striking “and”*
 25 *at the end;*

(B) in subparagraph (E), by striking the period at the end and inserting “, and”; and

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

“(F) adjustments in practice expense relative value units under subsection (c)(2)(H).”.

(3) *MULTIPLE CHEMOTHERAPY AGENTS AND OTHER SERVICES CURRENTLY ON THE NON-PHYSICIAN WORK POOL.*—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations of payment amounts, methods, or adjustments under paragraphs (2) and (3) of subsection (b).

(e) *STUDIES AND REPORTS.*—

(1) *GAO STUDY AND REPORT ON BENEFICIARY ACCESS TO DRUGS AND BIOLOGICALS.*—

(A) *STUDY.*—The Comptroller General of the United States shall conduct a study that examines the impact the provisions of, and the amendments made by, this section have on access by medicare beneficiaries to drugs and biologicals covered under the medicare program.

(B) *REPORT.*—Not later than January 1, 2006, the Comptroller General shall submit a report to Congress on the study conducted under

1 subparagraph (A) together with such rec-
 2 ommendations as the Comptroller General deter-
 3 mines to be appropriate.

4 (2) *STUDY AND REPORT BY THE HHS INSPECTOR*
 5 *GENERAL ON MARKET PRICES OF DRUGS AND*
 6 *BIOLOGICALS.—*

7 (A) *STUDY.—The Inspector General of the*
 8 *Department of Health and Human Services shall*
 9 *conduct 1 or more studies that—*

10 (i) *examine the market prices that*
 11 *drugs and biologicals covered under the*
 12 *medicare program are widely available to*
 13 *physicians and suppliers; and*

14 (ii) *compare such widely available*
 15 *market prices to the payment amount for*
 16 *such drugs and biologicals under section*
 17 *1842(o) of the Social Security Act (42*
 18 *U.S.C. 1395u(o).*

19 (B) *REQUIREMENT.—In conducting the*
 20 *study under subparagraph (A), the Inspector*
 21 *General shall focus on those drugs and*
 22 *biologicals that represent the largest portions of*
 23 *expenditures under the medicare program for*
 24 *drugs and biologicals.*

1 (C) *REPORT.*—*The Inspector General shall*
 2 *prepare a report on any study conducted under*
 3 *subparagraph (A).*

4 **SEC. 434. INDEXING PART B DEDUCTIBLE TO INFLATION.**

5 *The first sentence of section 1833(b) (42 U.S.C.*
 6 *1395l(b)) is amended by striking “and \$100 for 1991 and*
 7 *subsequent years” and inserting the following: “, \$100 for*
 8 *1991 through 2005, \$125 for 2006, and for 2007 and there-*
 9 *after, the amount in effect for the previous year, increase*
 10 *by the percentage increase in the consumer price index for*
 11 *all urban consumers (U.S. city average) for the 12-month*
 12 *period ending with June of the previous year, rounded to*
 13 *the nearest dollar”.*

14 **SEC. 435. REVISIONS TO REASSIGNMENT PROVISIONS.**

15 (a) *IN GENERAL.*—*Section 1842(b)(6)(A)(ii) (42*
 16 *U.S.C. 1395u(b)(6)(A)(ii)) is amended to read as follows:*
 17 *“(ii) where the service was provided under a contractual*
 18 *arrangement between such physician or other person and*
 19 *an entity (as defined by the Secretary), to the entity if*
 20 *under such arrangement such entity submits the bill for*
 21 *such service and such arrangement meets such program in-*
 22 *tegrity and other safeguards as the Secretary may deter-*
 23 *mine to be appropriate,”.*

24 (b) *CONFORMING AMENDMENT.*—*The second sentence*
 25 *of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended*

1 by striking “except to an employer or facility as described
 2 in clause (A)” and inserting “except to an employer or enti-
 3 ty as described in subparagraph (A)”.

4 (c) *EFFECTIVE DATE.*—The amendments made by this
 5 section shall apply to payments made on or after the date
 6 that is 30 days after the Secretary publishes a final rule
 7 with respect to the amendments made by this section.

8 **SEC. 436. EXTENSION OF TREATMENT OF CERTAIN PHYSI-**
 9 **CIAN PATHOLOGY SERVICES UNDER MEDI-**
 10 **CARE.**

11 Section 542(c) of BIPA (114 Stat. 2763A–551) is
 12 amended by inserting “, and for services furnished during
 13 2005” before the period at the end.

14 **SEC. 437. TREATMENT OF PASS-THROUGH DRUGS AND THE**
 15 **PROSPECTIVE PAYMENT SYSTEM FOR HOS-**
 16 **PITAL OUTPATIENT DEPARTMENT SERVICES.**

17 (a) *EXEMPTION FROM AWP MODIFICATIONS FOR OPD*
 18 *PASS-THROUGH DRUGS AND BIOLOGICALS.*—For purposes
 19 of applying section 1833(t)(6)(D)(i) of the Social Security
 20 Act (42 U.S.C. 1395l(t)(6)(D)(i)) for 2004, the Secretary
 21 of Health and Human Services shall treat the amount that
 22 would have been determined under section 1842(o) of such
 23 Act (42 U.S.C. 1395u(o)) for 2005 as if the amendments
 24 made by section 423 of the Prescription Drug and Medicare
 25 Improvement Act of 2003 had not been enacted.

1 **(b) GAO STUDY AND REPORT.—**

2 **(1) STUDY.—***The Comptroller General of the*
 3 *United States shall conduct a study of the appro-*
 4 *priateness of the payment amount included in pay-*
 5 *ments made to hospital outpatient departments under*
 6 *section 1833(t) of the Social Security Act (42 U.S.C.*
 7 *1395l(t)) for 2005 for drugs and biologicals for which*
 8 *payment is no longer made under the pass-through*
 9 *provision under section 1833(t)(6) of such Act (42*
 10 *U.S.C. 1395l(t)(6)). In conducting such study, the*
 11 *Comptroller General shall consider the appropriate-*
 12 *ness of payments for handling and acquisition made*
 13 *to hospital outpatient departments for such drugs and*
 14 *biologicals.*

15 **(2) REPORT.—***Not later than July 1, 2004, the*
 16 *Comptroller General shall submit to Congress a report*
 17 *on the study conducted under paragraph (1) together*
 18 *with such recommendations for legislation and ad-*
 19 *ministrative action as the Comptroller General deter-*
 20 *mines to be appropriate.*

21 **SEC. 438. LIMITATION OF APPLICATION OF FUNCTIONAL**
 22 **EQUIVALENCE STANDARD.**

23 *Section 1833(t)(6) (42 U.S.C. 1395l(t)(6)) is amended*
 24 *by adding at the end the following new subparagraph:*

1 “(F) *LIMITATION OF APPLICATION OF FUNC-*
 2 *TIONAL EQUIVALENCE STANDARD.*—

3 “(i) *IN GENERAL.*—*The Secretary may*
 4 *not publish regulations that apply a func-*
 5 *tional equivalence standard to a drug or bi-*
 6 *ological under this paragraph.*

7 “(ii) *APPLICATION.*—*Paragraph (1)*
 8 *shall apply to the application of a func-*
 9 *tional equivalence standard to a drug or bi-*
 10 *ological on or after the date of enactment of*
 11 *the Prescription Drug and Medicare Im-*
 12 *provement Act of 2003 unless such applica-*
 13 *tion was being made to such drug or bio-*
 14 *logical prior to such date of enactment.”.*

15 **SEC. 439. MEDICARE COVERAGE OF ROUTINE COSTS ASSO-**
 16 **CIATED WITH CERTAIN CLINICAL TRIALS.**

17 “(a) *IN GENERAL.*—*With respect to the coverage of rou-*
 18 *tine costs of care for beneficiaries participating in a quali-*
 19 *fying clinical trial, as set forth on the date of the enactment*
 20 *of this Act in National Coverage Determination 30-1 of the*
 21 *Medicare Coverage Issues Manual, the Secretary shall deem*
 22 *clinical trials conducted in accordance with an investiga-*
 23 *tional device exemption approved under section 520(g) of*
 24 *the Federal Food, Drug, and Cosmetic Act (42 U.S.C.*
 25 *360j(g)) to be automatically qualified for such coverage.*

1 (b) *RULE OF CONSTRUCTION.*—*Nothing in this section*
 2 *shall be construed as authorizing or requiring the Secretary*
 3 *to modify the regulations set forth on the date of the enact-*
 4 *ment of this Act at subpart B of part 405 of title 42, Code*
 5 *of Federal Regulations, or subpart A of part 411 of such*
 6 *title, relating to coverage of, and payment for, a medical*
 7 *device that is the subject of an investigational device exemp-*
 8 *tion by the Food and Drug Administration (except as may*
 9 *be necessary to implement subsection (a)).*

10 (c) *EFFECTIVE DATE.*—*This section shall apply to*
 11 *clinical trials begun before, on, or after January 1, 2005.*

12 **SEC. 440. WAIVER OF PART B LATE ENROLLMENT PENALTY**
 13 **FOR CERTAIN MILITARY RETIREES; SPECIAL**
 14 **ENROLLMENT PERIOD.**

15 (a) *WAIVER OF PENALTY.*—

16 (1) *IN GENERAL.*—*Section 1839(b) (42 U.S.C.*
 17 *1395r(b)) is amended by adding at the end the fol-*
 18 *lowing new sentence: “No increase in the premium*
 19 *shall be effected for a month in the case of an indi-*
 20 *vidual who is 65 years of age or older, who enrolls*
 21 *under this part during 2002, 2003, 2004, or 2005 and*
 22 *who demonstrates to the Secretary before December*
 23 *31, 2005, that the individual is a covered beneficiary*
 24 *(as defined in section 1072(5) of title 10, United*
 25 *States Code). The Secretary shall consult with the*

1 *Secretary of Defense in identifying individuals de-*
 2 *scribed in the previous sentence.”.*

3 (2) *EFFECTIVE DATE.*—*The amendment made by*
 4 *paragraph (1) shall apply to premiums for months*
 5 *beginning with January 2005. The Secretary shall es-*
 6 *tablish a method for providing rebates of premium*
 7 *penalties paid for months on or after January 2005*
 8 *for which a penalty does not apply under such*
 9 *amendment but for which a penalty was previously*
 10 *collected.*

11 (b) *MEDICARE PART B SPECIAL ENROLLMENT PE-*
 12 *RIOD.*—

13 (1) *IN GENERAL.*—*In the case of any individual*
 14 *who, as of the date of enactment of this Act, is 65*
 15 *years of age or older, is eligible to enroll but is not*
 16 *enrolled under part B of title XVIII of the Social Se-*
 17 *curity Act, and is a covered beneficiary (as defined*
 18 *in section 1072(5) of title 10, United States Code), the*
 19 *Secretary shall provide for a special enrollment pe-*
 20 *riod during which the individual may enroll under*
 21 *such part. Such period shall begin 1 year after the*
 22 *date of the enactment of this Act and shall end on De-*
 23 *cember 31, 2005.*

24 (2) *COVERAGE PERIOD.*—*In the case of an indi-*
 25 *vidual who enrolls during the special enrollment pe-*

1 *riod provided under paragraph (1), the coverage pe-*
 2 *riod under part B of title XVIII of the Social Secu-*
 3 *rity Act shall begin on the first day of the month fol-*
 4 *lowing the month in which the individual enrolls.*

5 **SEC. 441. DEMONSTRATION OF COVERAGE OF CHIRO-**
 6 **PRACTIC SERVICES UNDER MEDICARE.**

7 (a) *DEFINITIONS.—In this section:*

8 (1) *CHIROPRACTIC SERVICES.—The term “chiro-*
 9 *practic services” has the meaning given that term by*
 10 *the Secretary for purposes of the demonstration*
 11 *projects, but shall include, at a minimum—*

12 (A) *care for neuromusculoskeletal conditions*
 13 *typical among eligible beneficiaries; and*

14 (B) *diagnostic and other services that a chi-*
 15 *ropractor is legally authorized to perform by the*
 16 *State or jurisdiction in which such treatment is*
 17 *provided.*

18 (2) *DEMONSTRATION PROJECT.—The term “dem-*
 19 *onstration project” means a demonstration project es-*
 20 *tablished by the Secretary under subsection (b)(1).*

21 (3) *ELIGIBLE BENEFICIARY.—The term “eligible*
 22 *beneficiary” means an individual who is enrolled*
 23 *under part B of the medicare program.*

24 (4) *MEDICARE PROGRAM.—The term “medicare*
 25 *program” means the health benefits program under*

1 *title XVIII of the Social Security Act (42 U.S.C. 1395*
 2 *et seq.).*

3 *(b) DEMONSTRATION OF COVERAGE OF CHIROPRACTIC*
 4 *SERVICES UNDER MEDICARE.—*

5 *(1) ESTABLISHMENT.—The Secretary shall estab-*
 6 *lish demonstration projects in accordance with the*
 7 *provisions of this section for the purpose of evaluating*
 8 *the feasibility and advisability of covering chiro-*
 9 *practic services under the medicare program (in addi-*
 10 *tion to the coverage provided for services consisting of*
 11 *treatment by means of manual manipulation of the*
 12 *spine to correct a subluxation described in section*
 13 *1861(r)(5) of the Social Security Act (42 U.S.C.*
 14 *1395x(r)(5))).*

15 *(2) NO PHYSICIAN APPROVAL REQUIRED.—In es-*
 16 *tablishing the demonstration projects, the Secretary*
 17 *shall ensure that an eligible beneficiary who partici-*
 18 *pates in a demonstration project, including an eligi-*
 19 *ble beneficiary who is enrolled for coverage under a*
 20 *Medicare+Choice plan (or, on and after January 1,*
 21 *2006, under a MedicareAdvantage plan), is not re-*
 22 *quired to receive approval from a physician or other*
 23 *health care provider in order to receive a chiropractic*
 24 *service under a demonstration project.*

1 (3) *CONSULTATION.*—*In establishing the dem-*
 2 *onstration projects, the Secretary shall consult with*
 3 *chiropractors, organizations representing chiroprac-*
 4 *tors, eligible beneficiaries, and organizations rep-*
 5 *resenting eligible beneficiaries.*

6 (4) *PARTICIPATION.*—*Any eligible beneficiary*
 7 *may participate in the demonstration projects on a*
 8 *voluntary basis.*

9 (c) *CONDUCT OF DEMONSTRATION PROJECTS.*—

10 (1) *DEMONSTRATION SITES.*—

11 (A) *SELECTION OF DEMONSTRATION*
 12 *SITES.*—*The Secretary shall conduct demonstra-*
 13 *tion projects at 6 demonstration sites.*

14 (B) *GEOGRAPHIC DIVERSITY.*—*Of the sites*
 15 *described in subparagraph (A)—*

16 (i) *3 shall be in rural areas; and*

17 (ii) *3 shall be in urban areas.*

18 (C) *SITES LOCATED IN HPSAS.*—*At least 1*
 19 *site described in clause (i) of subparagraph (B)*
 20 *and at least 1 site described in clause (ii) of such*
 21 *subparagraph shall be located in an area that is*
 22 *designated under section 332(a)(1)(A) of the*
 23 *Public Health Service Act (42 U.S.C.*
 24 *254e(a)(1)(A)) as a health professional shortage*
 25 *area.*

1 (2) *IMPLEMENTATION; DURATION.*—

2 (A) *IMPLEMENTATION.*—*The Secretary shall*
3 *not implement the demonstration projects before*
4 *October 1, 2004.*

5 (B) *DURATION.*—*The Secretary shall com-*
6 *plete the demonstration projects by the date that*
7 *is 3 years after the date on which the first dem-*
8 *onstration project is implemented.*

9 (d) *EVALUATION AND REPORT.*—

10 (1) *EVALUATION.*—*The Secretary shall conduct*
11 *an evaluation of the demonstration projects—*

12 (A) *to determine whether eligible bene-*
13 *ficiaries who use chiropractic services use a less-*
14 *er overall amount of items and services for which*
15 *payment is made under the medicare program*
16 *than eligible beneficiaries who do not use such*
17 *services;*

18 (B) *to determine the cost of providing pay-*
19 *ment for chiropractic services under the medicare*
20 *program;*

21 (C) *to determine the satisfaction of eligible*
22 *beneficiaries participating in the demonstration*
23 *projects and the quality of care received by such*
24 *beneficiaries; and*

1 (D) to evaluate such other matters as the
2 Secretary determines is appropriate.

3 (2) *REPORT.*—Not later than the date that is 1
4 year after the date on which the demonstration
5 projects conclude, the Secretary shall submit to Con-
6 gress a report on the evaluation conducted under
7 paragraph (1) together with such recommendations
8 for legislation or administrative action as the Sec-
9 retary determines is appropriate.

10 (e) *WAIVER OF MEDICARE REQUIREMENTS.*—The Sec-
11 retary shall waive compliance with such requirements of the
12 medicare program to the extent and for the period the Sec-
13 retary finds necessary to conduct the demonstration
14 projects.

15 (f) *FUNDING.*—

16 (1) *DEMONSTRATION PROJECTS.*—

17 (A) *IN GENERAL.*—Subject to subparagraph
18 (B) and paragraph (2), the Secretary shall pro-
19 vide for the transfer from the Federal Supple-
20 mentary Insurance Trust Fund under section
21 1841 of the Social Security Act (42 U.S.C.
22 1395t) of such funds as are necessary for the
23 costs of carrying out the demonstration projects
24 under this section.

(B) *LIMITATION.*—*In conducting the demonstration projects under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under the medicare program do not exceed the amount which the Secretary would have paid under the medicare program if the demonstration projects under this section were not implemented.*

(2) *EVALUATION AND REPORT.*—*There are authorized to be appropriated such sums as are necessary for the purpose of developing and submitting the report to Congress under subsection (d).*

SEC. 442. MEDICARE HEALTH CARE QUALITY DEMONSTRATION PROGRAMS.

Title XVIII (42 U.S.C. 1395 et seq.) is amended by inserting after section 1866B the following new section:

“HEALTH CARE QUALITY DEMONSTRATION PROGRAM

“SEC. 1866C. (a) DEFINITIONS.—In this section:

“(1) BENEFICIARY.—The term ‘beneficiary’ means a beneficiary who is enrolled in the original medicare fee-for-service program under parts A and B or a beneficiary in a staff model or dedicated group model health maintenance organization under the Medicare+Choice program (or, on and after January 1, 2006, under the MedicareAdvantage program) under part C.

1 “(2) *HEALTH CARE GROUP.*—

2 “(A) *IN GENERAL.*—*The term ‘health care*
3 *group’ means—*

4 “(i) *a group of physicians that is orga-*
5 *nized at least in part for the purpose of*
6 *providing physician’s services under this*
7 *title;*

8 “(ii) *an integrated health care delivery*
9 *system that delivers care through coordi-*
10 *nated hospitals, clinics, home health agen-*
11 *cies, ambulatory surgery centers, skilled*
12 *nursing facilities, rehabilitation facilities*
13 *and clinics, and employed, independent, or*
14 *contracted physicians; or*

15 “(iii) *an organization representing re-*
16 *gional coalitions of groups or systems de-*
17 *scribed in clause (i) or (ii).*

18 “(B) *INCLUSION.*—*As the Secretary deter-*
19 *mines appropriate, a health care group may in-*
20 *clude a hospital or any other individual or enti-*
21 *ty furnishing items or services for which pay-*
22 *ment may be made under this title that is affili-*
23 *ated with the health care group under an ar-*
24 *rangement structured so that such hospital, indi-*

1 *vidual, or entity participates in a demonstration*
2 *project under this section.*

3 “(3) *PHYSICIAN.*—*Except as otherwise provided*
4 *for by the Secretary, the term ‘physician’ means any*
5 *individual who furnishes services that may be paid*
6 *for as physicians’ services under this title.*

7 “(b) *DEMONSTRATION PROJECTS.*—*The Secretary*
8 *shall establish a 5-year demonstration program under*
9 *which the Secretary shall approve demonstration projects*
10 *that examine health delivery factors that encourage the de-*
11 *livery of improved quality in patient care, including—*

12 “(1) *the provision of incentives to improve the*
13 *safety of care provided to beneficiaries;*

14 “(2) *the appropriate use of best practice guide-*
15 *lines by providers and services by beneficiaries;*

16 “(3) *reduced scientific uncertainty in the deliv-*
17 *ery of care through the examination of variations in*
18 *the utilization and allocation of services, and out-*
19 *comes measurement and research;*

20 “(4) *encourage shared decision making between*
21 *providers and patients;*

22 “(5) *the provision of incentives for improving the*
23 *quality and safety of care and achieving the efficient*
24 *allocation of resources;*

1 “(6) the appropriate use of culturally and eth-
2 nically sensitive health care delivery; and

3 “(7) the financial effects on the health care mar-
4 ketplace of altering the incentives for care delivery
5 and changing the allocation of resources.

6 “(c) *ADMINISTRATION BY CONTRACT.*—

7 “(1) *IN GENERAL.*—*Except as otherwise provided*
8 *in this section, the Secretary may administer the*
9 *demonstration program established under this section*
10 *in a manner that is similar to the manner in which*
11 *the demonstration program established under section*
12 *1866A is administered in accordance with section*
13 *1866B.*

14 “(2) *ALTERNATIVE PAYMENT SYSTEMS.*—*A*
15 *health care group that receives assistance under this*
16 *section may, with respect to the demonstration project*
17 *to be carried out with such assistance, include pro-*
18 *posals for the use of alternative payment systems for*
19 *items and services provided to beneficiaries by the*
20 *group that are designed to—*

21 “(A) *encourage the delivery of high quality*
22 *care while accomplishing the objectives described*
23 *in subsection (b); and*

1 “(B) streamline documentation and report-
 2 ing requirements otherwise required under this
 3 title.

4 “(3) *BENEFITS*.—A health care group that re-
 5 ceives assistance under this section may, with respect
 6 to the demonstration project to be carried out with
 7 such assistance, include modifications to the package
 8 of benefits available under the traditional fee-for-serv-
 9 ice program under parts A and B or the package of
 10 benefits available through a staff model or a dedicated
 11 group model health maintenance organization under
 12 part C. The criteria employed under the demonstra-
 13 tion program under this section to evaluate outcomes
 14 and determine best practice guidelines and incentives
 15 shall not be used as a basis for the denial of medicare
 16 benefits under the demonstration program to patients
 17 against their wishes (or if the patient is incompetent,
 18 against the wishes of the patient’s surrogate) on the
 19 basis of the patient’s age or expected length of life or
 20 of the patient’s present or predicted disability, degree
 21 of medical dependency, or quality of life.

22 “(d) *ELIGIBILITY CRITERIA*.—To be eligible to receive
 23 assistance under this section, an entity shall—

24 “(1) be a health care group;

1 “(2) meet quality standards established by the
2 Secretary, including—

3 “(A) the implementation of continuous
4 quality improvement mechanisms that are aimed
5 at integrating community-based support services,
6 primary care, and referral care;

7 “(B) the implementation of activities to in-
8 crease the delivery of effective care to bene-
9 ficiaries;

10 “(C) encouraging patient participation in
11 preference-based decisions;

12 “(D) the implementation of activities to en-
13 courage the coordination and integration of med-
14 ical service delivery; and

15 “(E) the implementation of activities to
16 measure and document the financial impact on
17 the health care marketplace of altering the incen-
18 tives of health care delivery and changing the al-
19 location of resources; and

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

22 “(e) WAIVER AUTHORITY.—The Secretary may waive
23 such requirements of titles XI and XVIII as may be nec-
24 essary to carry out the purposes of the demonstration pro-
25 gram established under this section.

1 “(f) *BUDGET NEUTRALITY.*—*With respect to the 5-year*
 2 *period of the demonstration program under subsection (b),*
 3 *the aggregate expenditures under this title for such period*
 4 *shall not exceed the aggregate expenditures that would have*
 5 *been expended under this title if the program established*
 6 *under this section had not been implemented.*

7 “(g) *NOTICE REQUIREMENTS.*—*In the case of an indi-*
 8 *vidual that receives health care items or services under a*
 9 *demonstration program carried out under this section, the*
 10 *Secretary shall ensure that such individual is notified of*
 11 *any waivers of coverage or payment rules that are applica-*
 12 *ble to such individual under this title as a result of the*
 13 *participation of the individual in such program.*

14 “(h) *PARTICIPATION AND SUPPORT BY FEDERAL*
 15 *AGENCIES.*—*In carrying out the demonstration program*
 16 *under this section, the Secretary may direct—*

17 “(1) *the Director of the National Institutes of*
 18 *Health to expand the efforts of the Institutes to evalu-*
 19 *ate current medical technologies and improve the*
 20 *foundation for evidence-based practice;*

21 “(2) *the Administrator of the Agency for*
 22 *Healthcare Research and Quality to, where possible*
 23 *and appropriate, use the program under this section*
 24 *as a laboratory for the study of quality improvement*

1 *strategies and to evaluate, monitor, and disseminate*
 2 *information relevant to such program; and*

3 *“(3) the Administrator of the Centers for Medi-*
 4 *care & Medicaid Services and the Administrator of*
 5 *the Center for Medicare Choices to support linkages of*
 6 *relevant medicare data to registry information from*
 7 *participating health care groups for the beneficiary*
 8 *populations served by the participating groups, for*
 9 *analysis supporting the purposes of the demonstration*
 10 *program, consistent with the applicable provisions of*
 11 *the Health Insurance Portability and Accountability*
 12 *Act of 1996.*

13 *“(i) IMPLEMENTATION.—The Secretary shall not im-*
 14 *plement the demonstration program before October 1,*
 15 *2004.”.*

16 **SEC. 443. MEDICARE COMPLEX CLINICAL CARE MANAGE-**
 17 **MENT PAYMENT DEMONSTRATION.**

18 *(a) ESTABLISHMENT.—*

19 *(1) IN GENERAL.—The Secretary shall establish*
 20 *a demonstration program to make the medicare pro-*
 21 *gram more responsive to needs of eligible beneficiaries*
 22 *by promoting continuity of care, helping stabilize*
 23 *medical conditions, preventing or minimizing acute*
 24 *exacerbations of chronic conditions, and reducing ad-*

1 *verse health outcomes, such as adverse drug inter-*
2 *actions related to polypharmacy.*

3 (2) *SITES.*—*The Secretary shall designate 6 sites*
4 *at which to conduct the demonstration program under*
5 *this section, of which at least 3 shall be in an urban*
6 *area and at least 1 shall be in a rural area. One of*
7 *the sites shall be located in the State of Arkansas.*

8 (3) *DURATION.*—*The Secretary shall conduct the*
9 *demonstration program under this section for a 3-*
10 *year period.*

11 (4) *IMPLEMENTATION.*—*The Secretary shall not*
12 *implement the demonstration program before October*
13 *1, 2004.*

14 (b) *PARTICIPANTS.*—*Any eligible beneficiary who re-*
15 *sides in an area designated by the Secretary as a dem-*
16 *onstration site under subsection (a)(2) may participate in*
17 *the demonstration program under this section if such bene-*
18 *ficiary identifies a principal care physician who agrees to*
19 *manage the complex clinical care of the eligible beneficiary*
20 *under the demonstration program.*

21 (c) *PRINCIPAL CARE PHYSICIAN RESPONSIBILITIES.*—
22 *The Secretary shall enter into an agreement with each prin-*
23 *icipal care physician who agrees to manage the complex*
24 *clinical care of an eligible beneficiary under subsection (b)*
25 *under which the principal care physician shall—*

1 (1) serve as the primary contact of the eligible
2 beneficiary in accessing items and services for which
3 payment may be made under the medicare program;

4 (2) maintain medical information related to care
5 provided by other health care providers who provide
6 health care items and services to the eligible bene-
7 ficiary, including clinical reports, medication and
8 treatments prescribed by other physicians, hospital
9 and hospital outpatient services, skilled nursing home
10 care, home health care, and medical equipment serv-
11 ices;

12 (3) monitor and advocate for the continuity of
13 care of the eligible beneficiary and the use of evidence-
14 based guidelines;

15 (4) promote self-care and family caregiver in-
16 volvement where appropriate;

17 (5) have appropriate staffing arrangements to
18 conduct patient self-management and other care co-
19 ordination activities as specified by the Secretary;

20 (6) refer the eligible beneficiary to community
21 services organizations and coordinate the services of
22 such organizations with the care provided by health
23 care providers; and

24 (7) meet such other complex care management
25 requirements as the Secretary may specify.

1 (d) *COMPLEX CLINICAL CARE MANAGEMENT FEE.*—

2 (1) *PAYMENT.*—*Under an agreement entered into*
 3 *under subsection (c), the Secretary shall pay to each*
 4 *principal care physician, on behalf of each eligible*
 5 *beneficiary under the care of that physician, the com-*
 6 *plex clinical care management fee developed by the*
 7 *Secretary under paragraph (2).*

8 (2) *DEVELOPMENT OF FEE.*—*The Secretary shall*
 9 *develop a complex care management fee under this*
 10 *paragraph that is paid on a monthly basis and which*
 11 *shall be payment in full for all the functions per-*
 12 *formed by the principal care physician under the*
 13 *demonstration program, including any functions per-*
 14 *formed by other qualified practitioners acting on be-*
 15 *half of the physician, appropriate staff under the su-*
 16 *pervision of the physician, and any other person*
 17 *under a contract with the physician, including any*
 18 *person who conducts patient self-management and*
 19 *caregiver education under subsection (c)(4).*

20 (e) *FUNDING.*—

21 (1) *IN GENERAL.*—*The Secretary shall provide*
 22 *for the transfer from the Federal Supplementary In-*
 23 *surance Trust Fund established under section 1841 of*
 24 *the Social Security Act (42 U.S.C. 1395t) of such*

1 *funds as are necessary for the costs of carrying out*
 2 *the demonstration program under this section.*

3 (2) *BUDGET NEUTRALITY.*—*In conducting the*
 4 *demonstration program under this section, the Sec-*
 5 *retary shall ensure that the aggregate payments made*
 6 *by the Secretary do not exceed the amount which the*
 7 *Secretary would have paid if the demonstration pro-*
 8 *gram under this section was not implemented.*

9 (f) *WAIVER AUTHORITY.*—*The Secretary may waive*
 10 *such requirements of titles XI and XVIII of the Social Secu-*
 11 *rity Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be*
 12 *necessary for the purpose of carrying out the demonstration*
 13 *program under this section.*

14 (g) *REPORT.*—*Not later than 6 months after the com-*
 15 *pletion of the demonstration program under this section,*
 16 *the Secretary shall submit to Congress a report on such pro-*
 17 *gram, together with recommendations for such legislation*
 18 *and administrative action as the Secretary determines to*
 19 *be appropriate.*

20 (h) *DEFINITIONS.*—*In this section:*

21 (1) *ACTIVITY OF DAILY LIVING.*—*The term “ac-*
 22 *tivity of daily living” means eating, toiling, transfer-*
 23 *ring, bathing, dressing, and continence.*

24 (2) *CHRONIC CONDITION.*—*The term “chronic*
 25 *condition” means a biological, physical, or mental*

1 *condition that is likely to last a year or more, for*
 2 *which there is no known cure, for which there is a*
 3 *need for ongoing medical care, and which may affect*
 4 *an individual's ability to carry out activities of daily*
 5 *living or instrumental activities of daily living, or*
 6 *both.*

7 (3) *ELIGIBLE BENEFICIARY.*—*The term “eligible*
 8 *beneficiary” means any individual who—*

9 (A) *is enrolled for benefits under part B of*
 10 *the medicare program;*

11 (B) *has at least 4 complex medical condi-*
 12 *tions (one of which may be cognitive impair-*
 13 *ment); and*

14 (C) *has—*

15 (i) *an inability to self-manage their*
 16 *care; or*

17 (ii) *a functional limitation defined as*
 18 *an impairment in 1 or more activity of*
 19 *daily living or instrumental activity of*
 20 *daily living.*

21 (4) *INSTRUMENTAL ACTIVITY OF DAILY LIVING.*—

22 *The term “instrumental activity of daily living”*
 23 *means meal preparation, shopping, housekeeping,*
 24 *laundry, money management, telephone use, and*
 25 *transportation use.*

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

5 (6) *PRINCIPAL CARE PHYSICIAN.*—*The term*
 6 *“principal care physician” means the physician with*
 7 *primary responsibility for overall coordination of the*
 8 *care of an eligible beneficiary (as specified in a writ-*
 9 *ten plan of care) who may be a primary care physi-*
 10 *cian or a specialist.*

11 **SEC. 444. MEDICARE FEE-FOR-SERVICE CARE COORDINA-**
 12 **TION DEMONSTRATION PROGRAM.**

13 (a) *ESTABLISHMENT.*—

14 (1) *IN GENERAL.*—*The Secretary shall establish*
 15 *a demonstration program to contract with qualified*
 16 *care management organizations to provide health risk*
 17 *assessment and care management services to eligible*
 18 *beneficiaries who receive care under the original*
 19 *medicare fee-for-service program under parts A and B*
 20 *of title XVIII of the Social Security Act to eligible*
 21 *beneficiaries.*

22 (2) *SITES.*—*The Secretary shall designate 6 sites*
 23 *at which to conduct the demonstration program under*
 24 *this section. In selecting sites under this paragraph,*

1 *the Secretary shall give preference to sites located in*
2 *rural areas.*

3 (3) *DURATION.—The Secretary shall conduct the*
4 *demonstration program under this section for a 5-*
5 *year period.*

6 (4) *IMPLEMENTATION.—The Secretary shall not*
7 *implement the demonstration program before October*
8 *1, 2004.*

9 (b) *PARTICIPANTS.—Any eligible beneficiary who re-*
10 *sides in an area designated by the Secretary as a dem-*
11 *onstration site under subsection (a)(2) may participate in*
12 *the demonstration program under this section if such bene-*
13 *ficiary identifies a care management organization who*
14 *agrees to furnish care management services to the eligible*
15 *beneficiary under the demonstration program.*

16 (c) *CONTRACTS WITH CMOS.—*

17 (1) *IN GENERAL.—The Secretary shall enter into*
18 *a contract with care management organizations to*
19 *provide care management services to eligible bene-*
20 *ficiaries residing in the area served by the care man-*
21 *agement organization.*

22 (2) *CANCELLATION.—The Secretary may cancel*
23 *a contract entered into under paragraph (1) if the*
24 *care management organization does not meet nego-*

1 *tiated savings or quality outcomes targets for the*
 2 *year.*

3 (3) *NUMBER OF CMOS.*—*The Secretary may con-*
 4 *tract with more than 1 care management organiza-*
 5 *tion in a geographic area.*

6 (d) *PAYMENT TO CMOS.*—

7 (1) *PAYMENT.*—*Under an contract entered into*
 8 *under subsection (c), the Secretary shall pay care*
 9 *management organizations a fee for which the care*
 10 *management organization is partially at risk based*
 11 *on bids submitted by care management organizations.*

12 (2) *PORTION OF PAYMENT AT RISK.*—*The Sec-*
 13 *retary shall establish a benchmark for quality and*
 14 *cost against which the results of the care management*
 15 *organization are to be measured. The Secretary may*
 16 *not pay a care management organization the portion*
 17 *of the fee described in paragraph (1) that is at risk*
 18 *unless the Secretary determines that the care manage-*
 19 *ment organization has met the agreed upon savings*
 20 *and outcomes targets for the year.*

21 (e) *FUNDING.*—

22 (1) *IN GENERAL.*—*The Secretary shall provide*
 23 *for the transfer from the Federal Hospital Insurance*
 24 *Trust Fund under section 1817 of the Social Security*
 25 *Act (42 U.S.C. 1395i) and the Federal Supple-*

1 *mentary Insurance Trust Fund established under sec-*
 2 *tion 1841 of such Act (42 U.S.C. 1395t), in such pro-*
 3 *portion as the Secretary determines to be appropriate,*
 4 *of such funds as are necessary for the costs of car-*
 5 *rying out the demonstration program under this sec-*
 6 *tion.*

7 (2) *BUDGET NEUTRALITY.*—*In conducting the*
 8 *demonstration program under this section, the Sec-*
 9 *retary shall ensure that the aggregate payments made*
 10 *by the Secretary do not exceed the amount which the*
 11 *Secretary would have paid if the demonstration pro-*
 12 *gram under this section was not implemented.*

13 (f) *WAIVER AUTHORITY.*—

14 (1) *IN GENERAL.*—*The Secretary may waive*
 15 *such requirements of titles XI and XVIII of the Social*
 16 *Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as*
 17 *may be necessary for the purpose of carrying out the*
 18 *demonstration program under this section.*

19 (2) *WAIVER OF MEDIGAP PREEMPTIONS.*—*The*
 20 *Secretary shall waive any provision of section 1882*
 21 *of the Social Security Act that would prevent an in-*
 22 *surance carrier described in subsection (h)(3)(D) from*
 23 *participating in the demonstration program under*
 24 *this section.*

1 (g) *REPORT*.—Not later than 6 months after the com-
 2 pletion of the demonstration program under this section,
 3 the Secretary shall submit to Congress a report on such pro-
 4 gram, together with recommendations for such legislation
 5 and administrative action as the Secretary determines to
 6 be appropriate.

7 (h) *DEFINITIONS*.—In this section:

8 (1) *CARE MANAGEMENT SERVICES*.—The term
 9 “care management services” means services that are
 10 furnished to an eligible beneficiary (as defined in
 11 paragraph (2)) by a care management organization
 12 (as defined in paragraph (3)) in accordance with
 13 guidelines established by the Secretary that are con-
 14 sistent with guidelines established by the American
 15 Geriatrics Society.

16 (2) *ELIGIBLE BENEFICIARY*.—The term “eligible
 17 beneficiary” means an individual who is—

18 (A) entitled to (or enrolled for) benefits
 19 under part A and enrolled for benefits under
 20 part B of the Social Security Act (42 U.S.C.
 21 1395c et seq.; 1395j et seq.);

22 (B) not enrolled with a Medicare+Choice
 23 plan or a MedicareAdvantage plan under part
 24 C; and

(C) *at high-risk (as defined by the Secretary, but including eligible beneficiaries with multiple sclerosis or another disabling chronic condition, eligible beneficiaries residing in a nursing home or at risk for nursing home placement, or eligible beneficiaries eligible for assistance under a State plan under title XIX).*

(3) *CARE MANAGEMENT ORGANIZATION.—The term “care management organization” means an organization that meets such qualifications as the Secretary may specify and includes any of the following:*

(A) *A physician group practice, hospital, home health agency, or hospice program.*

(B) *A disease management organization.*

(C) *A Medicare+Choice or MedicareAdvantage organization.*

(D) *Insurance carriers offering medicare supplemental policies under section 1882 of the Social Security Act (42 U.S.C. 1395ss).*

(E) *Such other entity as the Secretary determines to be appropriate.*

SEC. 445. GAO STUDY OF GEOGRAPHIC DIFFERENCES IN PAYMENTS FOR PHYSICIANS’ SERVICES.

(a) *STUDY.—The Comptroller General of the United States shall conduct a study of differences in payment*

1 *amounts under the physician fee schedule under section*
2 *1848 of the Social Security Act (42 U.S.C. 1395w-4) for*
3 *physicians' services in different geographic areas. Such*
4 *study shall include—*

5 *(1) an assessment of the validity of the geo-*
6 *graphic adjustment factors used for each component of*
7 *the fee schedule;*

8 *(2) an evaluation of the measures used for such*
9 *adjustment, including the frequency of revisions;*

10 *(3) an evaluation of the methods used to deter-*
11 *mine professional liability insurance costs used in*
12 *computing the malpractice component, including a*
13 *review of increases in professional liability insurance*
14 *premiums and variation in such increases by State*
15 *and physician specialty and methods used to update*
16 *the geographic cost of practice index and relative*
17 *weights for the malpractice component;*

18 *(4) an evaluation of whether there is a sound*
19 *economic basis for the implementation of the adjust-*
20 *ment under subparagraphs (E) and (F) of section*
21 *1848(e)(1) of the Social Security Act (42 U.S.C.*
22 *1395w-4(e)(1)), as added by section 421, in those*
23 *areas in which the adjustment applies;*

1 (5) *an evaluation of the effect of such adjustment*
2 *on physician location and retention in areas affected*
3 *by such adjustment, taking into account—*

4 (A) *differences in recruitment costs and re-*
5 *tention rates for physicians, including special-*
6 *ists, between large urban areas and other areas;*
7 *and*

8 (B) *the mobility of physicians, including*
9 *specialists, over the last decade; and*

10 (6) *an evaluation of appropriateness of extend-*
11 *ing such adjustment or making such adjustment per-*
12 *manent.*

13 (b) *REPORT.—Not later than 1 year after the date of*
14 *enactment of this Act, the Comptroller General of the United*
15 *States shall submit to Congress a report on the study con-*
16 *ducted under subsection (a). The report shall include rec-*
17 *ommendations regarding the use of more current data in*
18 *computing geographic cost of practice indices as well as the*
19 *use of data directly representative of physicians' costs (rath-*
20 *er than proxy measures of such costs).*

1 ***Subtitle C—Provisions Relating to***
 2 ***Parts A and B***

3 ***SEC. 451. INCREASE FOR HOME HEALTH SERVICES FUR-***
 4 ***NISHED IN A RURAL AREA.***

5 (a) *IN GENERAL.*—*In the case of home health services*
 6 *furnished in a rural area (as defined in section*
 7 *1886(d)(2)(D) of the Social Security Act (42 U.S.C.*
 8 *1395ww(d)(2)(D))) on or after October 1, 2004, and before*
 9 *October 1, 2006, the Secretary shall increase the payment*
 10 *amount otherwise made under section 1895 of such Act (42*
 11 *U.S.C. 1395fff) for such services by 5 percent.*

12 (b) *WAIVING BUDGET NEUTRALITY.*—*The Secretary*
 13 *shall not reduce the standard prospective payment amount*
 14 *(or amounts) under section 1895 of the Social Security Act*
 15 *(42 U.S.C. 1395fff) applicable to home health services fur-*
 16 *nished during a period to offset the increase in payments*
 17 *resulting from the application of subsection (a).*

18 (c) *NO EFFECT ON SUBSEQUENT PERIODS.*—*The pay-*
 19 *ment increase provided under subsection (a) for a period*
 20 *under such subsection—*

21 (1) *shall not apply to episodes and visits ending*
 22 *after such period; and*

23 (2) *shall not be taken into account in calculating*
 24 *the payment amounts applicable for episodes and vis-*
 25 *its occurring after such period.*

1 **SEC. 452. LIMITATION ON REDUCTION IN AREA WAGE AD-**
 2 **JUSTMENT FACTORS UNDER THE PROSPEC-**
 3 **TIVE PAYMENT SYSTEM FOR HOME HEALTH**
 4 **SERVICES.**

5 *Section 1895(b)(4)(C) (42 U.S.C. 1395fff(b)(4)(C)) is*
 6 *amended—*

7 *(1) by striking “FACTORS.—The Secretary” and*
 8 *inserting FACTORS.—*

9 *“(i) IN GENERAL.—Subject to clause*
 10 *(ii), the Secretary”; and*

11 *(2) by adding at the end the following new*
 12 *clause:*

13 *“(ii) LIMITATION ON REDUCTION IN*
 14 *FISCAL YEAR 2005 AND 2006.—For fiscal*
 15 *years 2005 and 2006, the area wage adjust-*
 16 *ment factor applicable to home health serv-*
 17 *ices furnished in an area in the fiscal year*
 18 *may not be more that 3 percent less than*
 19 *the area wage adjustment factor applicable*
 20 *to home health services for the area for the*
 21 *previous year.”.*

1 **SEC. 453. EXCEPTION TO PHYSICIAN REFERRAL LIMITA-**
 2 **TION FOR CERTAIN TRANSFERS FROM SPE-**
 3 **CIALTY HOSPITALS TO GENERAL HOSPITALS.**

4 (a) *EXCEPTIONS TO BOTH OWNERSHIP AND COM-*
 5 *PENSATION ARRANGEMENT PROHIBITIONS.*—Section
 6 1877(d) (42 U.S.C. 1395nn(d)) is amended—

7 (1) in paragraph (2), by inserting “and such in-
 8 dividuals would not otherwise have access to such
 9 services” before the period at the end;

10 (2) by striking paragraph (3) and inserting the
 11 following new paragraph:

12 “(3) *HOSPITAL OWNERSHIP.*—

13 “(A) *WHOLE HOSPITAL EXCEPTION.*—Sub-
 14 ject to subparagraph (B), in the case of des-
 15 ignated health services provided by a hospital
 16 (other than a hospital described in paragraph
 17 (1) or a hospital designated by the Secretary
 18 that is primarily or exclusively devoted to car-
 19 diac, orthopedic, surgical, or another specialty)
 20 if—

21 “(i) the referring physician is author-
 22 ized to perform services at the hospital; and

23 “(ii) the ownership or investment in-
 24 terest is in the hospital itself (and not mere-
 25 ly in a subdivision of the hospital).

1 “(B) *INAPPLICABILITY OF EXCEPTION TO*
 2 *SPECIALTY HOSPITALS.*—*The Secretary shall*
 3 *promulgate a regulation establishing guidelines*
 4 *for the designation of hospitals under subpara-*
 5 *graph (A) that permit a physician to have a fi-*
 6 *nancial relationship with a hospital, but such*
 7 *regulation shall only apply to such a hospital*
 8 *if—*

9 “(i) *the comprehensive spectrum of in-*
 10 *patient and outpatient services are provided*
 11 *by the hospital; and*

12 “(ii) *the specialty and self-referrals of*
 13 *such a physician are insignificant in rela-*
 14 *tion to the overall scope of services provided*
 15 *by the hospital.”.*

16 (b) *EFFECTIVE DATE.*—*The amendments made by sub-*
 17 *section (a) apply to transfers occurring on or after January*
 18 *1, 2004, except in such circumstances as the Secretary de-*
 19 *termines that such hospital was substantially completed be-*
 20 *fore June 12, 2003.*

21 **SEC. 454. DEMONSTRATION PROGRAM FOR SUBSTITUTE**
 22 **ADULT DAY SERVICES.**

23 (a) *ESTABLISHMENT.*—*The Secretary shall establish a*
 24 *demonstration program (in this section referred to as the*
 25 *“demonstration program”) under which the Secretary pro-*

1 *vides eligible medicare beneficiaries with coverage under the*
 2 *medicare program of substitute adult day services furnished*
 3 *by an adult day services facility.*

4 (b) *PAYMENT RATE FOR SUBSTITUTE ADULT DAY*
 5 *SERVICES.—*

6 (1) *PAYMENT RATE.—For purposes of making*
 7 *payments to an adult day services facility for sub-*
 8 *stitute adult day services under the demonstration*
 9 *program, the following rules shall apply:*

10 (A) *ESTIMATION OF PAYMENT AMOUNT.—*

11 *The Secretary shall estimate the amount that*
 12 *would otherwise be payable to a home health*
 13 *agency under section 1895 of the Social Security*
 14 *Act (42 U.S.C. 1395fff) for all home health serv-*
 15 *ices described in subsection (i)(4)(B)(i) under the*
 16 *plan of care.*

17 (B) *AMOUNT OF PAYMENT.—Subject to*
 18 *paragraph (3)(B), the total amount payable for*
 19 *substitute adult day services under the plan of*
 20 *care is equal to 95 percent of the amount esti-*
 21 *mated to be payable under subparagraph (A).*

22 (2) *LIMITATION ON BALANCE BILLING.—Under*
 23 *the demonstration program, an adult day services fa-*
 24 *cility shall accept as payment in full for substitute*
 25 *adult day services (including those services described*

1 *in clauses (ii) through (iv) of subsection (i)(4)(B))*
 2 *furnished by the facility to an eligible medicare bene-*
 3 *ficiary the amount of payment provided under the*
 4 *demonstration program for home health services con-*
 5 *sisting of substitute adult services.*

6 (3) *ADJUSTMENT IN CASE OF OVERUTILIZATION*
 7 *OF SUBSTITUTE ADULT DAY SERVICES TO ENSURE*
 8 *BUDGET NEUTRALITY.—The Secretary shall monitor*
 9 *the expenditures under the demonstration program*
 10 *and under title XVIII of the Social Security Act for*
 11 *home health services. If the Secretary estimates that*
 12 *the total expenditures under the demonstration pro-*
 13 *gram and under such title XVIII for home health*
 14 *services for a period determined by the Secretary ex-*
 15 *ceed expenditures that would have been made under*
 16 *such title XVIII for home health services for such pe-*
 17 *riod if the demonstration program had not been con-*
 18 *ducted, the Secretary shall adjust the rate of payment*
 19 *to adult day services facilities under paragraph*
 20 *(1)(B) in order to eliminate such excess.*

21 (c) *DEMONSTRATION PROGRAM SITES.—The dem-*
 22 *onstration program shall be conducted in not more than*
 23 *3 sites selected by the Secretary.*

24 (d) *DURATION; IMPLEMENTATION.—*

1 (1) *DURATION.*—*The Secretary shall conduct the*
 2 *demonstration program for a period of 3 years.*

3 (2) *IMPLEMENTATION.*—*The Secretary may not*
 4 *implement the demonstration program before October*
 5 *1, 2004.*

6 (e) *VOLUNTARY PARTICIPATION.*—*Participation of eli-*
 7 *gible medicare beneficiaries in the demonstration program*
 8 *shall be voluntary.*

9 (f) *WAIVER AUTHORITY.*—

10 (1) *IN GENERAL.*—*Except as provided in para-*
 11 *graph (2), the Secretary may waive such require-*
 12 *ments of titles XI and XVIII of the Social Security*
 13 *Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be*
 14 *necessary for the purposes of carrying out the dem-*
 15 *onstration program.*

16 (2) *MAY NOT WAIVE ELIGIBILITY REQUIREMENTS*
 17 *FOR HOME HEALTH SERVICES.*—*The Secretary may*
 18 *not waive the beneficiary eligibility requirements for*
 19 *home health services under title XVIII of the Social*
 20 *Security Act.*

21 (g) *EVALUATION AND REPORT.*—

22 (1) *EVALUATION.*—*The Secretary shall conduct*
 23 *an evaluation of the clinical and cost effectiveness of*
 24 *the demonstration program.*

1 (2) *REPORT.*—Not later than 30 months after the
 2 commencement of the demonstration program, the
 3 Secretary shall submit to Congress a report on the
 4 evaluation conducted under paragraph (1) and shall
 5 include in the report the following:

6 (A) *An analysis of the patient outcomes and*
 7 *costs of furnishing care to the eligible medicare*
 8 *beneficiaries participating in the demonstration*
 9 *program as compared to such outcomes and costs*
 10 *to such beneficiaries receiving only home health*
 11 *services under title XVIII of the Social Security*
 12 *Act for the same health conditions.*

13 (B) *Such recommendations regarding the*
 14 *extension, expansion, or termination of the pro-*
 15 *gram as the Secretary determines appropriate.*

16 (i) *DEFINITIONS.*—In this section:

17 (1) *ADULT DAY SERVICES FACILITY.*—

18 (A) *IN GENERAL.*—Except as provided in
 19 subparagraphs (B) and (C), the term “adult day
 20 services facility” means a public agency or pri-
 21 vate organization, or a subdivision of such an
 22 agency or organization, that—

23 (i) *is engaged in providing skilled*
 24 *nursing services and other therapeutic serv-*

ices directly or under arrangement with a
home health agency;

(ii) provides the items and services described in paragraph (4)(B); and

(iii) meets the requirements of paragraphs (2) through (8) of subsection (o).

(B) *INCLUSION.*—Notwithstanding subparagraph (A), the term “adult day services facility” shall include a home health agency in which the items and services described in clauses (ii) through (iv) of paragraph (4)(B) are provided—

(i) by an adult day services program that is licensed or certified by a State, or accredited, to furnish such items and services in the State; and

(ii) under arrangements with that program made by such agency.

(C) *WAIVER OF SURETY BOND.*—The Secretary may waive the requirement of a surety bond under section 1861(o)(7) of the Social Security Act (42 U.S.C. 1395x(o)(7)) in the case of an agency or organization that provides a comparable surety bond under State law.

(2) *ELIGIBLE MEDICARE BENEFICIARY.*—The term “eligible medicare beneficiary” means an indi-

vidual eligible for home health services under title XVIII of the Social Security Act.

(3) *HOME HEALTH AGENCY*.—The term “home health agency” has the meaning given such term in section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(4) *SUBSTITUTE ADULT DAY SERVICES*.—

(A) *IN GENERAL*.—The term “substitute adult day services” means the items and services described in subparagraph (B) that are furnished to an individual by an adult day services facility as a part of a plan under section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)) that substitutes such services for some or all of the items and services described in subparagraph (B)(i) furnished by a home health agency under the plan, as determined by the physician establishing the plan.

(B) *ITEMS AND SERVICES DESCRIBED*.—The items and services described in this subparagraph are the following items and services:

(i) Items and services described in paragraphs (1) through (7) of such section 1861(m).

(ii) Meals.

1 (iii) *A program of supervised activities*
2 *designed to promote physical and mental*
3 *health and furnished to the individual by*
4 *the adult day services facility in a group*
5 *setting for a period of not fewer than 4 and*
6 *not greater than 12 hours per day.*

7 (iv) *A medication management pro-*
8 *gram (as defined in subparagraph (C)).*

9 (C) *MEDICATION MANAGEMENT PROGRAM.—For*
10 *purposes of subparagraph (B)(iv), the term “medica-*
11 *tion management program” means a program of serv-*
12 *ices, including medicine screening and patient and*
13 *health care provider education programs, that pro-*
14 *vides services to minimize—*

15 (i) *unnecessary or inappropriate use of*
16 *prescription drugs; and*

17 (ii) *adverse events due to unintended*
18 *prescription drug-to-drug interactions.*

1 **TITLE V—MEDICARE APPEALS,**
 2 **REGULATORY, AND CON-**
 3 **TRACTING IMPROVEMENTS**
 4 **Subtitle A—Regulatory Reform**

5 **SEC. 501. RULES FOR THE PUBLICATION OF A FINAL REGU-**
 6 **LATION BASED ON THE PREVIOUS PUBLICA-**
 7 **TION OF AN INTERIM FINAL REGULATION.**

8 (a) *IN GENERAL.*—Section 1871(a) (42 U.S.C.
 9 1395hh(a)) is amended by adding at the end the following
 10 new paragraph:

11 “(3)(A) With respect to the publication of a final regu-
 12 lation based on the previous publication of an interim final
 13 regulation—

14 “(i) subject to subparagraph (B), the Secretary
 15 shall publish the final regulation within the 12-month
 16 period that begins on the date of publication of the
 17 interim final regulation;

18 “(ii) if a final regulation is not published by the
 19 deadline established under this paragraph, the in-
 20 terim final regulation shall not continue in effect un-
 21 less the Secretary publishes a notice described in sub-
 22 paragraph (B) by such deadline; and

23 “(iii) the final regulation shall include responses
 24 to comments submitted in response to the interim
 25 final regulation.

(c) *STATUS OF PENDING INTERIM FINAL REGULATIONS.*—Not later than 6 months after the date of enactment of this Act, the Secretary shall publish a notice in the Federal Register that provides the status of each interim final regulation that was published on or before the date of enactment of this Act and for which no final regulation has been published. Such notice shall include the date by which the Secretary plans to publish the final regulation that is based on the interim final regulation.

23 (a) *NO RETROACTIVE APPLICATION OF SUBSTANTIVE*
24 *CHANGES.*—

1 (1) *IN GENERAL.*—Section 1871 (42 U.S.C.
2 1395hh) is amended by adding at the end the fol-
3 lowing new subsection:

4 “(d)(1)(A) A substantive change in regulations, man-
5 ual instructions, interpretative rules, statements of policy,
6 or guidelines of general applicability under this title shall
7 not be applied (by extrapolation or otherwise) retroactively
8 to items and services furnished before the effective date of
9 the change, unless the Secretary determines that—

10 “(i) such retroactive application is necessary to
11 comply with statutory requirements; or

12 “(ii) failure to apply the change retroactively
13 would be contrary to the public interest.”.

14 (2) *EFFECTIVE DATE.*—The amendment made by
15 paragraph (1) shall apply to substantive changes
16 issued on or after the date of enactment of this Act.

17 (b) *TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE*
18 *CHANGES AFTER NOTICE.*—

19 (1) *IN GENERAL.*—Section 1871(d)(1), as added
20 by subsection (a), is amended by adding at the end
21 the following:

22 “(B) A compliance action may be made against a pro-
23 vider of services, physician, practitioner, or other supplier
24 with respect to noncompliance with such a substantive

1 *change only for items and services furnished on or after*
 2 *the effective date of the change.*

3 “(C)(i) *Except as provided in clause (ii), a substantive*
 4 *change may not take effect before the date that is the end*
 5 *of the 30-day period that begins on the date that the Sec-*
 6 *retary has issued or published, as the case may be, the sub-*
 7 *stantive change.*

8 “(ii) *The Secretary may provide for a substantive*
 9 *change to take effect on a date that precedes the end of the*
 10 *30-day period under clause (i) if the Secretary finds that*
 11 *waiver of such 30-day period is necessary to comply with*
 12 *statutory requirements or that the application of such 30-*
 13 *day period is contrary to the public interest. If the Sec-*
 14 *retary provides for an earlier effective date pursuant to this*
 15 *clause, the Secretary shall include in the issuance or publi-*
 16 *cation of the substantive change a finding described in the*
 17 *first sentence, and a brief statement of the reasons for such*
 18 *finding.”.*

19 (2) *EFFECTIVE DATE.—The amendment made by*
 20 *paragraph (1) shall apply to compliance actions un-*
 21 *dertaken on or after the date of enactment of this Act.*

1 **SEC. 503. REPORT ON LEGAL AND REGULATORY INCONSIST-**
2 **ENCIES.**

3 *Section 1871 (42 U.S.C. 1395hh), as amended by sec-*
4 *tion 502(a)(1), is amended by adding at the end the fol-*
5 *lowing new subsection:*

6 *“(e)(1) Not later than 2 years after the date of enact-*
7 *ment of this subsection, and every 3 years thereafter, the*
8 *Secretary shall submit to Congress a report with respect*
9 *to the administration of this title and areas of inconsistency*
10 *or conflict among the various provisions under law and reg-*
11 *ulation.*

12 *“(2) In preparing a report under paragraph (1), the*
13 *Secretary shall collect—*

14 *“(A) information from beneficiaries, providers of*
15 *services, physicians, practitioners, and other suppliers*
16 *with respect to such areas of inconsistency and con-*
17 *flict; and*

18 *“(B) information from medicare contractors that*
19 *tracks the nature of all communications and cor-*
20 *respondence.*

21 *“(3) A report under paragraph (1) shall include a de-*
22 *scription of efforts by the Secretary to reduce such inconsist-*
23 *ency or conflicts, and recommendations for legislation or*
24 *administrative action that the Secretary determines appro-*
25 *priate to further reduce such inconsistency or conflicts.”.*

1 ***Subtitle B—Appeals Process Reform***

2 ***SEC. 511. SUBMISSION OF PLAN FOR TRANSFER OF RE-***
 3 ***SPONSIBILITY FOR MEDICARE APPEALS.***

4 *(a) SUBMISSION OF TRANSITION PLAN.—*

5 *(1) IN GENERAL.—Not later than April 1, 2004,*
 6 *the Commissioner of Social Security and the Sec-*
 7 *retary shall develop and transmit to Congress and the*
 8 *Comptroller General of the United States a plan*
 9 *under which the functions of administrative law*
 10 *judges responsible for hearing cases under title XVIII*
 11 *of the Social Security Act (and related provisions in*
 12 *title XI of such Act) are transferred from the responsi-*
 13 *bility of the Commissioner and the Social Security*
 14 *Administration to the Secretary and the Department*
 15 *of Health and Human Services.*

16 *(2) CONTENTS.—The plan shall include informa-*
 17 *tion on the following:*

18 *(A) WORKLOAD.—The number of such ad-*
 19 *ministrative law judges and support staff re-*
 20 *quired now and in the future to hear and decide*
 21 *such cases in a timely manner, taking into ac-*
 22 *count the current and anticipated claims volume,*
 23 *appeals, number of beneficiaries, and statutory*
 24 *changes.*

1 (B) *COST PROJECTIONS AND FINANCING.*—
 2 *Funding levels required for fiscal year 2005 and*
 3 *subsequent fiscal years to carry out the functions*
 4 *transferred under the plan and how such transfer*
 5 *should be financed.*

6 (C) *TRANSITION TIMETABLE.*—*A timetable*
 7 *for the transition.*

8 (D) *REGULATIONS.*—*The establishment of*
 9 *specific regulations to govern the appeals process.*

10 (E) *CASE TRACKING.*—*The development of a*
 11 *unified case tracking system that will facilitate*
 12 *the maintenance and transfer of case specific*
 13 *data across both the fee-for-service and managed*
 14 *care components of the medicare program.*

15 (F) *FEASIBILITY OF PRECEDENTIAL AU-*
 16 *THORITY.*—*The feasibility of developing a proc-*
 17 *ess to give decisions of the Departmental Appeals*
 18 *Board in the Department of Health and Human*
 19 *Services addressing broad legal issues binding,*
 20 *precedential authority.*

21 (G) *ACCESS TO ADMINISTRATIVE LAW*
 22 *JUDGES.*—*The feasibility of—*

23 (i) *filing appeals with administrative*
 24 *law judges electronically; and*

1 (ii) conducting hearings using tele- or
2 video-conference technologies.

3 (H) INDEPENDENCE OF ADMINISTRATIVE
4 LAW JUDGES.—The steps that should be taken to
5 ensure the independence of administrative law
6 judges, including ensuring that such judges are
7 in an office that is functionally and operation-
8 ally separate from the Centers for Medicare &
9 Medicaid Services and the Center for Medicare
10 Choices.

11 (I) GEOGRAPHIC DISTRIBUTION.—The steps
12 that should be taken to provide for an appro-
13 priate geographic distribution of administrative
14 law judges throughout the United States to en-
15 sure timely access to such judges.

16 (J) HIRING.—The steps that should be taken
17 to hire administrative law judges (and support
18 staff).

19 (K) PERFORMANCE STANDARDS.—The es-
20 tablishment of performance standards for admin-
21 istrative law judges with respect to timelines for
22 decisions in cases under title XVIII of the Social
23 Security Act.

24 (L) SHARED RESOURCES.—The feasibility
25 of the Secretary entering into such arrangements

1 *with the Commissioner of Social Security as*
 2 *may be appropriate with respect to transferred*
 3 *functions under the plan to share office space,*
 4 *support staff, and other resources, with appro-*
 5 *priate reimbursement.*

6 (M) *TRAINING.*—*The training that should*
 7 *be provided to administrative law judges with*
 8 *respect to laws and regulations under title XVIII*
 9 *of the Social Security Act.*

10 (3) *ADDITIONAL INFORMATION.*—*The plan may*
 11 *also include recommendations for further congres-*
 12 *sional action, including modifications to the require-*
 13 *ments and deadlines established under section 1869 of*
 14 *the Social Security Act (as amended by sections 521*
 15 *and 522 of BIPA (114 Stat. 2763A–534) and this*
 16 *Act).*

17 (b) *GAO EVALUATION.*—*The Comptroller General of*
 18 *the United States shall—*

19 (1) *evaluate the plan submitted under subsection*
 20 (a); *and*

21 (2) *not later than 6 months after such submis-*
 22 *sion, submit to Congress, the Commissioner of Social*
 23 *Security, and the Secretary a report on such evalua-*
 24 *tion.*

1 (c) *SUBMISSION OF GAO REPORT REQUIRED BEFORE*
 2 *PLAN IMPLEMENTATION.*—*The Commissioner of Social Se-*
 3 *curity and the Secretary may not implement the plan devel-*
 4 *oped under subsection (a) before the date that is 6 months*
 5 *after the date the report required under subsection (b)(2)*
 6 *is submitted to the Commissioner and the Secretary.*

7 **SEC. 512. EXPEDITED ACCESS TO JUDICIAL REVIEW.**

8 (a) *IN GENERAL.*—*Section 1869(b) (42 U.S.C.*
 9 *1395ff(b)) is amended—*

10 (1) *in paragraph (1)(A), by inserting “, subject*
 11 *to paragraph (2),” before “to judicial review of the*
 12 *Secretary’s final decision”; and*

13 (2) *by adding at the end the following new para-*
 14 *graph:*

15 “(2) *EXPEDITED ACCESS TO JUDICIAL RE-*
 16 *VIEW.*—

17 “(A) *IN GENERAL.*—*The Secretary shall es-*
 18 *tablish a process under which a provider of serv-*
 19 *ices or supplier that furnishes an item or service*
 20 *or a beneficiary who has filed an appeal under*
 21 *paragraph (1) (other than an appeal filed under*
 22 *paragraph (1)(F)(i)) may obtain access to judi-*
 23 *cial review when a review entity (described in*
 24 *subparagraph (D)), on its own motion or at the*
 25 *request of the appellant, determines that the De-*

1 *partmental Appeals Board does not have the au-*
2 *thority to decide the question of law or regula-*
3 *tion relevant to the matters in controversy and*
4 *that there is no material issue of fact in dispute.*
5 *The appellant may make such request only once*
6 *with respect to a question of law or regulation*
7 *for a specific matter in dispute in a case of an*
8 *appeal.*

9 *“(B) PROMPT DETERMINATIONS.—If, after*
10 *or coincident with appropriately filing a request*
11 *for an administrative hearing, the appellant re-*
12 *quests a determination by the appropriate review*
13 *entity that the Departmental Appeals Board does*
14 *not have the authority to decide the question of*
15 *law or regulations relevant to the matters in con-*
16 *troversy and that there is no material issue of*
17 *fact in dispute, and if such request is accom-*
18 *panied by the documents and materials as the*
19 *appropriate review entity shall require for pur-*
20 *poses of making such determination, such review*
21 *entity shall make a determination on the request*
22 *in writing within 60 days after the date such re-*
23 *view entity receives the request and such accom-*
24 *panying documents and materials. Such a deter-*
25 *mination by such review entity shall be consid-*

1 *ered a final decision and not subject to review by*
 2 *the Secretary.*

3 “(C) *ACCESS TO JUDICIAL REVIEW.*—

4 “(i) *IN GENERAL.*—*If the appropriate*
 5 *review entity—*

6 “(I) *determines that there are no*
 7 *material issues of fact in dispute and*
 8 *that the only issues to be adjudicated*
 9 *are ones of law or regulation that the*
 10 *Departmental Appeals Board does not*
 11 *have authority to decide; or*

12 “(II) *fails to make such deter-*
 13 *mination within the period provided*
 14 *under subparagraph (B);*
 15 *then the appellant may bring a civil action*
 16 *as described in this subparagraph.*

17 “(ii) *DEADLINE FOR FILING.*—*Such*
 18 *action shall be filed, in the case described*
 19 *in—*

20 “(I) *clause (i)(I), within 60 days*
 21 *of the date of the determination de-*
 22 *scribed in such clause; or*

23 “(II) *clause (i)(II), within 60*
 24 *days of the end of the period provided*

1 under subparagraph (B) for the deter-
 2 mination.

3 “(iii) *VENUE*.—Such action shall be
 4 brought in the district court of the United
 5 States for the judicial district in which the
 6 appellant is located (or, in the case of an
 7 action brought jointly by more than 1 ap-
 8 plicant, the judicial district in which the
 9 greatest number of applicants are located)
 10 or in the District Court for the District of
 11 Columbia.

12 “(iv) *INTEREST ON ANY AMOUNTS IN*
 13 *CONTROVERSY*.—Where a provider of serv-
 14 ices or supplier is granted judicial review
 15 pursuant to this paragraph, the amount in
 16 controversy (if any) shall be subject to an-
 17 nual interest beginning on the first day of
 18 the first month beginning after the 60-day
 19 period as determined pursuant to clause (ii)
 20 and equal to the rate of interest on obliga-
 21 tions issued for purchase by the Federal
 22 Supplementary Medical Insurance Trust
 23 Fund for the month in which the civil ac-
 24 tion authorized under this paragraph is
 25 commenced, to be awarded by the reviewing

1 *court in favor of the prevailing party. No*
 2 *interest awarded pursuant to the preceding*
 3 *sentence shall be deemed income or cost for*
 4 *the purposes of determining reimbursement*
 5 *due providers of services, physicians, practi-*
 6 *tioners, and other suppliers under this Act.*

7 “(D) *REVIEW ENTITY DEFINED.*—*For pur-*
 8 *poses of this subsection, a ‘review entity’ is a*
 9 *panel of no more than 3 members from the De-*
 10 *partmental Appeals Board, selected for the pur-*
 11 *pose of making determinations under this para-*
 12 *graph.”.*

13 (b) *APPLICATION TO PROVIDER AGREEMENT DETER-*
 14 *MINATIONS.*—*Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1))*
 15 *is amended—*

16 (1) *by inserting “(A)” after “(h)(1)”;* and
 17 (2) *by adding at the end the following new sub-*
 18 *paragraph:*

19 “(B) *An institution or agency described in subpara-*
 20 *graph (A) that has filed for a hearing under subparagraph*
 21 *(A) shall have expedited access to judicial review under this*
 22 *subparagraph in the same manner as providers of services,*
 23 *suppliers, and beneficiaries may obtain expedited access to*
 24 *judicial review under the process established under section*
 25 *1869(b)(2). Nothing in this subparagraph shall be construed*

1 *to affect the application of any remedy imposed under sec-*
 2 *tion 1819 during the pendency of an appeal under this sub-*
 3 *paragraph.”.*

4 *(c) GAO STUDY AND REPORT ON ACCESS TO JUDICIAL*
 5 *REVIEW.—*

6 *(1) STUDY.—The Comptroller General of the*
 7 *United States shall conduct a study on the access of*
 8 *medicare beneficiaries and health care providers to*
 9 *judicial review of actions of the Secretary and the De-*
 10 *partment of Health and Human Services with respect*
 11 *to items and services under title XVIII of the Social*
 12 *Security Act subsequent to February 29, 2000, the*
 13 *date of the decision of Shalala, Secretary of Health*
 14 *and Human Services, et al. v. Illinois Council on*
 15 *Long Term Care, Inc. (529 U.S. 1 (2000)).*

16 *(2) REPORT.—Not later than 1 year after the*
 17 *date of enactment of this Act, the Comptroller General*
 18 *shall submit to Congress a report on the study con-*
 19 *ducted under paragraph (1) together with such rec-*
 20 *ommendations as the Comptroller General determines*
 21 *to be appropriate.*

22 *(d) CONFORMING AMENDMENT.—Section*
 23 *1869(b)(1)(F)(ii) (42 U.S.C. 1395ff(b)(1)(F)(ii)) is amend-*
 24 *ed to read as follows:*

1 “(ii) *REFERENCE TO EXPEDITED AC-*
 2 *CESS TO JUDICIAL REVIEW.—For the provi-*
 3 *sion relating to expedited access to judicial*
 4 *review, see paragraph (2).’.*”

5 (e) *EFFECTIVE DATE.—The amendments made by this*
 6 *section shall apply to appeals filed on or after October 1,*
 7 *2004.*

8 **SEC. 513. EXPEDITED REVIEW OF CERTAIN PROVIDER**
 9 **AGREEMENT DETERMINATIONS.**

10 (a) *TERMINATION AND CERTAIN OTHER IMMEDIATE*
 11 *REMEDIES.—*

12 (1) *IN GENERAL.—The Secretary shall develop*
 13 *and implement a process to expedite proceedings*
 14 *under sections 1866(h) of the Social Security Act (42*
 15 *U.S.C. 1395cc(h)) in which—*

16 (A) *the remedy of termination of participa-*
 17 *tion has been imposed;*

18 (B) *a sanction described in clause (i) or*
 19 *(iii) of section 1819(h)(2)(B) of such Act (42*
 20 *U.S.C. 1395i–3(h)(2)(B)) has been imposed, but*
 21 *only if such sanction has been imposed on an*
 22 *immediate basis; or*

23 (C) *the Secretary has required a skilled*
 24 *nursing facility to suspend operations of a nurse*
 25 *aide training program.*

1 (2) *PRIORITY FOR CASES OF TERMINATION.*—

2 *Under the process described in paragraph (1), pri-*
 3 *ority shall be provided in cases of termination de-*
 4 *scribed in subparagraph (A) of such paragraph.*

5 (b) *INCREASED FINANCIAL SUPPORT.*—*In addition to*
 6 *any amounts otherwise appropriated, to reduce by 50 per-*
 7 *cent the average time for administrative determinations on*
 8 *appeals under section 1866(h) of the Social Security Act*
 9 *(42 U.S.C. 1395cc(h)), there are authorized to be appro-*
 10 *priated (in appropriate part from the Federal Hospital In-*
 11 *surance Trust Fund and the Federal Supplementary Med-*
 12 *ical Insurance Trust Fund) to the Secretary such sums for*
 13 *fiscal year 2004 and each subsequent fiscal year as may*
 14 *be necessary to increase the number of administrative law*
 15 *judges (and their staffs) at the Departmental Appeals Board*
 16 *of the Department of Health and Human Services and to*
 17 *educate such judges and staff on long-term care issues.*

18 **SEC. 514. REVISIONS TO MEDICARE APPEALS PROCESS.**

19 (a) *TIMEFRAMES FOR THE COMPLETION OF THE*
 20 *RECORD.*—*Section 1869(b) (42 U.S.C. 1395ff(b)), as*
 21 *amended by section 512(a)(2), is amended by adding at the*
 22 *end the following new paragraph:*

23 “(3) *TIMELY COMPLETION OF THE RECORD.*—

24 “(A) *DEADLINE.*—*Subject to subparagraph*

25 *(B), the deadline to complete the record in a*

1 *hearing before an administrative law judge or a*
 2 *review by the Departmental Appeals Board is 90*
 3 *days after the date the request for the review or*
 4 *hearing is filed.*

5 “(B) *EXTENSIONS FOR GOOD CAUSE.—The*
 6 *person filing a request under subparagraph (A)*
 7 *may request an extension of such deadline for*
 8 *good cause. The administrative law judge, in the*
 9 *case of a hearing, and the Departmental Appeals*
 10 *Board, in the case of a review, may extend such*
 11 *deadline based upon a finding of good cause to*
 12 *a date specified by the judge or Board, as the*
 13 *case may be.*

14 “(C) *DELAY IN DECISION DEADLINES UNTIL*
 15 *COMPLETION OF RECORD.—Notwithstanding any*
 16 *other provision of this section, the deadlines oth-*
 17 *erwise established under subsection (d) for the*
 18 *making of determinations in hearings or review*
 19 *under this section are 90 days after the date on*
 20 *which the record is complete.*

21 “(D) *COMPLETE RECORD DESCRIBED.—For*
 22 *purposes of this paragraph, a record is complete*
 23 *when the administrative law judge, in the case*
 24 *of a hearing, or the Departmental Appeals*
 25 *Board, in the case of a review, has received—*

1 “(i) *written or testimonial evidence, or*
 2 *both, submitted by the person filing the re-*
 3 *quest,*

4 “(ii) *written or oral argument, or both,*
 5 “(iii) *the decision of, and the record*
 6 *for, the prior level of appeal, and*

7 “(iv) *such other evidence as such judge*
 8 *or Board, as the case may be, determines is*
 9 *required to make a determination on the re-*
 10 *quest.”.*

11 (b) *USE OF PATIENTS’ MEDICAL RECORDS.*—Section
 12 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)) is amended
 13 by inserting “(including the medical records of the indi-
 14 vidual involved)” after “clinical experience”.

15 (c) *NOTICE REQUIREMENTS FOR MEDICARE AP-*
 16 *PEALS.*—

17 (1) *INITIAL DETERMINATIONS AND REDETER-*
 18 *MINATIONS.*—Section 1869(a) (42 U.S.C. 1395ff(a)) is
 19 amended by adding at the end the following new
 20 paragraph:

21 “(4) *REQUIREMENTS OF NOTICE OF DETERMINA-*
 22 *TIONS AND REDETERMINATIONS.*—A written notice of
 23 a determination on an initial determination or on a
 24 redetermination, insofar as such determination or re-
 25 determination results in a denial of a claim for bene-

fits, shall be provided in printed form and written in
a manner to be understood by the beneficiary and
shall include—

“(A) the reasons for the determination, including, as appropriate—

“(i) upon request in the case of an initial determination, the provision of the policy, manual, or regulation that resulted in the denial; and

“(ii) in the case of a redetermination, a summary of the clinical or scientific evidence used in making the determination (as appropriate);

“(B) the procedures for obtaining additional information concerning the determination or redetermination; and

“(C) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination or appeal under this section.”.

(2) *RECONSIDERATIONS.*—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)) is amended to read as follows:

“(E) *EXPLANATION OF DECISION.*—Any decision with respect to a reconsideration of a

1 *qualified independent contractor shall be in*
 2 *writing in a manner to be understood by the*
 3 *beneficiary and shall include—*

4 *“(i) to the extent appropriate, a de-*
 5 *tailed explanation of the decision as well as*
 6 *a discussion of the pertinent facts and ap-*
 7 *plicable regulations applied in making such*
 8 *decision;*

9 *“(ii) a notification of the right to ap-*
 10 *peal such determination and instructions on*
 11 *how to initiate such appeal under this sec-*
 12 *tion; and*

13 *“(iii) in the case of a determination of*
 14 *whether an item or service is reasonable and*
 15 *necessary for the diagnosis or treatment of*
 16 *illness or injury (under section*
 17 *1862(a)(1)(A)) an explanation of the med-*
 18 *ical or scientific rationale for the decision.”.*

19 (3) *APPEALS.—Section 1869(d) (42 U.S.C.*
 20 *1395ff(d)) is amended—*

21 *(A) in the heading, by inserting “; NOTICE”*
 22 *after “SECRETARY”; and*

23 *(B) by adding at the end the following new*
 24 *paragraph:*

1 “(4) NOTICE.—Notice of the decision of an ad-
 2 ministrative law judge shall be in writing in a man-
 3 ner to be understood by the beneficiary and shall in-
 4 clude—

5 “(A) the specific reasons for the determina-
 6 tion (including, to the extent appropriate, a
 7 summary of the clinical or scientific evidence
 8 used in making the determination);

9 “(B) the procedures for obtaining addi-
 10 tional information concerning the decision; and

11 “(C) notification of the right to appeal the
 12 decision and instructions on how to initiate such
 13 an appeal under this section.”.

14 (4) PREPARATION OF RECORD FOR APPEAL.—
 15 Section 1869(c)(3)(J) (42 U.S.C. 1395ff(c)(3)(J)) is
 16 amended by striking “such information as is required
 17 for an appeal” and inserting “the record for the ap-
 18 peal”.

19 (d) QUALIFIED INDEPENDENT CONTRACTORS.—

20 (1) ELIGIBILITY REQUIREMENTS OF QUALIFIED
 21 INDEPENDENT CONTRACTORS.—Section 1869(c) (42
 22 U.S.C. 1395ff(c)) is amended—

23 (A) in paragraph (2)—

24 (i) by inserting “(except in the case of
 25 a utilization and quality control peer re-

view organization, as defined in section 1152)” after “means an entity or organization that”; and

(ii) by striking the period at the end and inserting the following: “and meets the following requirements:

“(A) GENERAL REQUIREMENTS.—

“(i) The entity or organization has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing to carry out duties of a qualified independent contractor under this section on a timely basis.

“(ii) The entity or organization has provided assurances that it will conduct activities consistent with the applicable requirements of this section, including that it will not conduct any activities in a case unless the independence requirements of subparagraph (B) are met with respect to the case.

1 “(iii) *The entity or organization meets*
 2 *such other requirements as the Secretary*
 3 *provides by regulation.*

4 “(B) *INDEPENDENCE REQUIREMENTS.—*

5 “(i) *IN GENERAL.—Subject to clause*
 6 *(ii), an entity or organization meets the*
 7 *independence requirements of this subpara-*
 8 *graph with respect to any case if the enti-*
 9 *ty—*

10 “(I) *is not a related party (as de-*
 11 *finied in subsection (g)(5));*

12 “(II) *does not have a material fa-*
 13 *milial, financial, or professional rela-*
 14 *tionship with such a party in relation*
 15 *to such case; and*

16 “(III) *does not otherwise have a*
 17 *conflict of interest with such a party*
 18 *(as determined under regulations).*

19 “(ii) *EXCEPTION FOR COMPENSA-*
 20 *TION.—Nothing in clause (i) shall be con-*
 21 *strued to prohibit receipt by a qualified*
 22 *independent contractor of compensation*
 23 *from the Secretary for the conduct of activi-*
 24 *ties under this section if the compensation*
 25 *is provided consistent with clause (iii).*

1 “(iii) *LIMITATIONS ON ENTITY COM-*
 2 *PENSATION.*—*Compensation provided by the*
 3 *Secretary to a qualified independent con-*
 4 *tractor in connection with reviews under*
 5 *this section shall not be contingent on any*
 6 *decision rendered by the contractor or by*
 7 *any reviewing professional.”; and*

8 *(B) in paragraph (3)(A), by striking “, and*
 9 *shall have sufficient training and expertise in*
 10 *medical science and legal matters to make recon-*
 11 *siderations under this subsection”.*

12 (2) *ELIGIBILITY REQUIREMENTS FOR REVIEW-*
 13 *ERS.*—*Section 1869 (42 U.S.C. 1395ff) is amended—*

14 *(A) by amending subsection (c)(3)(D) to*
 15 *read as follows:*

16 “(D) *QUALIFICATIONS OF REVIEWERS.*—*The*
 17 *requirements of subsection (g) shall be met (relat-*
 18 *ing to qualifications of reviewing profes-*
 19 *sionals).”; and*

20 *(B) by adding at the end the following new*
 21 *subsection:*

22 “(g) *QUALIFICATIONS OF REVIEWERS.*—

23 “(1) *IN GENERAL.*—*In reviewing determinations*
 24 *under this section, a qualified independent contractor*
 25 *shall assure that—*

1 “(A) each individual conducting a review
2 shall meet the qualifications of paragraph (2);

3 “(B) compensation provided by the con-
4 tractor to each such reviewer is consistent with
5 paragraph (3); and

6 “(C) in the case of a review by a panel de-
7 scribed in subsection (c)(3)(B) composed of phy-
8 sicians or other health care professionals (each in
9 this subsection referred to as a ‘reviewing profes-
10 sional’), each reviewing professional meets the
11 qualifications described in paragraph (4).

12 “(2) INDEPENDENCE.—

13 “(A) IN GENERAL.—Subject to subpara-
14 graph (B), each individual conducting a review
15 in a case shall—

16 “(i) not be a related party (as defined
17 in paragraph (5));

18 “(ii) not have a material familial, fi-
19 nancial, or professional relationship with
20 such a party in the case under review; and

21 “(iii) not otherwise have a conflict of
22 interest with such a party (as determined
23 under regulations).

24 “(B) EXCEPTION.—Nothing in subpara-
25 graph (A) shall be construed to—

1 “(i) prohibit an individual, solely on
2 the basis of affiliation with a fiscal inter-
3 mediary, carrier, or other contractor, from
4 serving as a reviewing professional if—

5 “(I) a nonaffiliated individual is
6 not reasonably available;

7 “(II) the affiliated individual is
8 not involved in the provision of items
9 or services in the case under review;

10 “(III) the fact of such an affili-
11 ation is disclosed to the Secretary and
12 the beneficiary (or authorized rep-
13 resentative) and neither party objects;
14 and

15 “(IV) the affiliated individual is
16 not an employee of the intermediary,
17 carrier, or contractor and does not pro-
18 vide services exclusively or primarily
19 to or on behalf of such intermediary,
20 carrier, or contractor;

21 “(ii) prohibit an individual who has
22 staff privileges at the institution where the
23 treatment involved takes place from serving
24 as a reviewer merely on the basis of such af-
25 filiation if the affiliation is disclosed to the

1 *Secretary and the beneficiary (or authorized*
 2 *representative), and neither party objects; or*
 3 *“(iii) prohibit receipt of compensation*
 4 *by a reviewing professional from a con-*
 5 *tractor if the compensation is provided con-*
 6 *sistent with paragraph (3).*

7 *“(3) LIMITATIONS ON REVIEWER COMPENSA-*
 8 *TION.—Compensation provided by a qualified inde-*
 9 *pendent contractor to a reviewer in connection with*
 10 *a review under this section shall not be contingent on*
 11 *the decision rendered by the reviewer.*

12 *“(4) LICENSURE AND EXPERTISE.—Each review-*
 13 *ing professional shall be a physician (allopathic or*
 14 *osteopathic) or health care professional who—*

15 *“(A) is appropriately credentialed or li-*
 16 *censed in 1 or more States to deliver health care*
 17 *services; and*

18 *“(B) has medical expertise in the field of*
 19 *practice that is appropriate for the items or serv-*
 20 *ices at issue.*

21 *“(5) RELATED PARTY DEFINED.—For purposes*
 22 *of this section, the term ‘related party’ means, with*
 23 *respect to a case under this title involving an indi-*
 24 *vidual beneficiary, any of the following:*

1 “(A) *The Secretary, the medicare adminis-*
 2 *trative contractor involved, or any fiduciary, of-*
 3 *ficer, director, or employee of the Department of*
 4 *Health and Human Services, or of such con-*
 5 *tractor.*

6 “(B) *The individual (or authorized rep-*
 7 *resentative).*

8 “(C) *The health care professional that pro-*
 9 *vides the items or services involved in the case.*

10 “(D) *The institution at which the items or*
 11 *services (or treatment) involved in the case are*
 12 *provided.*

13 “(E) *The manufacturer of any drug or*
 14 *other item that is included in the items or serv-*
 15 *ices involved in the case.*

16 “(F) *Any other party determined under any*
 17 *regulations to have a substantial interest in the*
 18 *case involved.”.*

19 (3) *NUMBER OF QUALIFIED INDEPENDENT CON-*
 20 *TRACTORS.—Section 1869(c)(4) (42 U.S.C.*
 21 *1395ff(c)(4)) is amended by striking “12” and insert-*
 22 *ing “4”.*

23 (e) *IMPLEMENTATION OF CERTAIN BIPA REFORMS.—*

1 (1) *DELAY IN CERTAIN BIPA REFORMS.*—Section
 2 521(d) of BIPA (114 Stat. 2763A–543) is amended to
 3 read as follows:

4 “(d) *EFFECTIVE DATE.*—

5 “(1) *IN GENERAL.*—Except as specified in para-
 6 graph (2), the amendments made by this section shall
 7 apply with respect to initial determinations made on
 8 or after December 1, 2004.

9 “(2) *EXPEDITED PROCEEDINGS AND RECONSID-*
 10 *ERATION REQUIREMENTS.*—For the following provi-
 11 sions, the amendments made by subsection (a) shall
 12 apply with respect to initial determinations made on
 13 or after October 1, 2003:

14 “(A) Subsection (b)(1)(F)(i) of section 1869
 15 of the Social Security Act.

16 “(B) Subsection (c)(3)(C)(iii) of such sec-
 17 tion.

18 “(C) Subsection (c)(3)(C)(iv) of such section
 19 to the extent that it applies to expedited recon-
 20 siderations under subsection (c)(3)(C)(iii) of
 21 such section.

22 “(3) *TRANSITIONAL USE OF PEER REVIEW ORGA-*
 23 *NIZATIONS TO CONDUCT EXPEDITED RECONSIDER-*
 24 *ATIONS UNTIL QICS ARE OPERATIONAL.*—Expedited
 25 reconsiderations of initial determinations under sec-

1 *tion 1869(c)(3)(C)(iii) of the Social Security Act*
 2 *shall be made by peer review organizations until*
 3 *qualified independent contractors are available for*
 4 *such expedited reconsiderations.”.*

5 (2) *CONFORMING AMENDMENTS.—Section 521(c)*
 6 *of BIPA (114 Stat. 2763A–543) and section*
 7 *1869(c)(3)(C)(iii)(III) of the Social Security Act (42*
 8 *U.S.C. 1395ff(c)(3)(C)(iii)(III)), as added by section*
 9 *521 of BIPA, are repealed.*

10 (f) *EFFECTIVE DATE.—The amendments made by this*
 11 *section shall be effective as if included in the enactment of*
 12 *the respective provisions of subtitle C of title V of BIPA,*
 13 *114 Stat. 2763A–534.*

14 (g) *TRANSITION.—In applying section 1869(g) of the*
 15 *Social Security Act (as added by subsection (d)(2)), any*
 16 *reference to a medicare administrative contractor shall be*
 17 *deemed to include a reference to a fiscal intermediary under*
 18 *section 1816 of the Social Security Act (42 U.S.C. 1395h)*
 19 *and a carrier under section 1842 of such Act (42 U.S.C.*
 20 *1395u).*

1 **SEC. 515. HEARING RIGHTS RELATED TO DECISIONS BY**
 2 **THE SECRETARY TO DENY OR NOT RENEW A**
 3 **MEDICARE ENROLLMENT AGREEMENT; CON-**
 4 **SULTATION BEFORE CHANGING PROVIDER**
 5 **ENROLLMENT FORMS.**

6 *(a) HEARING RIGHTS.—*

7 *(1) IN GENERAL.—Section 1866 (42 U.S.C.*
 8 *1395cc) is amended by adding at the end the fol-*
 9 *lowing new subsection:*

10 *“(j) HEARING RIGHTS IN CASES OF DENIAL OR NON-*
 11 *RENEWAL.—The Secretary shall establish by regulation pro-*
 12 *cedures under which—*

13 *“(1) there are deadlines for actions on applica-*
 14 *tions for enrollment (and, if applicable, renewal of*
 15 *enrollment); and*

16 *“(2) providers of services, physicians, practi-*
 17 *tioners, and suppliers whose application to enroll (or,*
 18 *if applicable, to renew enrollment) are denied are*
 19 *provided a mechanism to appeal such denial and a*
 20 *deadline for consideration of such appeals.”.*

21 *(2) EFFECTIVE DATE.—The Secretary shall pro-*
 22 *vide for the establishment of the procedures under the*
 23 *amendment made by paragraph (1) within 18 months*
 24 *after the date of enactment of this Act.*

25 *(b) CONSULTATION BEFORE CHANGING PROVIDER EN-*
 26 *ROLLMENT FORMS.—Section 1871 (42 U.S.C. 1395hh), as*

1 amended by sections 502 and 503, is amended by adding
 2 at the end the following new subsection:

3 “(f) The Secretary shall consult with providers of serv-
 4 ices, physicians, practitioners, and suppliers before making
 5 changes in the provider enrollment forms required of such
 6 providers, physicians, practitioners, and suppliers to be eli-
 7 gible to submit claims for which payment may be made
 8 under this title.”.

9 **SEC. 516. APPEALS BY PROVIDERS WHEN THERE IS NO**
 10 **OTHER PARTY AVAILABLE.**

11 (a) *IN GENERAL.*—Section 1870 (42 U.S.C. 1395gg)
 12 is amended by adding at the end the following new sub-
 13 section:

14 “(h) Notwithstanding subsection (f) or any other pro-
 15 vision of law, the Secretary shall permit a provider of serv-
 16 ices, physician, practitioner, or other supplier to appeal
 17 any determination of the Secretary under this title relating
 18 to services rendered under this title to an individual who
 19 subsequently dies if there is no other party available to ap-
 20 peal such determination.”.

21 (b) *EFFECTIVE DATE.*—The amendment made by sub-
 22 section (a) shall take effect on the date of enactment of this
 23 Act and shall apply to items and services furnished on or
 24 after such date.

1 **SEC. 517. PROVIDER ACCESS TO REVIEW OF LOCAL COV-**
 2 **ERAGE DETERMINATIONS.**

3 (a) *PROVIDER ACCESS TO REVIEW OF LOCAL COV-*
 4 *ERAGE DETERMINATIONS.*—Section 1869(f)(5) (42 U.S.C.
 5 1395ff(f)(5)) is amended to read as follows:

6 “(5) *AGGRIEVED PARTY DEFINED.*—In this sec-
 7 tion, the term ‘aggrieved party’ means—

8 “(A) with respect to a national coverage de-
 9 termination, an individual entitled to benefits
 10 under part A, or enrolled under part B, or both,
 11 who is in need of the items or services that are
 12 the subject of the coverage determination; and

13 “(B) with respect to a local coverage deter-
 14 mination—

15 “(i) an individual who is entitled to
 16 benefits under part A, or enrolled under
 17 part B, or both, who is adversely affected by
 18 such a determination; or

19 “(ii) a provider of services, physician,
 20 practitioner, or supplier that is adversely
 21 affected by such a determination.”.

22 (b) *CLARIFICATION OF LOCAL COVERAGE DETERMINA-*
 23 *TION DEFINITION.*—Section 1869(f)(2)(B) (42 U.S.C.
 24 1395ff(f)(2)(B)) is amended by inserting “, including,
 25 where appropriate, the specific requirements and clinical

1 *indications relating to the medical necessity of an item or*
 2 *service” before the period at the end.*

3 *(c) REQUEST FOR LOCAL COVERAGE DETERMINATIONS*
 4 *BY PROVIDERS.—Section 1869 (42 U.S.C. 1395ff), as*
 5 *amended by section 514(d)(2)(B), is amended by adding at*
 6 *the end the following new subsection:*

7 *“(h) REQUEST FOR LOCAL COVERAGE DETERMINA-*
 8 *TIONS BY PROVIDERS.—*

9 *“(1) ESTABLISHMENT OF PROCESS.—The Sec-*
 10 *retary shall establish a process under which a pro-*
 11 *vider of services, physician, practitioner, or supplier*
 12 *who certifies that they meet the requirements estab-*
 13 *lished in paragraph (3) may request a local coverage*
 14 *determination in accordance with the succeeding pro-*
 15 *visions of this subsection.*

16 *“(2) PROVIDER LOCAL COVERAGE DETERMINA-*
 17 *TION REQUEST DEFINED.—In this subsection, the*
 18 *term ‘provider local coverage determination request’*
 19 *means a request, filed with the Secretary, at such*
 20 *time and in such form and manner as the Secretary*
 21 *may specify, that the Secretary, pursuant to para-*
 22 *graph (4)(A), require a fiscal intermediary, carrier,*
 23 *or program safeguard contractor to make or revise a*
 24 *local coverage determination under this section with*
 25 *respect to an item or service.*

1 “(3) *REQUEST REQUIREMENTS.*—Under the
2 *process established under paragraph (1), by not later*
3 *than 30 days after the date on which a provider local*
4 *coverage determination request is filed under para-*
5 *graph (1), the Secretary shall determine whether such*
6 *request establishes that—*

7 “(A) *there have been at least 5 reversals of*
8 *redeterminations made by a fiscal intermediary*
9 *or carrier after a hearing before an administra-*
10 *tive law judge on claims submitted by the pro-*
11 *vider in at least 2 different cases before an ad-*
12 *ministrative law judge;*

13 “(B) *each reversal described in subpara-*
14 *graph (A) involves substantially similar mate-*
15 *rial facts;*

16 “(C) *each reversal described in subpara-*
17 *graph (A) involves the same medical necessity*
18 *issue; and*

19 “(D) *at least 50 percent of the total number*
20 *of claims submitted by such provider within the*
21 *past year involving the substantially similar*
22 *material facts described in subparagraph (B)*
23 *and the same medical necessity issue described in*
24 *subparagraph (C) have been denied and have*
25 *been reversed by an administrative law judge.*

1 “(4) *APPROVAL OR REJECTION OF REQUEST.*—

2 “(A) *APPROVAL OF REQUEST.*—If the Sec-
3 retary determines that subparagraphs (A)
4 through (D) of paragraph (3) have been satisfied,
5 the Secretary shall require the fiscal inter-
6 mediary, carrier, or program safeguard con-
7 tractor identified in the provider local coverage
8 determination request, to make or revise a local
9 coverage determination with respect to the item
10 or service that is the subject of the request not
11 later than the date that is 210 days after the
12 date on which the Secretary makes the deter-
13 mination. Such fiscal intermediary, carrier, or
14 program safeguard contractor shall retain the
15 discretion to determine whether or not, and/or
16 the circumstances under which, to cover the item
17 or service for which a local coverage determina-
18 tion is requested. Nothing in this subsection shall
19 be construed to require a fiscal intermediary,
20 carrier or program safeguard contractor to de-
21 velop a local coverage determination that is in-
22 consistent with any national coverage determina-
23 tion, or any coverage provision in this title or in
24 regulation, manual, or interpretive guidance of
25 the Secretary.

1 “(B) *REJECTION OF REQUEST.*—If the Sec-
 2 retary determines that subparagraphs (A)
 3 through (D) of paragraph (3) have not been sat-
 4 isfied, the Secretary shall reject the provider
 5 local coverage determination request and shall
 6 notify the provider of services, physician, practi-
 7 tioner, or supplier that filed the request of the
 8 reason for such rejection and no further pro-
 9 ceedings in relation to such request shall be con-
 10 ducted.”.

11 (d) *STUDY AND REPORT ON THE USE OF CONTRAC-*
 12 *TORS TO MONITOR MEDICARE APPEALS.*—

13 (1) *STUDY.*—The Secretary shall conduct a study
 14 on the feasibility and advisability of requiring fiscal
 15 intermediaries and carriers to monitor and track—

16 (A) the subject matter and status of claims
 17 denied by the fiscal intermediary or carrier (as
 18 applicable) that are appealed under section 1869
 19 of the Social Security Act (42 U.S.C. 1395ff), as
 20 added by section 522 of BIPA (114 Stat. 2763A–
 21 543) and amended by this Act; and

22 (B) any final determination made with re-
 23 spect to such claims.

24 (2) *REPORT.*—Not later than the date that is 1
 25 year after the date of enactment of this Act, the Sec-

1 retary shall submit to Congress a report on the study
 2 conducted under paragraph (1) together with such
 3 recommendations for legislation and administrative
 4 action as the Commission determines appropriate.

5 (e) *AUTHORIZATION OF APPROPRIATIONS.*—There are
 6 authorized to be appropriated such sums as are necessary
 7 to carry out the amendments made by subsections (a), (b),
 8 and (c).

9 (f) *EFFECTIVE DATES.*—

10 (1) *PROVIDER ACCESS TO REVIEW OF LOCAL*
 11 *COVERAGE DETERMINATIONS.*—The amendments
 12 made by subsections (a) and (b) shall apply to—

13 (A) any review of any local coverage deter-
 14 mination filed on or after October 1, 2003;

15 (B) any request to make such a determina-
 16 tion made on or after such date; or

17 (C) any local coverage determination made
 18 on or after such date.

19 (2) *PROVIDER LOCAL COVERAGE DETERMINATION*
 20 *REQUESTS.*—The amendment made by subsection (c)
 21 shall apply with respect to provider local coverage de-
 22 termination requests (as defined in section 1869(h)(2)
 23 of the Social Security Act, as added by subsection (c))
 24 filed on or after the date of enactment of this Act.

1 ***Subtitle C—Contracting Reform***

2 ***SEC. 521. INCREASED FLEXIBILITY IN MEDICARE ADMINIS-***
 3 ***TRATION.***

4 *(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE*
 5 *ADMINISTRATION.—*

6 *(1) IN GENERAL.—Title XVIII is amended by in-*
 7 *serting after section 1874 the following new section:*

8 ***“CONTRACTS WITH MEDICARE ADMINISTRATIVE***
 9 ***CONTRACTORS***

10 ***“SEC. 1874A. (a) AUTHORITY.—***

11 ***“(1) AUTHORITY TO ENTER INTO CONTRACTS.—***
 12 *The Secretary may enter into contracts with any eli-*
 13 *gible entity to serve as a medicare administrative*
 14 *contractor with respect to the performance of any or*
 15 *all of the functions described in paragraph (4) or*
 16 *parts of those functions (or, to the extent provided in*
 17 *a contract, to secure performance thereof by other en-*
 18 *tities).*

19 ***“(2) ELIGIBILITY OF ENTITIES.—An entity is el-***
 20 *igible to enter into a contract with respect to the per-*
 21 *formance of a particular function described in para-*
 22 *graph (4) only if—*

23 ***“(A) the entity has demonstrated capability***
 24 ***to carry out such function;***

1 “(B) the entity complies with such conflict
2 of interest standards as are generally applicable
3 to Federal acquisition and procurement;

4 “(C) the entity has sufficient assets to fi-
5 nancially support the performance of such func-
6 tion; and

7 “(D) the entity meets such other require-
8 ments as the Secretary may impose.

9 “(3) *MEDICARE ADMINISTRATIVE CONTRACTOR*
10 *DEFINED.*—For purposes of this title and title XI—

11 “(A) *IN GENERAL.*—The term ‘medicare ad-
12 ministrative contractor’ means an agency, orga-
13 nization, or other person with a contract under
14 this section.

15 “(B) *APPROPRIATE MEDICARE ADMINISTRA-*
16 *TIVE CONTRACTOR.*—With respect to the perform-
17 ance of a particular function in relation to an
18 individual entitled to benefits under part A or
19 enrolled under part B, or both, a specific pro-
20 vider of services, physician, practitioner, facility,
21 or supplier (or class of such providers of services,
22 physicians, practitioners, facilities, or suppliers),
23 the ‘appropriate’ medicare administrative con-
24 tractor is the medicare administrative contractor
25 that has a contract under this section with re-

1 *spect to the performance of that function in rela-*
 2 *tion to that individual, provider of services, phy-*
 3 *sician, practitioner, facility, or supplier or class*
 4 *of provider of services, physician, practitioner,*
 5 *facility, or supplier.*

6 “(4) *FUNCTIONS DESCRIBED.*—*The functions re-*
 7 *ferred to in paragraphs (1) and (2) are payment*
 8 *functions (including the function of developing local*
 9 *coverage determinations, as defined in section*
 10 *1869(f)(2)(B)), provider services functions, and bene-*
 11 *ficiary services functions as follows:*

12 “(A) *DETERMINATION OF PAYMENT*
 13 *AMOUNTS.*—*Determining (subject to the provi-*
 14 *sions of section 1878 and to such review by the*
 15 *Secretary as may be provided for by the con-*
 16 *tracts) the amount of the payments required pur-*
 17 *suant to this title to be made to providers of*
 18 *services, physicians, practitioners, facilities, sup-*
 19 *pliers, and individuals.*

20 “(B) *MAKING PAYMENTS.*—*Making pay-*
 21 *ments described in subparagraph (A) (including*
 22 *receipt, disbursement, and accounting for funds*
 23 *in making such payments).*

24 “(C) *BENEFICIARY EDUCATION AND ASSIST-*
 25 *ANCE.*—*Serving as a center for, and commu-*

1 *nicating to individuals entitled to benefits under*
 2 *part A or enrolled under part B, or both, with*
 3 *respect to education and outreach for those indi-*
 4 *viduals, and assistance with specific issues, con-*
 5 *cerns, or problems of those individuals.*

6 “(D) PROVIDER CONSULTATIVE SERV-
 7 *ICES.—Providing consultative services to institu-*
 8 *tions, agencies, and other persons to enable them*
 9 *to establish and maintain fiscal records nec-*
 10 *essary for purposes of this title and otherwise to*
 11 *qualify as providers of services, physicians, prac-*
 12 *titioners, facilities, or suppliers.*

13 “(E) COMMUNICATION WITH PROVIDERS.—
 14 *Serving as a center for, and communicating to*
 15 *providers of services, physicians, practitioners,*
 16 *facilities, and suppliers, any information or in-*
 17 *structions furnished to the medicare administra-*
 18 *tive contractor by the Secretary, and serving as*
 19 *a channel of communication from such pro-*
 20 *viders, physicians, practitioners, facilities, and*
 21 *suppliers to the Secretary.*

22 “(F) PROVIDER EDUCATION AND TECHNICAL
 23 *ASSISTANCE.—Performing the functions de-*
 24 *scribed in subsections (e) and (f), relating to*
 25 *education, training, and technical assistance to*

1 *providers of services, physicians, practitioners,*
2 *facilities, and suppliers.*

3 “(G) *ADDITIONAL FUNCTIONS.—Performing*
4 *such other functions, including (subject to para-*
5 *graph (5)) functions under the Medicare Integ-*
6 *rity Program under section 1893, as are nec-*
7 *essary to carry out the purposes of this title.*

8 “(5) *RELATIONSHIP TO MIP CONTRACTS.—*

9 “(A) *NONDUPLICATION OF ACTIVITIES.—In*
10 *entering into contracts under this section, the*
11 *Secretary shall assure that activities of medicare*
12 *administrative contractors do not duplicate ac-*
13 *tivities carried out under contracts entered into*
14 *under the Medicare Integrity Program under sec-*
15 *tion 1893. The previous sentence shall not apply*
16 *with respect to the activity described in section*
17 *1893(b)(5) (relating to prior authorization of*
18 *certain items of durable medical equipment*
19 *under section 1834(a)(15)).*

20 “(B) *CONSTRUCTION.—An entity shall not*
21 *be treated as a medicare administrative con-*
22 *tractor merely by reason of having entered into*
23 *a contract with the Secretary under section*
24 *1893.*

1 “(6) *APPLICATION OF FEDERAL ACQUISITION*
 2 *REGULATION.—Except to the extent inconsistent with*
 3 *a specific requirement of this title, the Federal Acqui-*
 4 *sition Regulation applies to contracts under this title.*

5 “(b) *CONTRACTING REQUIREMENTS.—*

6 “(1) *USE OF COMPETITIVE PROCEDURES.—*

7 “(A) *IN GENERAL.—Except as provided in*
 8 *laws with general applicability to Federal acqui-*
 9 *sition and procurement, the Federal Acquisition*
 10 *Regulation, or in subparagraph (B), the Sec-*
 11 *retary shall use competitive procedures when en-*
 12 *tering into contracts with medicare administra-*
 13 *tive contractors under this section.*

14 “(B) *RENEWAL OF CONTRACTS.—The Sec-*
 15 *retary may renew a contract with a medicare*
 16 *administrative contractor under this section*
 17 *from term to term without regard to section 5 of*
 18 *title 41, United States Code, or any other provi-*
 19 *sion of law requiring competition, if the medi-*
 20 *care administrative contractor has met or ex-*
 21 *ceeded the performance requirements applicable*
 22 *with respect to the contract and contractor, ex-*
 23 *cept that the Secretary shall provide for the ap-*
 24 *plication of competitive procedures under such a*

1 *contract not less frequently than once every 6*
 2 *years.*

3 “(C) *TRANSFER OF FUNCTIONS.*—*The Sec-*
 4 *retary may transfer functions among medicare*
 5 *administrative contractors without regard to any*
 6 *provision of law requiring competition. The Sec-*
 7 *retary shall ensure that performance quality is*
 8 *considered in such transfers. The Secretary shall*
 9 *provide notice (whether in the Federal Register*
 10 *or otherwise) of any such transfer (including a*
 11 *description of the functions so transferred and*
 12 *contact information for the contractors involved)*
 13 *to providers of services, physicians, practitioners,*
 14 *facilities, and suppliers affected by the transfer.*

15 “(D) *INCENTIVES FOR QUALITY.*—*The Sec-*
 16 *retary may provide incentives for medicare ad-*
 17 *ministrative contractors to provide quality serv-*
 18 *ice and to promote efficiency.*

19 “(2) *COMPLIANCE WITH REQUIREMENTS.*—*No*
 20 *contract under this section shall be entered into with*
 21 *any medicare administrative contractor unless the*
 22 *Secretary finds that such medicare administrative*
 23 *contractor will perform its obligations under the con-*
 24 *tract efficiently and effectively and will meet such re-*
 25 *quirements as to financial responsibility, legal au-*

1 *thority, and other matters as the Secretary finds per-*
 2 *tinent.*

3 “(3) *PERFORMANCE REQUIREMENTS.*—

4 “(A) *DEVELOPMENT OF SPECIFIC PERFORM-*
 5 *ANCE REQUIREMENTS.*—*The Secretary shall de-*
 6 *velop contract performance requirements to carry*
 7 *out the specific requirements applicable under*
 8 *this title to a function described in subsection*
 9 *(a)(4) and shall develop standards for measuring*
 10 *the extent to which a contractor has met such re-*
 11 *quirements. In developing such performance re-*
 12 *quirements and standards for measurement, the*
 13 *Secretary shall consult with providers of services,*
 14 *organizations representative of beneficiaries*
 15 *under this title, and organizations and agencies*
 16 *performing functions necessary to carry out the*
 17 *purposes of this section with respect to such per-*
 18 *formance requirements. The Secretary shall make*
 19 *such performance requirements and measurement*
 20 *standards available to the public.*

21 “(B) *CONSIDERATIONS.*—*The Secretary*
 22 *shall include, as 1 of the standards, provider and*
 23 *beneficiary satisfaction levels.*

24 “(C) *INCLUSION IN CONTRACTS.*—*All con-*
 25 *tractor performance requirements shall be set*

1 *forth in the contract between the Secretary and*
 2 *the appropriate medicare administrative con-*
 3 *tractor. Such performance requirements—*

4 *“(i) shall reflect the performance re-*
 5 *quirements published under subparagraph*
 6 *(A), but may include additional perform-*
 7 *ance requirements;*

8 *“(ii) shall be used for evaluating con-*
 9 *tractor performance under the contract; and*

10 *“(iii) shall be consistent with the writ-*
 11 *ten statement of work provided under the*
 12 *contract.*

13 *“(4) INFORMATION REQUIREMENTS.—The Sec-*
 14 *retary shall not enter into a contract with a medicare*
 15 *administrative contractor under this section unless*
 16 *the contractor agrees—*

17 *“(A) to furnish to the Secretary such timely*
 18 *information and reports as the Secretary may*
 19 *find necessary in performing his functions under*
 20 *this title; and*

21 *“(B) to maintain such records and afford*
 22 *such access thereto as the Secretary finds nec-*
 23 *essary to assure the correctness and verification*
 24 *of the information and reports under subpara-*

1 *graph (A) and otherwise to carry out the pur-*
 2 *poses of this title.*

3 “(5) *SURETY BOND.*—*A contract with a medi-*
 4 *care administrative contractor under this section may*
 5 *require the medicare administrative contractor, and*
 6 *any of its officers or employees certifying payments or*
 7 *disbursing funds pursuant to the contract, or other-*
 8 *wise participating in carrying out the contract, to*
 9 *give surety bond to the United States in such amount*
 10 *as the Secretary may deem appropriate.*

11 “(6) *RETAINING DIVERSITY OF LOCAL COVERAGE*
 12 *DETERMINATIONS.*—*A contract with a medicare ad-*
 13 *ministrative contractor under this section to perform*
 14 *the function of developing local coverage determina-*
 15 *tions (as defined in section 1869(f)(2)(B)) shall pro-*
 16 *vide that the contractor shall—*

17 “(A) *designate at least 1 different indi-*
 18 *vidual to serve as medical director for each State*
 19 *for which such contract performs such function;*

20 “(B) *utilize such medical director in the*
 21 *performance of such function; and*

22 “(C) *appoint a contractor advisory com-*
 23 *mittee with respect to each such State to provide*
 24 *a formal mechanism for physicians in the State*
 25 *to be informed of, and participate in, the devel-*

1 *opment of a local coverage determination in an*
 2 *advisory capacity.*

3 “(c) *TERMS AND CONDITIONS.*—

4 “(1) *IN GENERAL.*—Subject to subsection (a)(6),
 5 *a contract with any medicare administrative con-*
 6 *tractor under this section may contain such terms*
 7 *and conditions as the Secretary finds necessary or ap-*
 8 *propriate and may provide for advances of funds to*
 9 *the medicare administrative contractor for the mak-*
 10 *ing of payments by it under subsection (a)(4)(B).*

11 “(2) *PROHIBITION ON MANDATES FOR CERTAIN*
 12 *DATA COLLECTION.*—The Secretary may not require,
 13 *as a condition of entering into, or renewing, a con-*
 14 *tract under this section, that the medicare adminis-*
 15 *trative contractor match data obtained other than in*
 16 *its activities under this title with data used in the ad-*
 17 *ministration of this title for purposes of identifying*
 18 *situations in which the provisions of section 1862(b)*
 19 *may apply.*

20 “(d) *LIMITATION ON LIABILITY OF MEDICARE ADMIN-*
 21 *ISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.*—

22 “(1) *CERTIFYING OFFICER.*—No individual des-
 23 *ignated pursuant to a contract under this section as*
 24 *a certifying officer shall, in the absence of the reckless*
 25 *disregard of the individual’s obligations or the intent*

1 *by that individual to defraud the United States, be*
 2 *liable with respect to any payments certified by the*
 3 *individual under this section.*

4 “(2) *DISBURSING OFFICER.*—No disbursing offi-
 5 *cer shall, in the absence of the reckless disregard of the*
 6 *officer’s obligations or the intent by that officer to de-*
 7 *fraud the United States, be liable with respect to any*
 8 *payment by such officer under this section if it was*
 9 *based upon an authorization (which meets the appli-*
 10 *cable requirements for such internal controls estab-*
 11 *lished by the Comptroller General) of a certifying offi-*
 12 *cer designated as provided in paragraph (1) of this*
 13 *subsection.*

14 “(3) *LIABILITY OF MEDICARE ADMINISTRATIVE*
 15 *CONTRACTOR.*—No medicare administrative con-
 16 *tractor shall be liable to the United States for a pay-*
 17 *ment by a certifying or disbursing officer unless, in*
 18 *connection with such a payment, the medicare ad-*
 19 *ministrative contractor acted with reckless disregard*
 20 *of its obligations under its medicare administrative*
 21 *contract or with intent to defraud the United States.*

22 “(4) *RELATIONSHIP TO FALSE CLAIMS ACT.*—
 23 *Nothing in this subsection shall be construed to limit*
 24 *liability for conduct that would constitute a violation*
 25 *of sections 3729 through 3731 of title 31, United*

1 *States Code (commonly known as the “False Claims*
2 *Act”).*

3 “(5) *INDEMNIFICATION BY SECRETARY.*—

4 “(A) *IN GENERAL.*—*Notwithstanding any*
5 *other provision of law and subject to the suc-*
6 *ceeding provisions of this paragraph, in the case*
7 *of a medicare administrative contractor (or a*
8 *person who is a director, officer, or employee of*
9 *such a contractor or who is engaged by the con-*
10 *tractor to participate directly in the claims ad-*
11 *ministration process) who is made a party to*
12 *any judicial or administrative proceeding aris-*
13 *ing from, or relating directly to, the claims ad-*
14 *ministration process under this title, the Sec-*
15 *retary may, to the extent specified in the con-*
16 *tract with the contractor, indemnify the con-*
17 *tractor (and such persons).*

18 “(B) *CONDITIONS.*—*The Secretary may not*
19 *provide indemnification under subparagraph (A)*
20 *insofar as the liability for such costs arises di-*
21 *rectly from conduct that is determined by the*
22 *Secretary to be criminal in nature, fraudulent,*
23 *or grossly negligent.*

24 “(C) *SCOPE OF INDEMNIFICATION.*—*Indem-*
25 *nification by the Secretary under subparagraph*

1 (A) may include payment of judgments, settle-
2 ments (subject to subparagraph (D)), awards,
3 and costs (including reasonable legal expenses).

4 “(D) WRITTEN APPROVAL FOR SETTLE-
5 MENTS.—A contractor or other person described
6 in subparagraph (A) may not propose to nego-
7 tiate a settlement or compromise of a proceeding
8 described in such subparagraph without the
9 prior written approval of the Secretary to nego-
10 tiate a settlement. Any indemnification under
11 subparagraph (A) with respect to amounts paid
12 under a settlement are conditioned upon the Sec-
13 retary’s prior written approval of the final set-
14 tlement.

15 “(E) CONSTRUCTION.—Nothing in this
16 paragraph shall be construed—

17 “(i) to change any common law immu-
18 nity that may be available to a medicare
19 administrative contractor or person de-
20 scribed in subparagraph (A); or

21 “(ii) to permit the payment of costs
22 not otherwise allowable, reasonable, or allo-
23 cable under the Federal Acquisition Regula-
24 tions.”.

(1) The heading is amended to read as follows:

“PROVISIONS RELATING TO THE ADMINISTRATION OF PART

A”.

23 (3) Subsection (b) is repealed.

25 (A) by striking paragraph (1); and

1 (3) *Subsection (b) is amended—*

2 (A) *by striking paragraph (1);*

3 (B) *in paragraph (2)—*

4 (i) *by striking subparagraphs (A) and*
5 *(B);*

6 (ii) *in subparagraph (C), by striking*
7 *“carriers” and inserting “medicare admin-*
8 *istrative contractors”; and*

9 (iii) *by striking subparagraphs (D)*
10 *and (E);*

11 (C) *in paragraph (3)—*

12 (i) *in the matter before subparagraph*
13 *(A), by striking “Each such contract shall*
14 *provide that the carrier” and inserting*
15 *“The Secretary”;*

16 (ii) *by striking “will” the first place it*
17 *appears in each of subparagraphs (A), (B),*
18 *(F), (G), (H), and (L) and inserting*
19 *“shall”;*

20 (iii) *in subparagraph (B), in the mat-*
21 *ter before clause (i), by striking “to the pol-*
22 *icyholders and subscribers of the carrier”*
23 *and inserting “to the policyholders and sub-*
24 *scribers of the medicare administrative con-*
25 *tractor”;*

1 (iv) by striking subparagraphs (C),
2 (D), and (E);

3 (v) in subparagraph (H)—

4 (I) by striking “if it makes deter-
5 minations or payments with respect to
6 physicians’ services,”; and

7 (II) by striking “carrier” and in-
8 serting “medicare administrative con-
9 tractor”;

10 (vi) by striking subparagraph (I);

11 (vii) in subparagraph (L), by striking
12 the semicolon and inserting a period;

13 (viii) in the first sentence, after sub-
14 paragraph (L), by striking “and shall con-
15 tain” and all that follows through the pe-
16 riod; and

17 (ix) in the seventh sentence, by insert-
18 ing “medicare administrative contractor,”
19 after “carrier,”;

20 (D) by striking paragraph (5);

21 (E) in paragraph (6)(D)(iv), by striking
22 “carrier” and inserting “medicare administra-
23 tive contractor”; and

1 (F) in paragraph (7), by striking “the car-
 2 rier” and inserting “the Secretary” each place it
 3 appears.

4 (4) Subsection (c) is amended—

5 (A) by striking paragraph (1);

6 (B) in paragraph (2), by striking “contract
 7 under this section which provides for the dis-
 8 bursement of funds, as described in subsection
 9 (a)(1)(B),” and inserting “contract under section
 10 1874A that provides for making payments under
 11 this part”;

12 (C) in paragraph (3)(A), by striking “sub-
 13 section (a)(1)(B)” and inserting “section
 14 1874A(a)(3)(B)”;

15 (D) in paragraph (4), by striking “carrier”
 16 and inserting “medicare administrative con-
 17 tractor”;

18 (E) in paragraph (5), by striking “contract
 19 under this section which provides for the dis-
 20 bursement of funds, as described in subsection
 21 (a)(1)(B), shall require the carrier” and “carrier
 22 responses” and inserting “contract under section
 23 1874A that provides for making payments under
 24 this part shall require the medicare administra-

1 *tive contractor” and “contractor responses”, re-*
 2 *spectively; and*

3 *(F) by striking paragraph (6).*

4 *(5) Subsections (d), (e), and (f) are repealed.*

5 *(6) Subsection (g) is amended by striking “car-*
 6 *rier or carriers” and inserting “medicare administra-*
 7 *tive contractor or contractors”.*

8 *(7) Subsection (h) is amended—*

9 *(A) in paragraph (2)—*

10 *(i) by striking “Each carrier having*
 11 *an agreement with the Secretary under sub-*
 12 *section (a)” and inserting “The Secretary”;*
 13 *and*

14 *(ii) by striking “Each such carrier”*
 15 *and inserting “The Secretary”;*

16 *(B) in paragraph (3)(A)—*

17 *(i) by striking “a carrier having an*
 18 *agreement with the Secretary under sub-*
 19 *section (a)” and inserting “medicare ad-*
 20 *ministrative contractor having a contract*
 21 *under section 1874A that provides for mak-*
 22 *ing payments under this part”; and*

23 *(ii) by striking “such carrier” and in-*
 24 *serting “such contractor”;*

25 *(C) in paragraph (3)(B)—*

1 (i) by striking “a carrier” and insert-
 2 ing “a medicare administrative contractor”
 3 each place it appears; and

4 (ii) by striking “the carrier” and in-
 5 serting “the contractor” each place it ap-
 6 pears; and

7 (D) in paragraphs (5)(A) and (5)(B)(iii),
 8 by striking “carriers” and inserting “medicare
 9 administrative contractors” each place it ap-
 10 pears.

11 (8) Subsection (l) is amended—

12 (A) in paragraph (1)(A)(iii), by striking
 13 “carrier” and inserting “medicare administra-
 14 tive contractor”; and

15 (B) in paragraph (2), by striking “carrier”
 16 and inserting “medicare administrative con-
 17 tractor”.

18 (9) Subsection (p)(3)(A) is amended by striking
 19 “carrier” and inserting “medicare administrative
 20 contractor”.

21 (10) Subsection (q)(1)(A) is amended by striking
 22 “carrier”.

23 (d) *EFFECTIVE DATE; TRANSITION RULE.*—

24 (1) *EFFECTIVE DATE.*—

1 (A) *IN GENERAL.*—*Except as otherwise pro-*
 2 *vided in this subsection, the amendments made*
 3 *by this section shall take effect on October 1,*
 4 *2005, and the Secretary is authorized to take*
 5 *such steps before such date as may be necessary*
 6 *to implement such amendments on a timely*
 7 *basis.*

8 (B) *CONSTRUCTION FOR CURRENT CON-*
 9 *TRACTS.*—*Such amendments shall not apply to*
 10 *contracts in effect before the date specified under*
 11 *subparagraph (A) that continue to retain the*
 12 *terms and conditions in effect on such date (ex-*
 13 *cept as otherwise provided under this title, other*
 14 *than under this section) until such date as the*
 15 *contract is let out for competitive bidding under*
 16 *such amendments.*

17 (C) *DEADLINE FOR COMPETITIVE BID-*
 18 *DING.*—*The Secretary shall provide for the let-*
 19 *ting by competitive bidding of all contracts for*
 20 *functions of medicare administrative contractors*
 21 *for annual contract periods that begin on or*
 22 *after October 1, 2011.*

23 (2) *GENERAL TRANSITION RULES.*—

24 (A) *AUTHORITY TO CONTINUE TO ENTER*
 25 *INTO NEW AGREEMENTS AND CONTRACTS AND*

1 WAIVER OF PROVIDER NOMINATION PROVISIONS

2 DURING TRANSITION.—Prior to the date specified
 3 in paragraph (1)(A), the Secretary may, con-
 4 sistent with subparagraph (B), continue to enter
 5 into agreements under section 1816 and con-
 6 tracts under section 1842 of the Social Security
 7 Act (42 U.S.C. 1395h, 1395u). The Secretary
 8 may enter into new agreements under section
 9 1816 during the time period without regard to
 10 any of the provider nomination provisions of
 11 such section.

12 (B) APPROPRIATE TRANSITION.—The Sec-
 13 retary shall take such steps as are necessary to
 14 provide for an appropriate transition from
 15 agreements under section 1816 and contracts
 16 under section 1842 of the Social Security Act (42
 17 U.S.C. 1395h, 1395u) to contracts under section
 18 1874A, as added by subsection (a)(1).

19 (3) AUTHORIZING CONTINUATION OF MIP ACTIVI-
 20 TIES UNDER CURRENT CONTRACTS AND AGREEMENTS
 21 AND UNDER TRANSITION CONTRACTS.—The provisions
 22 contained in the exception in section 1893(d)(2) of the
 23 Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall
 24 continue to apply notwithstanding the amendments
 25 made by this section, and any reference in such provi-

1 *sions to an agreement or contract shall be deemed to*
 2 *include agreements and contracts entered into pursu-*
 3 *ant to paragraph (2)(A).*

4 *(e) REFERENCES.—On and after the effective date pro-*
 5 *vided under subsection (d)(1), any reference to a fiscal*
 6 *intermediary or carrier under title XI or XVIII of the So-*
 7 *cial Security Act (or any regulation, manual instruction,*
 8 *interpretative rule, statement of policy, or guideline issued*
 9 *to carry out such titles) shall be deemed a reference to an*
 10 *appropriate medicare administrative contractor (as pro-*
 11 *vided under section 1874A of the Social Security Act).*

12 *(f) SECRETARIAL SUBMISSION OF LEGISLATIVE PRO-*
 13 *POSAL.—Not later than 6 months after the date of enact-*
 14 *ment of this Act, the Secretary shall submit to the appro-*
 15 *priate committees of Congress a legislative proposal pro-*
 16 *viding for such technical and conforming amendments in*
 17 *the law as are required by the provisions of this section.*

18 *(g) REPORTS ON IMPLEMENTATION.—*

19 *(1) PROPOSAL FOR IMPLEMENTATION.—At least*
 20 *1 year before the date specified in subsection*
 21 *(d)(1)(A), the Secretary shall submit a report to Con-*
 22 *gress and the Comptroller General of the United*
 23 *States that describes a plan for an appropriate tran-*
 24 *sition. The Comptroller General shall conduct an*
 25 *evaluation of such plan and shall submit to Congress,*

1 *not later than 6 months after the date the report is*
 2 *received, a report on such evaluation and shall in-*
 3 *clude in such report such recommendations as the*
 4 *Comptroller General deems appropriate.*

5 (2) *STATUS OF IMPLEMENTATION.*—*The Sec-*
 6 *retary shall submit a report to Congress not later*
 7 *than October 1, 2008, that describes the status of im-*
 8 *plementation of such amendments and that includes*
 9 *a description of the following:*

10 (A) *The number of contracts that have been*
 11 *competitively bid as of such date.*

12 (B) *The distribution of functions among*
 13 *contracts and contractors.*

14 (C) *A timeline for complete transition to*
 15 *full competition.*

16 (D) *A detailed description of how the Sec-*
 17 *retary has modified oversight and management*
 18 *of medicare contractors to adapt to full competi-*
 19 *tion.*

20 ***Subtitle D—Education and***
 21 ***Outreach Improvements***

22 ***SEC. 531. PROVIDER EDUCATION AND TECHNICAL ASSIST-***
 23 ***ANCE.***

24 (a) *COORDINATION OF EDUCATION FUNDING.*—

1 (1) *IN GENERAL.*—*The Social Security Act is*
 2 *amended by inserting after section 1888 the following*
 3 *new section:*

4 “*PROVIDER EDUCATION AND TECHNICAL ASSISTANCE*

5 “*SEC. 1889. (a) COORDINATION OF EDUCATION FUND-*
 6 *ING.*—*The Secretary shall coordinate the educational activi-*
 7 *ties provided through medicare contractors (as defined in*
 8 *subsection (e), including under section 1893) in order to*
 9 *maximize the effectiveness of Federal education efforts for*
 10 *providers of services, physicians, practitioners, and sup-*
 11 *pliers.”.*

12 (2) *EFFECTIVE DATE.*—*The amendment made by*
 13 *paragraph (1) shall take effect on the date of enact-*
 14 *ment of this Act.*

15 (3) *REPORT.*—*Not later than October 1, 2004,*
 16 *the Secretary shall submit to Congress a report that*
 17 *includes a description and evaluation of the steps*
 18 *taken to coordinate the funding of provider education*
 19 *under section 1889(a) of the Social Security Act, as*
 20 *added by paragraph (1).*

21 (b) *INCENTIVES TO IMPROVE CONTRACTOR PERFORM-*
 22 *ANCE.*—

23 (1) *IN GENERAL.*—*Section 1874A, as added by*
 24 *section 521(a)(1), is amended by adding at the end*
 25 *the following new subsection:*

1 “(e) *INCENTIVES TO IMPROVE CONTRACTOR PERFORM-*
 2 *ANCE IN PROVIDER EDUCATION AND OUTREACH.*—

3 “(1) *METHODOLOGY TO MEASURE CONTRACTOR*
 4 *ERROR RATES.*—*In order to give medicare contractors*
 5 *(as defined in paragraph (3)) an incentive to imple-*
 6 *ment effective education and outreach programs for*
 7 *providers of services, physicians, practitioners, and*
 8 *suppliers, the Secretary shall develop and implement*
 9 *by October 1, 2004, a methodology to measure the spe-*
 10 *cific claims payment error rates of such contractors*
 11 *in the processing or reviewing of medicare claims.*

12 “(2) *GAO REVIEW OF METHODOLOGY.*—*The*
 13 *Comptroller General of the United States shall review,*
 14 *and make recommendations to the Secretary, regard-*
 15 *ing the adequacy of such methodology.*

16 “(3) *MEDICARE CONTRACTOR DEFINED.*—*For*
 17 *purposes of this subsection, the term ‘medicare con-*
 18 *tractor’ includes a medicare administrative con-*
 19 *tractor, a fiscal intermediary with a contract under*
 20 *section 1816, and a carrier with a contract under sec-*
 21 *tion 1842.’.*

22 “(2) *REPORT.*—*The Secretary shall submit to*
 23 *Congress a report that describes how the Secretary in-*
 24 *tends to use the methodology developed under section*
 25 *1874A(e)(1) of the Social Security Act, as added by*

1 *paragraph (1), in assessing medicare contractor per-*
 2 *formance in implementing effective education and*
 3 *outreach programs, including whether to use such*
 4 *methodology as a basis for performance bonuses.*

5 *(c) IMPROVED PROVIDER EDUCATION AND TRAIN-*
 6 *ING.—*

7 *(1) INCREASED FUNDING FOR ENHANCED EDU-*
 8 *CATION AND TRAINING THROUGH MEDICARE INTEG-*
 9 *RITY PROGRAM.—Section 1817(k)(4) (42 U.S.C.*
 10 *1395i(k)(4)) is amended—*

11 *(A) in subparagraph (A), by striking “sub-*
 12 *paragraph (B)” and inserting “subparagraphs*
 13 *(B) and (C)”;*

14 *(B) in subparagraph (B), by striking “The*
 15 *amount appropriated” and inserting “Subject to*
 16 *subparagraph (C), the amount appropriated”;*
 17 *and*

18 *(C) by adding at the end the following new*
 19 *subparagraph:*

20 *“(C) ENHANCED PROVIDER EDUCATION AND*
 21 *TRAINING.—*

22 *“(i) IN GENERAL.—In addition to the*
 23 *amount appropriated under subparagraph*
 24 *(B), the amount appropriated under sub-*
 25 *paragraph (A) for a fiscal year (beginning*

with fiscal year 2004) is increased by
\$35,000,000.

“(ii) *USE.*—The funds made available
under this subparagraph shall be used only
to increase the conduct by medicare contrac-
tors of education and training of providers
of services, physicians, practitioners, and
suppliers regarding billing, coding, and
other appropriate items and may also be
used to improve the accuracy, consistency,
and timeliness of contractor responses to
written and phone inquiries from providers
of services, physicians, practitioners, and
suppliers.”.

(2) *TAILORING EDUCATION AND TRAINING FOR
SMALL PROVIDERS OR SUPPLIERS.*—

(A) *IN GENERAL.*—Section 1889, as added
by subsection (a), is amended by adding at the
end the following new subsection:

“(b) *TAILORING EDUCATION AND TRAINING ACTIVI-
TIES FOR SMALL PROVIDERS OR SUPPLIERS.*—

“(1) *IN GENERAL.*—Insofar as a medicare con-
tractor conducts education and training activities, it
shall take into consideration the special needs of small
providers of services or suppliers (as defined in para-

graph (2)). Such education and training activities for small providers of services and suppliers may include the provision of technical assistance (such as review of billing systems and internal controls to determine program compliance and to suggest more efficient and effective means of achieving such compliance).

“(2) *SMALL PROVIDER OF SERVICES OR SUPPLIER.*—In this subsection, the term ‘small provider of services or supplier’ means—

“(A) an institutional provider of services with fewer than 25 full-time-equivalent employees; or

“(B) a physician, practitioner, or supplier with fewer than 10 full-time-equivalent employees.”.

(B) *EFFECTIVE DATE.*—The amendment made by subparagraph (A) shall take effect on January 1, 2004.

(d) *ADDITIONAL PROVIDER EDUCATION PROVISIONS.*—

(1) *IN GENERAL.*—Section 1889, as added by subsection (a) and as amended by subsection (c)(2), is amended by adding at the end the following new subsections:

1 “(c) *ENCOURAGEMENT OF PARTICIPATION IN EDU-*
 2 *CATION PROGRAM ACTIVITIES.*—A medicare contractor
 3 *may not use a record of attendance at (or failure to attend)*
 4 *educational activities or other information gathered during*
 5 *an educational program conducted under this section or*
 6 *otherwise by the Secretary to select or track providers of*
 7 *services, physicians, practitioners, or suppliers for the pur-*
 8 *pose of conducting any type of audit or prepayment review.*

9 “(d) *CONSTRUCTION.*—Nothing in this section or sec-
 10 *tion 1893(g) shall be construed as providing for disclosure*
 11 *by a medicare contractor—*

12 “(1) *of the screens used for identifying claims*
 13 *that will be subject to medical review; or*

14 “(2) *of information that would compromise*
 15 *pending law enforcement activities or reveal findings*
 16 *of law enforcement-related audits.*

17 “(e) *DEFINITIONS.*—For purposes of this section and
 18 *section 1817(k)(4)(C), the term ‘medicare contractor’ in-*
 19 *cludes the following:*

20 “(1) *A medicare administrative contractor with*
 21 *a contract under section 1874A, a fiscal intermediary*
 22 *with a contract under section 1816, and a carrier*
 23 *with a contract under section 1842.*

24 “(2) *An eligible entity with a contract under sec-*
 25 *tion 1893.*

1 *Such term does not include, with respect to activities of a*
 2 *specific provider of services, physician, practitioner, or sup-*
 3 *plier an entity that has no authority under this title or*
 4 *title XI with respect to such activities and such provider*
 5 *of services, physician, practitioner, or supplier.”.*

6 (2) *EFFECTIVE DATE.*—*The amendment made by*
 7 *paragraph (1) shall take effect on the date of enact-*
 8 *ment of this Act.*

9 **SEC. 532. ACCESS TO AND PROMPT RESPONSES FROM MEDI-**
 10 **CARE CONTRACTORS.**

11 (a) *IN GENERAL.*—*Section 1874A, as added by section*
 12 *521(a)(1) and as amended by section 531(b)(1), is amended*
 13 *by adding at the end the following new subsection:*

14 “(f) *COMMUNICATING WITH BENEFICIARIES AND PRO-*
 15 *VIDERS.*—

16 “(1) *COMMUNICATION PROCESS.*—*The Secretary*
 17 *shall develop a process for medicare contractors to*
 18 *communicate with beneficiaries and with providers of*
 19 *services, physicians, practitioners, and suppliers*
 20 *under this title.*

21 “(2) *RESPONSE TO WRITTEN INQUIRIES.*—*Each*
 22 *medicare contractor (as defined in paragraph (5))*
 23 *shall provide general written responses (which may be*
 24 *through electronic transmission) in a clear, concise,*
 25 *and accurate manner to inquiries by beneficiaries,*

1 providers of services, physicians, practitioners, and
 2 suppliers concerning the programs under this title
 3 within 45 business days of the date of receipt of such
 4 inquiries.

5 “(3) *RESPONSE TO TOLL-FREE LINES.*—The Sec-
 6 retary shall ensure that medicare contractors provide
 7 a toll-free telephone number at which beneficiaries,
 8 providers, physicians, practitioners, and suppliers
 9 may obtain information regarding billing, coding,
 10 claims, coverage, and other appropriate information
 11 under this title.

12 “(4) *MONITORING OF CONTRACTOR RE-*
 13 *SPONSES.*—

14 “(A) *IN GENERAL.*—Each medicare con-
 15 tractor shall, consistent with standards developed
 16 by the Secretary under subparagraph (B)—

17 “(i) *maintain a system for identifying*
 18 *who provides the information referred to in*
 19 *paragraphs (2) and (3); and*

20 “(ii) *monitor the accuracy, consist-*
 21 *ency, and timeliness of the information so*
 22 *provided.*

23 “(B) *DEVELOPMENT OF STANDARDS.*—

24 “(i) *IN GENERAL.*—The Secretary shall
 25 *establish (and publish in the Federal Reg-*

1 *ister) standards regarding the accuracy,*
2 *consistency, and timeliness of the informa-*
3 *tion provided in response to inquiries under*
4 *this subsection. Such standards shall be con-*
5 *sistent with the performance requirements*
6 *established under subsection (b)(3).*

7 “(ii) *EVALUATION.*—*In conducting*
8 *evaluations of individual medicare contrac-*
9 *tors, the Secretary shall consider the results*
10 *of the monitoring conducted under subpara-*
11 *graph (A) taking into account as perform-*
12 *ance requirements the standards established*
13 *under clause (i). The Secretary shall, in*
14 *consultation with organizations rep-*
15 *resenting providers of services, suppliers,*
16 *and individuals entitled to benefits under*
17 *part A or enrolled under part B, or both, es-*
18 *tablish standards relating to the accuracy,*
19 *consistency, and timeliness of the informa-*
20 *tion so provided.*

21 “(C) *DIRECT MONITORING.*—*Nothing in this*
22 *paragraph shall be construed as preventing the*
23 *Secretary from directly monitoring the accuracy,*
24 *consistency, and timeliness of the information so*
25 *provided.*

1 “(5) *MEDICARE CONTRACTOR DEFINED.*—For
 2 purposes of this subsection, the term ‘medicare con-
 3 tractor’ has the meaning given such term in sub-
 4 section (e)(3).”.

5 (b) *EFFECTIVE DATE.*—The amendment made by sub-
 6 section (a) shall take effect October 1, 2004.

7 **SEC. 533. RELIANCE ON GUIDANCE.**

8 (a) *IN GENERAL.*—Section 1871(d), as added by sec-
 9 tion 502(a), is amended by adding at the end the following
 10 new paragraph:

11 “(2) If—

12 “(A) a provider of services, physician, practi-
 13 tioner, or other supplier follows written guidance pro-
 14 vided—

15 “(i) by the Secretary; or

16 “(ii) by a medicare contractor (as defined
 17 in section 1889(e) and whether in the form of a
 18 written response to a written inquiry under sec-
 19 tion 1874A(f)(1) or otherwise) acting within the
 20 scope of the contractor’s contract authority,
 21 in response to a written inquiry with respect to the
 22 furnishing of items or services or the submission of a
 23 claim for benefits for such items or services;

24 “(B) the Secretary determines that—

1 “(i) the provider of services, physician,
2 practitioner, or supplier has accurately presented
3 the circumstances relating to such items, services,
4 and claim to the Secretary or the contractor in
5 the written guidance; and

6 “(ii) there is no indication of fraud or
7 abuse committed by the provider of services, phy-
8 sician, practitioner, or supplier against the pro-
9 gram under this title; and

10 “(C) the guidance was in error;
11 the provider of services, physician, practitioner, or supplier
12 shall not be subject to any penalty or interest under this
13 title (or the provisions of title XI insofar as they relate to
14 this title) relating to the provision of such items or service
15 or such claim if the provider of services, physician, practi-
16 tioner, or supplier reasonably relied on such guidance. In
17 applying this paragraph with respect to guidance in the
18 form of general responses to frequently asked questions, the
19 Secretary retains authority to determine the extent to which
20 such general responses apply to the particular cir-
21 cumstances of individual claims.”.

22 (b) *EFFECTIVE DATE.*—The amendment made by sub-
23 section (a) shall apply to penalties imposed on or after the
24 date of enactment of this Act.

1 **SEC. 534. MEDICARE PROVIDER OMBUDSMAN.**

2 (a) *MEDICARE PROVIDER OMBUDSMAN.*—Section 1868
3 (42 U.S.C. 1395ee) is amended—

4 (1) by adding at the end of the heading the fol-
5 lowing: “; *MEDICARE PROVIDER OMBUDSMAN*”;

6 (2) by inserting “*PRACTICING PHYSICIANS ADVI-*
7 *SORY COUNCIL.—(1)*” after “(a)”;

8 (3) in paragraph (1), as so redesignated under
9 paragraph (2), by striking “in this section” and in-
10 sserting “in this subsection”;

11 (4) by redesignating subsections (b) and (c) as
12 paragraphs (2) and (3), respectively; and

13 (5) by adding at the end the following new sub-
14 section:

15 “(b) *MEDICARE PROVIDER OMBUDSMAN.*—

16 “(1) *IN GENERAL.*—By not later than 1 year
17 after the date of enactment of the Prescription Drug
18 and Medicare Improvement Act of 2003, the Secretary
19 shall appoint a Medicare Provider Ombudsman.

20 “(2) *DUTIES.*—The Medicare Provider Ombuds-
21 man shall—

22 “(A) provide assistance, on a confidential
23 basis, to entities and individuals providing items
24 and services, including covered drugs under part
25 D, under this title with respect to complaints,
26 grievances, and requests for information con-

cerning the programs under this title (including provisions of title XI insofar as they relate to this title and are not administered by the Office of the Inspector General of the Department of Health and Human Services) and in the resolution of unclear or conflicting guidance given by the Secretary and medicare contractors to such providers of services and suppliers regarding such programs and provisions and requirements under this title and such provisions; and

“(B) submit recommendations to the Secretary for improvement in the administration of this title and such provisions, including—

“(i) recommendations to respond to recurring patterns of confusion in this title and such provisions (including recommendations regarding suspending imposition of sanctions where there is widespread confusion in program administration), and

“(ii) recommendations to provide for an appropriate and consistent response (including not providing for audits) in cases of self-identified overpayments by providers of services and suppliers.

1 “(3) *STAFF.*—*The Secretary shall provide the*
 2 *Medicare Provider Ombudsman with appropriate*
 3 *staff.*”.

4 (b) *FUNDING.*—*There are authorized to be appro-*
 5 *priated to the Secretary (in appropriate part from the Fed-*
 6 *eral Hospital Insurance Trust Fund and the Federal Sup-*
 7 *plementary Medical Insurance Trust Fund (including the*
 8 *Prescription Drug Account)) to carry out the provisions of*
 9 *subsection (b) of section 1868 of the Social Security Act*
 10 *(42 U.S.C. 1395ee) (relating to the Medicare Provider Om-*
 11 *budsman), as added by subsection (a)(5), such sums as are*
 12 *necessary for fiscal year 2004 and each succeeding fiscal*
 13 *year.*

14 **SEC. 535. BENEFICIARY OUTREACH DEMONSTRATION PRO-**
 15 **GRAMS.**

16 (a) *DEMONSTRATION ON THE PROVISION OF ADVICE*
 17 *AND ASSISTANCE TO MEDICARE BENEFICIARIES AT LOCAL*
 18 *OFFICES OF THE SOCIAL SECURITY ADMINISTRATION.*—

19 (1) *ESTABLISHMENT.*—*The Secretary shall estab-*
 20 *lish a demonstration program (in this subsection re-*
 21 *ferred to as the “demonstration program”) under*
 22 *which medicare specialists employed by the Depart-*
 23 *ment of Health and Human Services provide advice*
 24 *and assistance to medicare beneficiaries at the loca-*

tion of existing local offices of the Social Security Administration.

(2) *LOCATIONS.*—

(A) *IN GENERAL.*—The demonstration program shall be conducted in at least 6 offices or areas. Subject to subparagraph (B), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by medicare beneficiaries.

(B) *ASSISTANCE FOR RURAL BENEFICIARIES.*—The Secretary shall provide for the selection of at least 2 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

(3) *DURATION.*—The demonstration program shall be conducted over a 3-year period.

(4) *EVALUATION AND REPORT.*—

(A) *EVALUATION.*—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(i) utilization of, and beneficiary satisfaction with, the assistance provided under the program; and

(ii) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local social security offices.

(B) *REPORT.*—The Secretary shall submit to Congress a report on such evaluation and shall include in such report recommendations regarding the feasibility of permanently out-stationing Medicare specialists at local social security offices.

(b) *DEMONSTRATION ON PROVIDING PRIOR DETERMINATIONS.*—

(1) *ESTABLISHMENT.*—By not later than 1 year after the date of enactment of this Act, the Secretary shall establish a demonstration project to test the administrative feasibility of providing a process for medicare beneficiaries and entities and individuals furnishing such beneficiaries with items and services under title XVIII of the Social Security Act program to make a request for, and receive, a determination (after an advance beneficiary notice is issued with respect to the item or service involved but before such

1 *item or service is furnished to the beneficiary) as to*
 2 *whether the item or service is covered under such title*
 3 *consistent with the applicable requirements of section*
 4 *1862(a)(1)(A) of such Act (42 U.S.C. 1395y(a)(1)(A))*
 5 *(relating to medical necessity).*

6 (2) *EVALUATION AND REPORT.*—

7 (A) *EVALUATION.*—*The Secretary shall provide*
 8 *for an evaluation of the demonstration program con-*
 9 *ducted under paragraph (1).*

10 (B) *REPORT.*—*By not later than January 1,*
 11 *2006, the Secretary shall submit to Congress a report*
 12 *on such evaluation together with recommendations for*
 13 *such legislation and administrative actions as the*
 14 *Secretary considers appropriate.*

15 ***Subtitle E—Review, Recovery, and***
 16 ***Enforcement Reform***

17 ***SEC. 541. PREPAYMENT REVIEW.***

18 (a) *IN GENERAL.*—*Section 1874A, as added by section*
 19 *521(a)(1) and as amended by sections 531(b)(1) and*
 20 *532(a), is amended by adding at the end the following new*
 21 *subsection:*

22 “(g) *CONDUCT OF PREPAYMENT REVIEW.*—

23 “(1) *STANDARDIZATION OF RANDOM PREPAY-*
 24 *MENT REVIEW.*—*A medicare administrative con-*
 25 *tractor shall conduct random prepayment review only*

1 *in accordance with a standard protocol for random*
 2 *prepayment audits developed by the Secretary.*

3 “(2) *LIMITATIONS ON INITIATION OF NONRANDOM*
 4 *PREPAYMENT REVIEW.—A medicare administrative*
 5 *contractor may not initiate nonrandom prepayment*
 6 *review of a provider of services, physician, practi-*
 7 *tioner, or supplier based on the initial identification*
 8 *by that provider of services, physician, practitioner,*
 9 *or supplier of an improper billing practice unless*
 10 *there is a likelihood of sustained or high level of pay-*
 11 *ment error (as defined by the Secretary).*

12 “(3) *TERMINATION OF NONRANDOM PREPAYMENT*
 13 *REVIEW.—The Secretary shall establish protocols or*
 14 *standards relating to the termination, including ter-*
 15 *mination dates, of nonrandom prepayment review.*
 16 *Such regulations may vary such a termination date*
 17 *based upon the differences in the circumstances trig-*
 18 *gering prepayment review.*

19 “(4) *CONSTRUCTION.—Nothing in this subsection*
 20 *shall be construed as preventing the denial of pay-*
 21 *ments for claims actually reviewed under a random*
 22 *prepayment review. In the case of a provider of serv-*
 23 *ices, physician, practitioner, or supplier with respect*
 24 *to which amounts were previously overpaid, nothing*
 25 *in this subsection shall be construed as limiting the*

1 *ability of a medicare administrative contractor to re-*
 2 *quest the periodic production of records or supporting*
 3 *documentation for a limited sample of submitted*
 4 *claims to ensure that the previous practice is not con-*
 5 *tinuing.*

6 “(5) *RANDOM PREPAYMENT REVIEW DEFINED.*—
 7 *For purposes of this subsection, the term ‘random pre-*
 8 *payment review’ means a demand for the production*
 9 *of records or documentation absent cause with respect*
 10 *to a claim.’.*

11 *(b) EFFECTIVE DATE.*—

12 (1) *IN GENERAL.*—*Except as provided in this*
 13 *subsection, the amendment made by subsection (a)*
 14 *shall take effect on the date of enactment of this Act.*

15 (2) *DEADLINE FOR PROMULGATION OF CERTAIN*
 16 *REGULATIONS.*—*The Secretary shall first issue regula-*
 17 *tions under section 1874A(g) of the Social Security*
 18 *Act, as added by subsection (a), by not later than 1*
 19 *year after the date of enactment of this Act.*

20 (3) *APPLICATION OF STANDARD PROTOCOLS FOR*
 21 *RANDOM PREPAYMENT REVIEW.*—*Section 1874A(g)(1)*
 22 *of the Social Security Act, as added by subsection (a),*
 23 *shall apply to random prepayment reviews conducted*
 24 *on or after such date (not later than 1 year after the*
 25 *date of enactment of this Act) as the Secretary shall*

1 specify. The Secretary shall develop and publish the
 2 standard protocol under such section by not later
 3 than 1 year after the date of enactment of this Act.

4 **SEC. 542. RECOVERY OF OVERPAYMENTS.**

5 (a) *IN GENERAL*.—Section 1874A, as added by section
 6 521(a)(1) and as amended by sections 531(b)(1), 532(a),
 7 and 541(a), is amended by adding at the end the following
 8 new subsection:

9 “(h) *RECOVERY OF OVERPAYMENTS*.—

10 “(1) *USE OF REPAYMENT PLANS*.—

11 “(A) *IN GENERAL*.—If the repayment, with-
 12 in the period otherwise permitted by a provider
 13 of services, physician, practitioner, or other sup-
 14 plier, of an overpayment under this title meets
 15 the standards developed under subparagraph (B),
 16 subject to subparagraph (C), and the provider,
 17 physician, practitioner, or supplier requests the
 18 Secretary to enter into a repayment plan with
 19 respect to such overpayment, the Secretary shall
 20 enter into a plan with the provider, physician,
 21 practitioner, or supplier for the offset or repay-
 22 ment (at the election of the provider, physician,
 23 practitioner, or supplier) of such overpayment
 24 over a period of at least 1 year, but not longer
 25 than 3 years. Interest shall accrue on the balance

1 *through the period of repayment. The repayment*
2 *plan shall meet terms and conditions determined*
3 *to be appropriate by the Secretary.*

4 “(B) *DEVELOPMENT OF STANDARDS.—The*
5 *Secretary shall develop standards for the recov-*
6 *ery of overpayments. Such standards shall—*

7 “(i) *include a requirement that the*
8 *Secretary take into account (and weigh in*
9 *favor of the use of a repayment plan) the*
10 *reliance (as described in section 1871(d)(2))*
11 *by a provider of services, physician, practi-*
12 *tioner, and supplier on guidance when de-*
13 *termining whether a repayment plan should*
14 *be offered; and*

15 “(ii) *provide for consideration of the*
16 *financial hardship imposed on a provider of*
17 *services, physician, practitioner, or supplier*
18 *in considering such a repayment plan.*

19 *In developing standards with regard to financial*
20 *hardship with respect to a provider of services,*
21 *physician, practitioner, or supplier, the Sec-*
22 *retary shall take into account the amount of the*
23 *proposed recovery as a proportion of payments*
24 *made to that provider, physician, practitioner,*
25 *or supplier.*

1 “(C) *EXCEPTIONS.—Subparagraph (A)*
2 *shall not apply if—*

3 “(i) *the Secretary has reason to suspect*
4 *that the provider of services, physician,*
5 *practitioner, or supplier may file for bank-*
6 *ruptcy or otherwise cease to do business or*
7 *discontinue participation in the program*
8 *under this title; or*

9 “(ii) *there is an indication of fraud or*
10 *abuse committed against the program.*

11 “(D) *IMMEDIATE COLLECTION IF VIOLATION*
12 *OF REPAYMENT PLAN.—If a provider of services,*
13 *physician, practitioner, or supplier fails to make*
14 *a payment in accordance with a repayment plan*
15 *under this paragraph, the Secretary may imme-*
16 *diately seek to offset or otherwise recover the total*
17 *balance outstanding (including applicable inter-*
18 *est) under the repayment plan.*

19 “(E) *RELATION TO NO FAULT PROVISION.—*
20 *Nothing in this paragraph shall be construed as*
21 *affecting the application of section 1870(c) (re-*
22 *lating to no adjustment in the cases of certain*
23 *overpayments).*

24 “(2) *LIMITATION ON RECOUPMENT.—*

1 “(A) *NO RECOUPMENT UNTIL RECONSIDER-*
 2 *ATION EXERCISED.*—*In the case of a provider of*
 3 *services, physician, practitioner, or supplier that*
 4 *is determined to have received an overpayment*
 5 *under this title and that seeks a reconsideration*
 6 *of such determination by a qualified independent*
 7 *contractor under section 1869(c), the Secretary*
 8 *may not take any action (or authorize any other*
 9 *person, including any Medicare contractor, as*
 10 *defined in subparagraph (C)) to recoup the over-*
 11 *payment until the date the decision on the recon-*
 12 *sideration has been rendered.*

13 “(B) *PAYMENT OF INTEREST.*—

14 “(i) *RETURN OF RECOUPED AMOUNT*
 15 *WITH INTEREST IN CASE OF REVERSAL.*—
 16 *Insofar as such determination on appeal*
 17 *against the provider of services, physician,*
 18 *practitioner, or supplier is later reversed,*
 19 *the Secretary shall provide for repayment of*
 20 *the amount recouped plus interest for the*
 21 *period in which the amount was recouped.*

22 “(ii) *INTEREST IN CASE OF AFFIRMA-*
 23 *TION.*—*Insofar as the determination on*
 24 *such appeal is against the provider of serv-*
 25 *ices, physician, practitioner, or supplier,*

1 *interest on the overpayment shall accrue on*
 2 *and after the date of the original notice of*
 3 *overpayment.*

4 “(iii) *RATE OF INTEREST.*—*The rate of*
 5 *interest under this subparagraph shall be*
 6 *the rate otherwise applicable under this title*
 7 *in the case of overpayments.*

8 “(C) *MEDICARE CONTRACTOR DEFINED.*—
 9 *For purposes of this subsection, the term ‘medi-*
 10 *care contractor’ has the meaning given such term*
 11 *in section 1889(e).*

12 “(3) *PAYMENT AUDITS.*—

13 “(A) *WRITTEN NOTICE FOR POST-PAYMENT*
 14 *AUDITS.*—*Subject to subparagraph (C), if a*
 15 *medicare contractor decides to conduct a post-*
 16 *payment audit of a provider of services, physi-*
 17 *cian, practitioner, or supplier under this title,*
 18 *the contractor shall provide the provider of serv-*
 19 *ices, physician, practitioner, or supplier with*
 20 *written notice (which may be in electronic form)*
 21 *of the intent to conduct such an audit.*

22 “(B) *EXPLANATION OF FINDINGS FOR ALL*
 23 *AUDITS.*—*Subject to subparagraph (C), if a*
 24 *medicare contractor audits a provider of services,*

1 *physician, practitioner, or supplier under this*
2 *title, the contractor shall—*

3 “(i) *give the provider of services, phy-*
4 *sician, practitioner, or supplier a full re-*
5 *view and explanation of the findings of the*
6 *audit in a manner that is understandable*
7 *to the provider of services, physician, prac-*
8 *titioner, or supplier and permits the devel-*
9 *opment of an appropriate corrective action*
10 *plan;*

11 “(ii) *inform the provider of services,*
12 *physician, practitioner, or supplier of the*
13 *appeal rights under this title as well as con-*
14 *sent settlement options (which are at the*
15 *discretion of the Secretary); and*

16 “(iii) *give the provider of services, phy-*
17 *sician, practitioner, or supplier an oppor-*
18 *tunity to provide additional information to*
19 *the contractor.*

20 “(C) *EXCEPTION.—Subparagraphs (A) and*
21 *(B) shall not apply if the provision of notice or*
22 *findings would compromise pending law enforce-*
23 *ment activities, whether civil or criminal, or re-*
24 *veal findings of law enforcement-related audits.*

1 “(4) NOTICE OF OVER-UTILIZATION OF CODES.—

2 *The Secretary shall establish, in consultation with or-*
 3 *ganizations representing the classes of providers of*
 4 *services, physicians, practitioners, and suppliers, a*
 5 *process under which the Secretary provides for notice*
 6 *to classes of providers of services, physicians, practi-*
 7 *tioners, and suppliers served by a medicare contractor*
 8 *in cases in which the contractor has identified that*
 9 *particular billing codes may be overutilized by that*
 10 *class of providers of services, physicians, practi-*
 11 *tioners, or suppliers under the programs under this*
 12 *title (or provisions of title XI insofar as they relate*
 13 *to such programs).*

14 “(5) STANDARD METHODOLOGY FOR PROBE SAM-
 15 PLING.—*The Secretary shall establish a standard*
 16 *methodology for medicare administrative contractors*
 17 *to use in selecting a sample of claims for review in*
 18 *the case of an abnormal billing pattern.*

19 “(6) CONSENT SETTLEMENT REFORMS.—

20 “(A) IN GENERAL.—*The Secretary may use*
 21 *a consent settlement (as defined in subparagraph*
 22 *(D)) to settle a projected overpayment.*

23 “(B) OPPORTUNITY TO SUBMIT ADDITIONAL
 24 INFORMATION BEFORE CONSENT SETTLEMENT
 25 OFFER.—*Before offering a provider of services,*

1 *physician, practitioner, or supplier a consent*
2 *settlement, the Secretary shall—*

3 “(i) *communicate to the provider of*
4 *services, physician, practitioner, or supplier*
5 *in a nonthreatening manner that, based on*
6 *a review of the medical records requested by*
7 *the Secretary, a preliminary evaluation of*
8 *those records indicates that there would be*
9 *an overpayment; and*

10 “(ii) *provide for a 45-day period dur-*
11 *ing which the provider of services, physi-*
12 *cian, practitioner, or supplier may furnish*
13 *additional information concerning the med-*
14 *ical records for the claims that had been re-*
15 *viewed.*

16 “(C) *CONSENT SETTLEMENT OFFER.—The*
17 *Secretary shall review any additional informa-*
18 *tion furnished by the provider of services, physi-*
19 *cian, practitioner, or supplier under subpara-*
20 *graph (B)(ii). Taking into consideration such*
21 *information, the Secretary shall determine if*
22 *there still appears to be an overpayment. If so,*
23 *the Secretary—*

24 “(i) *shall provide notice of such deter-*
25 *mination to the provider of services, physi-*

1 *cian, practitioner, or supplier, including an*
 2 *explanation of the reason for such deter-*
 3 *mination; and*

4 *“(ii) in order to resolve the overpay-*
 5 *ment, may offer the provider of services,*
 6 *physician, practitioner, or supplier—*

7 *“(I) the opportunity for a statis-*
 8 *tically valid random sample; or*

9 *“(II) a consent settlement.*

10 *The opportunity provided under clause (ii)(I)*
 11 *does not waive any appeal rights with respect to*
 12 *the alleged overpayment involved.*

13 *“(D) CONSENT SETTLEMENT DEFINED.—*

14 *For purposes of this paragraph, the term ‘con-*
 15 *sent settlement’ means an agreement between the*
 16 *Secretary and a provider of services, physician,*
 17 *practitioner, or supplier whereby both parties*
 18 *agree to settle a projected overpayment based on*
 19 *less than a statistically valid sample of claims*
 20 *and the provider of services, physician, practi-*
 21 *tioner, or supplier agrees not to appeal the*
 22 *claims involved.”.*

23 *(b) EFFECTIVE DATES AND DEADLINES.—*

24 *(1) Not later than 1 year after the date of enact-*
 25 *ment of this Act, the Secretary shall first—*

1 (A) develop standards for the recovery of
2 overpayments under section 1874A(h)(1)(B) of
3 the Social Security Act, as added by subsection
4 (a);

5 (B) establish the process for notice of over-
6 utilization of billing codes under section
7 1874A(h)(4) of the Social Security Act, as added
8 by subsection (a); and

9 (C) establish a standard methodology for se-
10 lection of sample claims for abnormal billing
11 patterns under section 1874A(h)(5) of the Social
12 Security Act, as added by subsection (a).

13 (2) Section 1874A(h)(2) of the Social Security
14 Act, as added by subsection (a), shall apply to actions
15 taken after the date that is 1 year after the date of
16 enactment of this Act.

17 (3) Section 1874A(h)(3) of the Social Security
18 Act, as added by subsection (a), shall apply to audits
19 initiated after the date of enactment of this Act.

20 (4) Section 1874A(h)(6) of the Social Security
21 Act, as added by subsection (a), shall apply to consent
22 settlements entered into after the date of enactment of
23 this Act.

1 **SEC. 543. PROCESS FOR CORRECTION OF MINOR ERRORS**
 2 **AND OMISSIONS ON CLAIMS WITHOUT PUR-**
 3 **SUING APPEALS PROCESS.**

4 (a) *IN GENERAL.*—The Secretary shall develop, in con-
 5 sultation with appropriate medicare contractors (as defined
 6 in section 1889(e) of the Social Security Act, as added by
 7 section 531(d)(1)) and representatives of providers of serv-
 8 ices, physicians, practitioners, facilities, and suppliers, a
 9 process whereby, in the case of minor errors or omissions
 10 (as defined by the Secretary) that are detected in the sub-
 11 mission of claims under the programs under title XVIII of
 12 such Act, a provider of services, physician, practitioner, fa-
 13 cility, or supplier is given an opportunity to correct such
 14 an error or omission without the need to initiate an appeal.
 15 Such process shall include the ability to resubmit corrected
 16 claims.

17 (b) *DEADLINE.*—Not later than 1 year after the date
 18 of enactment of this Act, the Secretary shall first develop
 19 the process under subsection (a).

20 **SEC. 544. AUTHORITY TO WAIVE A PROGRAM EXCLUSION.**

21 The first sentence of section 1128(c)(3)(B) (42 U.S.C.
 22 1320a–7(c)(3)(B)) is amended to read as follows: “Subject
 23 to subparagraph (G), in the case of an exclusion under sub-
 24 section (a), the minimum period of exclusion shall be not
 25 less than 5 years, except that, upon the request of an admin-
 26 istrator of a Federal health care program (as defined in

1 *section 1128B(f)) who determines that the exclusion would*
 2 *impose a hardship on beneficiaries of that program, the Sec-*
 3 *retary may, after consulting with the Inspector General of*
 4 *the Department of Health and Human Services, waive the*
 5 *exclusion under subsection (a)(1), (a)(3), or (a)(4) with re-*
 6 *spect to that program in the case of an individual or entity*
 7 *that is the sole community physician or sole source of essen-*
 8 *tial specialized services in a community.”.*

9 ***TITLE VI—OTHER PROVISIONS***

10 ***SEC. 601. INCREASE IN MEDICAID DSH ALLOTMENTS FOR*** 11 ***FISCAL YEARS 2004 AND 2005.***

12 (a) *IN GENERAL.*—Section 1923(f)(4) (42 U.S.C.
 13 1396r–4(f)(4)) *is amended—*

14 (1) *in the paragraph heading, by striking “FIS-*
 15 *CAL YEARS 2001 AND 2002” and inserting “CERTAIN*
 16 *FISCAL YEARS”;*

17 (2) *in subparagraph (A)—*

18 (A) *in clause (i)—*

19 (i) *by striking “paragraph (2)” and*
 20 *inserting “paragraphs (2) and (3)”;* and

21 (ii) *by striking “and” at the end;*

22 (B) *in clause (ii), by striking the period*
 23 *and inserting a semicolon; and*

24 (C) *by adding at the end the following:*

1 “(iii) for fiscal year 2004, shall be the
 2 DSH allotment determined under para-
 3 graph (3) for that fiscal year increased by
 4 the amount equal to the product of 0.50 and
 5 the difference between—

6 “(I) the amount that the DSH al-
 7 lotment would be if the DSH allotment
 8 for the State determined under clause
 9 (ii) were increased, subject to subpara-
 10 graph (B) and paragraph (5), by the
 11 percentage change in the Consumer
 12 Price Index for all urban consumers
 13 (all items; U.S. city average) for each
 14 of fiscal years 2002 and 2003; and

15 “(II) the DSH allotment deter-
 16 mined under paragraph (3) for the
 17 State for fiscal year 2004; and

18 “(iv) for fiscal year 2005, shall be the
 19 DSH allotment determined under para-
 20 graph (3) for that fiscal year increased by
 21 the amount equal to the product of 0.50 and
 22 the difference between—

23 “(I) the amount that the DSH al-
 24 lotment would be if the DSH allotment
 25 for the State determined under clause

1 (ii) were increased, subject to subpara-
 2 graph (B) and paragraph (5), by the
 3 percentage change in the Consumer
 4 Price Index for all urban consumers
 5 (all items; U.S. city average) for each
 6 of fiscal years 2002, 2003, and 2004;
 7 and

8 “(II) the DSH allotment deter-
 9 mined under paragraph (3) for the
 10 State for fiscal year 2005.”; and

11 (3) in subparagraph (C)—

12 (A) in the subparagraph heading, by strik-
 13 ing “AFTER FISCAL YEAR 2002” and inserting
 14 “FOR OTHER FISCAL YEARS”; and

15 (B) by striking “2003 or” and inserting
 16 “2003, fiscal year 2004, fiscal year 2005, or”.

17 (b) DSH ALLOTMENT FOR THE DISTRICT OF COLUM-
 18 BIA.—Section 1923(f)(4) (42 U.S.C. 1396r-4(f)(4)), as
 19 amended by paragraph (1), is amended—

20 (1) in subparagraph (A), by inserting “and ex-
 21 cept as provided in subparagraph (C)” after “para-
 22 graph (2)”;

23 (2) by redesignating subparagraph (C) as sub-
 24 paragraph (D); and

1 (3) *by inserting after subparagraph (B) the fol-*
 2 *lowing:*

3 “(C) *DSH ALLOTMENT FOR THE DISTRICT*
 4 *OF COLUMBIA.—*

5 “(i) *IN GENERAL.—Notwithstanding*
 6 *subparagraph (A), the DSH allotment for*
 7 *the District of Columbia for fiscal year*
 8 *2004, shall be determined by substituting*
 9 *“49” for “32” in the item in the table con-*
 10 *tained in paragraph (2) with respect to the*
 11 *DSH allotment for FY 00 (fiscal year 2000)*
 12 *for the District of Columbia, and then in-*
 13 *creasing such allotment, subject to subpara-*
 14 *graph (B) and paragraph (5), by the per-*
 15 *centage change in the Consumer Price Index*
 16 *for all urban consumers (all items; U.S.*
 17 *city average) for each of fiscal years 2000,*
 18 *2001, 2002, and 2003.*

19 “(ii) *NO APPLICATION TO ALLOTMENTS*
 20 *AFTER FISCAL YEAR 2004.—The DSH allot-*
 21 *ment for the District of Columbia for fiscal*
 22 *year 2003, fiscal year 2005, or any suc-*
 23 *ceeding fiscal year shall be determined*
 24 *under paragraph (3) without regard to the*

1 *DSH allotment determined under clause*
 2 *(i).”.*

3 (c) *CONFORMING AMENDMENT.*—Section 1923(f)(3) of
 4 *such Act (42 U.S.C. 1396r-4(f)(3)) is amended by inserting*
 5 *“, paragraph (4),” after “subparagraph (B)”.*

6 **SEC. 602. INCREASE IN FLOOR FOR TREATMENT AS AN EX-**
 7 **TREMELY LOW DSH STATE UNDER THE MED-**
 8 **ICAID PROGRAM FOR FISCAL YEARS 2004 AND**
 9 **2005.**

10 (a) *IN GENERAL.*—Section 1923(f)(5) (42 U.S.C.
 11 *1396r-4(f)(5)) is amended—*

12 (1) *by striking “In the case of” and inserting the*
 13 *following:*

14 “(A) *IN GENERAL.*—*In the case of*”; and

15 (2) *by adding at the end the following:*

16 “(B) *INCREASE IN FLOOR FOR FISCAL*
 17 *YEARS 2004 AND 2005.—*

18 “(i) *FISCAL YEAR 2004.*—*In the case of*
 19 *a State in which the total expenditures*
 20 *under the State plan (including Federal*
 21 *and State shares) for disproportionate share*
 22 *hospital adjustments under this section for*
 23 *fiscal year 2000, as reported to the Admin-*
 24 *istrator of the Centers for Medicare & Med-*
 25 *icaid Services as of August 31, 2003, is*

greater than 0 but less than 3 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for fiscal year 2004 shall be increased to 3 percent of the State's total amount of expenditures under such plan for such assistance during such fiscal year.

“(ii) *FISCAL YEAR 2005.*—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 2001, as reported to the Administrator of the Centers for Medicare & Medicaid Services as of August 31, 2004, is greater than 0 but less than 3 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for fiscal year 2005 shall be the DSH allotment determined for the State for fiscal year 2004 (under clause (i) or paragraph (4) (as applicable)), increased by the percentage change in the consumer price index for all

1 urban consumers (all items; U.S. city aver-
2 age) for fiscal year 2004.

3 “(iii) NO APPLICATION TO ALLOT-
4 MENTS AFTER FISCAL YEAR 2005.—The
5 DSH allotment for any State for fiscal year
6 2006 or any succeeding fiscal year shall be
7 determined under this subsection without
8 regard to the DSH allotments determined
9 under this subparagraph.”.

10 (b) ALLOTMENT ADJUSTMENT.—

11 (1) IN GENERAL.—Section 1923(f) of the Social
12 Security Act (42 U.S.C. 1396r–4(f)) is amended—

13 (A) by redesignating paragraph (6) as
14 paragraph (7); and

15 (B) by inserting after paragraph (5) the fol-
16 lowing:

17 “(6) ALLOTMENT ADJUSTMENT.—Only with re-
18 spect to fiscal year 2004 or 2005, if a statewide waiv-
19 er under section 1115 that was implemented on Janu-
20 ary 1, 1994, is revoked or terminated before the end
21 of either such fiscal year, the Secretary shall—

22 “(A) permit the State whose waiver was re-
23 voked or terminated to submit an amendment to
24 its State plan that would describe the method-
25 ology to be used by the State (after the effective

1 *date of such revocation or termination) to iden-*
 2 *tify and make payments to disproportionate*
 3 *share hospitals, including children’s hospitals*
 4 *and institutions for mental diseases or other*
 5 *mental health facilities (other than State-owned*
 6 *institutions or facilities), on the basis of the pro-*
 7 *portion of patients served by such hospitals that*
 8 *are low-income patients with special needs; and*

9 *“(B) provide for purposes of this subsection*
 10 *for computation of an appropriate DSH allot-*
 11 *ment for the State for fiscal year 2004 or 2005*
 12 *(or both) that provides for the maximum amount*
 13 *(permitted consistent with paragraph (3)(B)(ii))*
 14 *that does not result in greater expenditures*
 15 *under this title than would have been made if*
 16 *such waiver had not been revoked or termi-*
 17 *nated.”.*

18 *(2) TREATMENT OF INSTITUTIONS FOR MENTAL*
 19 *DISEASES.—Section 1923(h)(1) of the Social Security*
 20 *Act (42 U.S.C. 1396r–4(h)(1)) is amended—*

21 *(A) in paragraph (1), in the matter pre-*
 22 *ceding subparagraph (A), by inserting “(subject*
 23 *to paragraph (3))” after “the lesser of the fol-*
 24 *lowing”; and*

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

3 “(3) *SPECIAL RULE.*—The limitation of para-
4 graph (1) shall not apply in the case of a State to
5 which subsection (f)(6) applies.”.

6 **SEC. 603. INCREASED REPORTING REQUIREMENTS TO EN-**
7 **SURE THE APPROPRIATENESS OF PAYMENT**
8 **ADJUSTMENTS TO DISPROPORTIONATE**
9 **SHARE HOSPITALS UNDER THE MEDICAID**
10 **PROGRAM.**

11 Section 1923 (42 U.S.C. 1396r–4) is amended by add-
12 ing at the end the following new subsection:

13 “(j) *ANNUAL REPORTS REGARDING PAYMENT ADJUST-*
14 *MENTS.*—With respect to fiscal year 2004 and each fiscal
15 year thereafter, the Secretary shall require a State, as a
16 condition of receiving a payment under section 1903(a)(1)
17 with respect to a payment adjustment made under this sec-
18 tion, to submit an annual report that—

19 “(1) identifies each disproportionate share hos-
20 pital that received a payment adjustment under this
21 section for the preceding fiscal year and the amount
22 of the payment adjustment made to such hospital for
23 the preceding fiscal year; and

24 “(2) includes such other information as the Sec-
25 retary determines necessary to ensure the appro-

1 *priateness of the payment adjustments made under*
 2 *this section for the preceding fiscal year.”.*

3 **SEC. 604. CLARIFICATION OF INCLUSION OF INPATIENT**
 4 **DRUG PRICES CHARGED TO CERTAIN PUBLIC**
 5 **HOSPITALS IN THE BEST PRICE EXEMPTIONS**
 6 **FOR THE MEDICAID DRUG REBATE PROGRAM.**

7 (a) *IN GENERAL.*—Section 1927(c)(1)(C)(i)(I) of the
 8 *Social Security Act (42 U.S.C. 1396r–8(c)(1)(C)(i)(I)) is*
 9 *amended by inserting before the semicolon the following:*
 10 *“(including inpatient prices charged to hospitals described*
 11 *in section 340B(a)(4)(L) of the Public Health Service Act)”.*

12 (b) *ANTI-DIVERSION PROTECTION.*—Section
 13 *1927(c)(1)(C) of the Social Security Act (42 U.S.C. 1396r–*
 14 *8(c)(1)(C)) is amended by adding at the end the following:*

15 *“(iii) APPLICATION OF AUDITING AND*
 16 *RECORDKEEPING REQUIREMENTS.*—*With re-*
 17 *spect to a covered entity described in section*
 18 *340B(a)(4)(L) of the Public Health Service*
 19 *Act, any drug purchased for inpatient use*
 20 *shall be subject to the auditing and record-*
 21 *keeping requirements described in section*
 22 *340B(a)(5)(C) of the Public Health Service*
 23 *Act.”.*

24 (c) *EFFECTIVE DATE.*—*The amendments made by this*
 25 *section take effect on October 1, 2003.*

1 **SEC. 605. ASSISTANCE WITH COVERAGE OF LEGAL IMMI-**
 2 **GRANTS UNDER THE MEDICAID PROGRAM**
 3 **AND SCHIP.**

4 (a) *MEDICAID PROGRAM*.—Section 1903(v) (42 U.S.C.
 5 1396b(v)) is amended—

6 (1) in paragraph (1), by striking “paragraph
 7 (2)” and inserting “paragraphs (2) and (4)”; and

8 (2) by adding at the end the following new para-
 9 graph:

10 “(4)(A) With respect to any or all of fiscal years 2005
 11 through 2007, a State may elect (in a plan amendment
 12 under this title) to provide medical assistance under this
 13 title (including under a waiver authorized by the Secretary)
 14 for aliens who are lawfully residing in the United States
 15 (including battered aliens described in section 431(c) of
 16 such Act) and who are otherwise eligible for such assistance,
 17 within either or both of the following eligibility categories:

18 “(i) *PREGNANT WOMEN*.—Women during preg-
 19 nancy (and during the 60-day period beginning on
 20 the last day of the pregnancy).

21 “(ii) *CHILDREN*.—Children (as defined under
 22 such plan), including optional targeted low-income
 23 children described in section 1905(u)(2)(B).

24 “(B)(i) In the case of a State that has elected to pro-
 25 vide medical assistance to a category of aliens under sub-
 26 paragraph (A), no debt shall accrue under an affidavit of

1 support against any sponsor of such an alien on the basis
 2 of provision of assistance to such category and the cost of
 3 such assistance shall not be considered as an unreimbursed
 4 cost.

5 “(ii) The provisions of sections 401(a), 402(b), 403,
 6 and 421 of the Personal Responsibility and Work Oppor-
 7 tunity Reconciliation Act of 1996 shall not apply to a State
 8 that makes an election under subparagraph (A).”.

9 (b) SCHIP.—Section 2107(e)(1) (42 U.S.C.
 10 1397gg(e)(1)) is amended by redesignating subparagraphs
 11 (C) and (D) as subparagraph (D) and (E), respectively,
 12 and by inserting after subparagraph (B) the following new
 13 subparagraph:

14 “(C) Section 1903(v)(4) (relating to op-
 15 tional coverage of categories of permanent resi-
 16 dent alien children), but only if the State has
 17 elected to apply such section to the category of
 18 children under title XIX and only with respect
 19 to any or all of fiscal years 2005 through 2007.”.

20 **SEC. 606. ESTABLISHMENT OF CONSUMER OMBUDSMAN AC-**
 21 **COUNT.**

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

24 “(i) CONSUMER OMBUDSMAN ACCOUNT.—

1 “(1) *ESTABLISHMENT.*—*There is hereby estab-*
 2 *lished in the Trust Fund an expenditure account to*
 3 *be known as the ‘Consumer Ombudsman Account’ (in*
 4 *this subsection referred to as the ‘Account’).*

5 “(2) *APPROPRIATED AMOUNTS TO ACCOUNT FOR*
 6 *HEALTH INSURANCE INFORMATION, COUNSELING, AND*
 7 *ASSISTANCE GRANTS.*—

8 “(A) *IN GENERAL.*—*There are hereby ap-*
 9 *propriated to the Account from the Trust Fund*
 10 *for each fiscal year beginning with fiscal year*
 11 *2005, the amount described in subparagraph (B)*
 12 *for such fiscal year for the purpose of making*
 13 *grants under section 4360 of the Omnibus Budg-*
 14 *et Reconciliation Act of 1990.*

15 “(B) *AMOUNT DESCRIBED.*—*For purposes of*
 16 *subparagraph (A), the amount described in this*
 17 *subparagraph for a fiscal year is the amount*
 18 *equal to the product of—*

19 “(i) \$1; and

20 “(ii) *the total number of individuals*
 21 *receiving benefits under this title for the cal-*
 22 *endar year ending on December 31 of the*
 23 *preceding fiscal year.”.*

1 (b) *CONFORMING AMENDMENT.*—Section 4360(g) of
 2 the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C.
 3 1395b–4(g)) is amended to read as follows:

4 “(g) *FUNDING.*—The Secretary shall use amounts ap-
 5 propriated to the Consumer Ombudsman Account in ac-
 6 cordance with section 1817(i) of the Social Security Act for
 7 a fiscal year for making grants under this section for that
 8 fiscal year.”.

9 **SEC. 607. GAO STUDY REGARDING IMPACT OF ASSETS TEST**
 10 **FOR LOW-INCOME BENEFICIARIES.**

11 (a) *STUDY.*—The Comptroller General of the United
 12 States shall conduct a study to determine the extent to
 13 which drug utilization and access to covered drugs for an
 14 individual described in subsection (b) differs from the drug
 15 utilization and access to covered drugs of an individual who
 16 qualifies for the transitional assistance prescription drug
 17 card program under section 1807A of the Social Security
 18 Act (as added by section 111) or for the premiums and cost-
 19 sharing subsidies applicable to a qualified medicare bene-
 20 ficiary, a specified low-income medicare beneficiary, or a
 21 qualifying individual under section 1860D–19 of the Social
 22 Security Act (as added by section 101).

23 (b) *INDIVIDUAL DESCRIBED.*—An individual is de-
 24 scribed in this subsection if the individual does not qualify
 25 for the transitional assistance prescription drug card pro-

1 *gram under section 1807A of the Social Security Act or*
 2 *for the premiums and cost-sharing subsidies applicable to*
 3 *a qualified medicare beneficiary, a specified low-income*
 4 *medicare beneficiary, or a qualifying individual under sec-*
 5 *tion 1860D–19 of the Social Security Act solely as a result*
 6 *of the application of an assets test to the individual.*

7 (c) *REPORT.*—Not later than September 30, 2007, the
 8 Comptroller General shall submit a report to Congress on
 9 the study conducted under subsection (a) that includes such
 10 recommendations for legislation as the Comptroller General
 11 determines are appropriate.

12 (d) *DEFINITIONS.*—In this section:

13 (1) *COVERED DRUGS.*—The term “covered drugs”
 14 has the meaning given that term in section
 15 1860D(a)(D) of the Social Security Act.

16 (2) *QUALIFIED MEDICARE BENEFICIARY; SPECI-*
 17 *FIED LOW-INCOME MEDICARE BENEFICIARY; QUALI-*
 18 *FYING INDIVIDUAL.*—The terms “qualified medicare
 19 beneficiary”, “specified low-income medicare bene-
 20 ficiary” and “qualifying individual” have the mean-
 21 ing given those terms under section 1860D–19 of the
 22 Social Security Act.

23 **SEC. 608. HEALTH CARE INFRASTRUCTURE IMPROVEMENT.**

24 *At the end of the Social Security Act, add the following*
 25 *new title:*

1 **“TITLE XXII—HEALTH CARE IN-**
 2 **FRASTRUCTURE IMPROVE-**
 3 **MENT**

4 **“SEC. 2201. DEFINITIONS.**

5 *“In this title, the following definitions apply:*

6 *“(1) ELIGIBLE PROJECT COSTS.—The term ‘eli-*
 7 *gible project costs’ means amounts substantially all of*
 8 *which are paid by, or for the account of, an obligor*
 9 *in connection with a project, including the cost of—*

10 *“(A) development phase activities, including*
 11 *planning, feasibility analysis, revenue fore-*
 12 *casting, environmental study and review, per-*
 13 *mitting, architectural engineering and design*
 14 *work, and other preconstruction activities;*

15 *“(B) construction, reconstruction, rehabili-*
 16 *tation, replacement, and acquisition of facilities*
 17 *and real property (including land related to the*
 18 *project and improvements to land), environ-*
 19 *mental mitigation, construction contingencies,*
 20 *and acquisition of equipment;*

21 *“(C) capitalized interest necessary to meet*
 22 *market requirements, reasonably required reserve*
 23 *funds, capital issuance expenses, and other car-*
 24 *rying costs during construction;*

1 “(D) major medical equipment determined
2 to be appropriate by the Secretary; and

3 “(E) refinancing projects or activities that
4 are otherwise eligible for financial assistance
5 under subparagraphs (A) through (D).

6 “(2) *FEDERAL CREDIT INSTRUMENT*.—The term
7 ‘Federal credit instrument’ means a secured loan,
8 loan guarantee, or line of credit authorized to be
9 made available under this title with respect to a
10 project.

11 “(3) *INVESTMENT-GRADE RATING*.—The term
12 ‘investment-grade rating’ means a rating category of
13 BBB minus, Baa3, or higher assigned by a rating
14 agency to project obligations offered into the capital
15 markets.

16 “(4) *LENDER*.—The term ‘lender’ means any
17 non-Federal qualified institutional buyer (as defined
18 in section 230.144A(a) of title 17, Code of Federal
19 Regulations (or any successor regulation), known as
20 Rule 144A(a) of the Securities and Exchange Com-
21 mission and issued under the Securities Act of 1933
22 (15 U.S.C. 77a et seq.)), including—

23 “(A) a qualified retirement plan (as defined
24 in section 4974(c) of the Internal Revenue Code

1 *of 1986) that is a qualified institutional buyer;*
 2 *and*

3 *“(B) a governmental plan (as defined in*
 4 *section 414(d) of the Internal Revenue Code of*
 5 *1986) that is a qualified institutional buyer.*

6 *“(5) LINE OF CREDIT.—The term ‘line of credit’*
 7 *means an agreement entered into by the Secretary*
 8 *with an obligor under section 2204 to provide a direct*
 9 *loan at a future date upon the occurrence of certain*
 10 *events.*

11 *“(6) LOAN GUARANTEE.—The term ‘loan guar-*
 12 *antee’ means any guarantee or other pledge by the*
 13 *Secretary to pay all or part of the principal of and*
 14 *interest on a loan or other debt obligation issued by*
 15 *an obligor and funded by a lender.*

16 *“(7) LOCAL SERVICER.—The term ‘local servicer’*
 17 *means a State or local government or any agency of*
 18 *a State or local government that is responsible for*
 19 *servicing a Federal credit instrument on behalf of the*
 20 *Secretary.*

21 *“(8) OBLIGOR.—The term ‘obligor’ means a*
 22 *party primarily liable for payment of the principal*
 23 *of or interest on a Federal credit instrument, which*
 24 *party may be a corporation, partnership, joint ven-*

1 *ture, trust, or governmental entity, agency, or instru-*
 2 *mentality.*

3 “(9) *PROJECT.*—*The term ‘project’ means any*
 4 *project that is designed to improve the health care in-*
 5 *frastructure, including the construction, renovation,*
 6 *or other capital improvement of any hospital, medical*
 7 *research facility, or other medical facility or the pur-*
 8 *chase of any equipment to be used in a hospital, re-*
 9 *search facility, or other medical research facility.*

10 “(10) *PROJECT OBLIGATION.*—*The term ‘project*
 11 *obligation’ means any note, bond, debenture, lease, in-*
 12 *stallment sale agreement, or other debt obligation*
 13 *issued or entered into by an obligor in connection*
 14 *with the financing of a project, other than a Federal*
 15 *credit instrument.*

16 “(11) *RATING AGENCY.*—*The term ‘rating agen-*
 17 *cy’ means a bond rating agency identified by the Se-*
 18 *curities and Exchange Commission as a Nationally*
 19 *Recognized Statistical Rating Organization.*

20 “(12) *SECURED LOAN.*—*The term ‘secured loan’*
 21 *means a direct loan or other debt obligation issued by*
 22 *an obligor and funded by the Secretary in connection*
 23 *with the financing of a project under section 2203.*

1 “(13) *STATE*.—The term ‘State’ has the meaning
2 given the term in section 101 of title 23, United
3 States Code.

4 “(14) *SUBSIDY AMOUNT*.—The term ‘subsidy
5 amount’ means the amount of budget authority suffi-
6 cient to cover the estimated long-term cost to the Fed-
7 eral Government of a Federal credit instrument, cal-
8 culated on a net present value basis, excluding ad-
9 ministrative costs and any incidental effects on gov-
10 ernmental receipts or outlays in accordance with the
11 provisions of the Federal Credit Reform Act of 1990
12 (2 U.S.C. 661 et seq.).

13 “(15) *SUBSTANTIAL COMPLETION*.—The term
14 ‘substantial completion’ means the opening of a
15 project to patients or for research purposes.

16 **“SEC. 2202. DETERMINATION OF ELIGIBILITY AND PROJECT**
17 **SELECTION.**

18 “(a) *ELIGIBILITY*.—To be eligible to receive financial
19 assistance under this title, a project shall meet the following
20 criteria:

21 “(1) *APPLICATION*.—A State, a local servicer
22 identified under section 2205(a), or the entity under-
23 taking a project shall submit a project application to
24 the Secretary.

1 “(2) *ELIGIBLE PROJECT COSTS.*—To be eligible
 2 for assistance under this title, a project shall have
 3 total eligible project costs that are reasonably antici-
 4 pated to equal or exceed \$40,000,000.

5 “(3) *SOURCES OF REPAYMENTS.*—Project financ-
 6 ing shall be repayable, in whole or in part, from reli-
 7 able revenue sources as described in the application
 8 submitted under paragraph (1).

9 “(4) *PUBLIC SPONSORSHIP OF PRIVATE ENTI-*
 10 *TIES.*—In the case of a project that is undertaken by
 11 an entity that is not a State or local government or
 12 an agency or instrumentality of a State or local gov-
 13 ernment, the project that the entity is undertaking
 14 shall be publicly sponsored or sponsored by an entity
 15 that is described in section 501(c)(3) of the Internal
 16 Revenue Code of 1986 and exempt from tax under sec-
 17 tion 501(a) of such Code.

18 “(b) *SELECTION AMONG ELIGIBLE PROJECTS.*—

19 “(1) *ESTABLISHMENT.*—The Secretary shall es-
 20 tablish criteria for selecting among projects that meet
 21 the eligibility criteria specified in subsection (a).

22 “(2) *SELECTION CRITERIA.*—

23 “(A) *IN GENERAL.*—The selection criteria
 24 shall include the following:

1 “(i) *The extent to which the project is*
2 *nationally or regionally significant, in*
3 *terms of expanding or improving the health*
4 *care infrastructure of the United States or*
5 *the region or in terms of the medical benefit*
6 *that the project will have.*

7 “(ii) *The creditworthiness of the*
8 *project, including a determination by the*
9 *Secretary that any financing for the project*
10 *has appropriate security features, such as a*
11 *rate covenant, credit enhancement require-*
12 *ments, or debt services coverages, to ensure*
13 *repayment.*

14 “(iii) *The extent to which assistance*
15 *under this title would foster innovative pub-*
16 *lic-private partnerships and attract private*
17 *debt or equity investment.*

18 “(iv) *The likelihood that assistance*
19 *under this title would enable the project to*
20 *proceed at an earlier date than the project*
21 *would otherwise be able to proceed.*

22 “(v) *The extent to which the project*
23 *uses or results in new technologies.*

1 “(vi) *The amount of budget authority*
 2 *required to fund the Federal credit instru-*
 3 *ment made available under this title.*

4 “(vii) *The extent to which the project*
 5 *helps maintain or protect the environment.*

6 “(B) *SPECIFIC REQUIREMENTS.—The selec-*
 7 *tion criteria shall require that a project appli-*
 8 *cant—*

9 “(i) *be engaged in research in the*
 10 *causes, prevention, and treatment of cancer;*

11 “(ii) *be designated as a cancer center*
 12 *for the National Cancer Institute or be des-*
 13 *ignated by the State as the sole official com-*
 14 *prehensive cancer effort for the State; and*

15 “(iii) *be located in a State that, on the*
 16 *date of enactment of this title, has a popu-*
 17 *lation of less than 3,000,000 individuals.*

18 “(C) *RATING LETTER.—For purposes of*
 19 *subparagraph (A)(ii), the Secretary shall require*
 20 *each project applicant to provide a rating letter*
 21 *from at least 1 rating agency indicating that the*
 22 *project’s senior obligations have the potential to*
 23 *achieve an investment-grade rating with or with-*
 24 *out credit enhancement.*

1 **“SEC. 2203. SECURED LOANS.**

2 “(a) *IN GENERAL.*—

3 “(1) *AGREEMENTS.*—Subject to paragraphs (2)
4 through (4), the Secretary may enter into agreements
5 with 1 or more obligors to make secured loans, the
6 proceeds of which shall be used—

7 “(A) to finance eligible project costs;

8 “(B) to refinance interim construction fi-
9 nancing of eligible project costs; or

10 “(C) to refinance existing debt or prior
11 project obligations;

12 of any project selected under section 2202.

13 “(2) *LIMITATION ON REFINANCING OF INTERIM*
14 *CONSTRUCTION FINANCING.*—A loan under paragraph
15 (1) shall not refinance interim construction financing
16 under paragraph (1)(B) later than 1 year after the
17 date of substantial completion of the project.

18 “(3) *RISK ASSESSMENT.*—Before entering into
19 an agreement for a secured loan under this subsection,
20 the Secretary, in consultation with each rating agen-
21 cy providing a rating letter under section
22 2202(b)(2)(B), shall determine an appropriate capital
23 reserve subsidy amount for each secured loan, taking
24 into account such letter.

25 “(4) *INVESTMENT-GRADE RATING REQUIRE-*
26 *MENT.*—The funding of a secured loan under this sec-

1 *tion shall be contingent on the project's senior obliga-*
 2 *tions receiving an investment-grade rating, except*
 3 *that—*

4 *“(A) the Secretary may fund an amount of*
 5 *the secured loan not to exceed the capital reserve*
 6 *subsidy amount determined under paragraph (3)*
 7 *prior to the obligations receiving an investment-*
 8 *grade rating; and*

9 *“(B) the Secretary may fund the remaining*
 10 *portion of the secured loan only after the obliga-*
 11 *tions have received an investment-grade rating*
 12 *by at least 1 rating agency.*

13 *“(b) TERMS AND LIMITATIONS.—*

14 *“(1) IN GENERAL.—A secured loan under this*
 15 *section with respect to a project shall be on such terms*
 16 *and conditions and contain such covenants, represen-*
 17 *tations, warranties, and requirements (including re-*
 18 *quirements for audits) as the Secretary determines*
 19 *appropriate.*

20 *“(2) MAXIMUM AMOUNT.—The amount of the se-*
 21 *cured loan shall not exceed 100 percent of the reason-*
 22 *ably anticipated eligible project costs.*

23 *“(3) PAYMENT.—The secured loan—*

24 *“(A) shall—*

1 “(i) be payable, in whole or in part,
2 from reliable revenue sources; and

3 “(ii) include a rate covenant, coverage
4 requirement, or similar security feature
5 supporting the project obligations; and

6 “(B) may have a lien on revenues described
7 in subparagraph (A) subject to any lien securing
8 project obligations.

9 “(4) *INTEREST RATE.*—The interest rate on the
10 secured loan shall be not less than the yield on mar-
11 ketable United States Treasury securities of a similar
12 maturity to the maturity of the secured loan on the
13 date of execution of the loan agreement.

14 “(5) *MATURITY DATE.*—The final maturity date
15 of the secured loan shall be not later than 30 years
16 after the date of substantial completion of the project.

17 “(6) *NONSUBORDINATION.*—The secured loan
18 shall not be subordinated to the claims of any holder
19 of project obligations in the event of bankruptcy, in-
20 solvency, or liquidation of the obligor.

21 “(7) *FEEES.*—The Secretary may establish fees at
22 a level sufficient to cover all or a portion of the costs
23 to the Federal Government of making a secured loan
24 under this section.

25 “(c) *REPAYMENT.*—

1 “(1) *SCHEDULE.*—*The Secretary shall establish*
2 *a repayment schedule for each secured loan under this*
3 *section based on the projected cash flow from project*
4 *revenues and other repayment sources.*

5 “(2) *COMMENCEMENT.*—*Scheduled loan repay-*
6 *ments of principal or interest on a secured loan under*
7 *this section shall commence not later than 5 years*
8 *after the date of substantial completion of the project.*

9 “(3) *SOURCES OF REPAYMENT FUNDS.*—*The*
10 *sources of funds for scheduled loan repayments under*
11 *this section shall include any revenue generated by*
12 *the project.*

13 “(4) *DEFERRED PAYMENTS.*—

14 “(A) *AUTHORIZATION.*—*If, at any time*
15 *during the 10 years after the date of substantial*
16 *completion of the project, the project is unable to*
17 *generate sufficient revenues to pay the scheduled*
18 *loan repayments of principal and interest on the*
19 *secured loan, the Secretary may, subject to sub-*
20 *paragraph (C), allow the obligor to add unpaid*
21 *principal and interest to the outstanding balance*
22 *of the secured loan.*

23 “(B) *INTEREST.*—*Any payment deferred*
24 *under subparagraph (A) shall—*

1 “(i) *continue to accrue interest in ac-*
 2 *cordance with subsection (b)(4) until fully*
 3 *repaid; and*

4 “(ii) *be scheduled to be amortized over*
 5 *the remaining term of the loan beginning*
 6 *not later than 10 years after the date of*
 7 *substantial completion of the project in ac-*
 8 *cordance with paragraph (1).*

9 “(C) *CRITERIA.—*

10 “(i) *IN GENERAL.—Any payment de-*
 11 *ferral under subparagraph (A) shall be con-*
 12 *tingent on the project meeting criteria es-*
 13 *tablished by the Secretary.*

14 “(ii) *REPAYMENT STANDARDS.—The*
 15 *criteria established under clause (i) shall*
 16 *include standards for reasonable assurance*
 17 *of repayment.*

18 “(5) *PREPAYMENT.—*

19 “(A) *USE OF EXCESS REVENUES.—Any ex-*
 20 *cess revenues that remain after satisfying sched-*
 21 *uled debt service requirements on the project obli-*
 22 *gations and secured loan and all deposit require-*
 23 *ments under the terms of any trust agreement,*
 24 *bond resolution, reimbursement agreement, credit*
 25 *agreement, loan agreement, or similar agreement*

1 *securing project obligations may be applied an-*
 2 *nually to prepay the secured loan without pen-*
 3 *alty.*

4 “(B) *USE OF PROCEEDS OF REFI-*
 5 *NANCING.—The secured loan may be prepaid at*
 6 *any time without penalty, regardless of whether*
 7 *such repayment is from the proceeds of refi-*
 8 *nancing from non-Federal funding sources.*

9 “(d) *SALE OF SECURED LOANS.—*

10 “(1) *IN GENERAL.—Subject to paragraph (2), as*
 11 *soon as practicable after substantial completion of a*
 12 *project and after notifying the obligor, the Secretary*
 13 *may sell to another entity or reoffer into the capital*
 14 *markets a secured loan for the project if the Secretary*
 15 *determines that the sale or reoffering can be made on*
 16 *favorable terms.*

17 “(2) *CONSENT OF OBLIGOR.—In making a sale*
 18 *or reoffering under paragraph (1), the Secretary may*
 19 *not change the original terms and conditions of the*
 20 *secured loan without the written consent of the obli-*
 21 *gor.*

22 “(e) *LOAN GUARANTEES.—*

23 “(1) *IN GENERAL.—The Secretary may provide*
 24 *a loan guarantee to a lender in lieu of making a se-*
 25 *cured loan if the Secretary determines that the budg-*

1 *etary cost of the loan guarantee is substantially the*
 2 *same as that of a secured loan.*

3 *“(2) TERMS.—The terms of a guaranteed loan*
 4 *shall be consistent with the terms set forth in this sec-*
 5 *tion for a secured loan, except that the rate on the*
 6 *guaranteed loan and any prepayment features shall*
 7 *be negotiated between the obligor and the lender, with*
 8 *the consent of the Secretary.*

9 **“SEC. 2204. LINES OF CREDIT.**

10 *“(a) IN GENERAL.—*

11 *“(1) AGREEMENTS.—Subject to paragraphs (2)*
 12 *through (4), the Secretary may enter into agreements*
 13 *to make available lines of credit to 1 or more obligors*
 14 *in the form of direct loans to be made by the Sec-*
 15 *retary at future dates on the occurrence of certain*
 16 *events for any project selected under section 2202.*

17 *“(2) USE OF PROCEEDS.—The proceeds of a line*
 18 *of credit made available under this section shall be*
 19 *available to pay debt service on project obligations*
 20 *issued to finance eligible project costs, extraordinary*
 21 *repair and replacement costs, operation and mainte-*
 22 *nance expenses, and costs associated with unexpected*
 23 *Federal or State environmental restrictions.*

24 *“(3) RISK ASSESSMENT.—Before entering into*
 25 *an agreement under this subsection, the Secretary, in*

1 *consultation with each rating agency providing a pre-*
 2 *liminary rating opinion letter under section*
 3 *2202(b)(2)(B), shall determine an appropriate capital*
 4 *reserve subsidy amount for each line of credit, taking*
 5 *into account such letter.*

6 “(4) *INVESTMENT-GRADE RATING REQUIRE-*
 7 *MENT.—The funding of a line of credit under this sec-*
 8 *tion shall be contingent on the project’s senior obliga-*
 9 *tions receiving an investment-grade rating from at*
 10 *least 1 rating agency.*

11 “(b) *TERMS AND LIMITATIONS.—*

12 “(1) *IN GENERAL.—A line of credit under this*
 13 *section with respect to a project shall be on such terms*
 14 *and conditions and contain such covenants, represen-*
 15 *tations, warranties, and requirements (including re-*
 16 *quirements for audits) as the Secretary determines*
 17 *appropriate.*

18 “(2) *MAXIMUM AMOUNTS.—*

19 “(A) *TOTAL AMOUNT.—The total amount of*
 20 *the line of credit shall not exceed 33 percent of*
 21 *the reasonably anticipated eligible project costs.*

22 “(B) *1-YEAR DRAWS.—The amount drawn*
 23 *in any 1 year shall not exceed 20 percent of the*
 24 *total amount of the line of credit.*

1 “(3) *DRAWS.*—Any draw on the line of credit
 2 shall represent a direct loan and shall be made only
 3 if net revenues from the project (including capitalized
 4 interest, any debt service reserve fund, and any other
 5 available reserve) are insufficient to pay the costs
 6 specified in subsection (a)(2).

7 “(4) *INTEREST RATE.*—The interest rate on a di-
 8 rect loan resulting from a draw on the line of credit
 9 shall be not less than the yield on 30-year marketable
 10 United States Treasury securities as of the date on
 11 which the line of credit is obligated.

12 “(5) *SECURITY.*—The line of credit—

13 “(A) shall—

14 “(i) be payable, in whole or in part,
 15 from reliable revenue sources; and

16 “(ii) include a rate covenant, coverage
 17 requirement, or similar security feature
 18 supporting the project obligations; and

19 “(B) may have a lien on revenues described
 20 in subparagraph (A) subject to any lien securing
 21 project obligations.

22 “(6) *PERIOD OF AVAILABILITY.*—The line of
 23 credit shall be available during the period beginning
 24 on the date of substantial completion of the project
 25 and ending not later than 10 years after that date.

1 “(7) *RIGHTS OF THIRD-PARTY CREDITORS.*—

2 “(A) *AGAINST FEDERAL GOVERNMENT.*—A
3 *third-party creditor of the obligor shall not have*
4 *any right against the Federal Government with*
5 *respect to any draw on the line of credit.*

6 “(B) *ASSIGNMENT.*—An obligor may assign
7 *the line of credit to 1 or more lenders or to a*
8 *trustee on the lenders’ behalf.*

9 “(8) *NONSUBORDINATION.*—A direct loan under
10 *this section shall not be subordinated to the claims of*
11 *any holder of project obligations in the event of bank-*
12 *ruptcy, insolvency, or liquidation of the obligor.*

13 “(9) *FEEES.*—The Secretary may establish fees at
14 *a level sufficient to cover all or a portion of the costs*
15 *to the Federal Government of providing a line of cred-*
16 *it under this section.*

17 “(10) *RELATIONSHIP TO OTHER CREDIT INSTRU-*
18 *MENTS.*—A project that receives a line of credit under
19 *this section also shall not receive a secured loan or*
20 *loan guarantee under section 183 of an amount that,*
21 *combined with the amount of the line of credit, ex-*
22 *ceeds 100 percent of eligible project costs.*

23 “(c) *REPAYMENT.*—

24 “(1) *TERMS AND CONDITIONS.*—The Secretary
25 *shall establish repayment terms and conditions for*

1 *each direct loan under this section based on the pro-*
 2 *jected cash flow from project revenues and other re-*
 3 *payment sources.*

4 “(2) *TIMING.*—*All scheduled repayments of prin-*
 5 *icipal or interest on a direct loan under this section*
 6 *shall commence not later than 5 years after the end*
 7 *of the period of availability specified in subsection*
 8 *(b)(6) and be fully repaid, with interest, by the date*
 9 *that is 25 years after the end of the period of avail-*
 10 *ability specified in subsection (b)(6).*

11 “(3) *SOURCES OF REPAYMENT FUNDS.*—*The*
 12 *sources of funds for scheduled loan repayments under*
 13 *this section shall include reliable revenue sources.*

14 **“SEC. 2205. PROJECT SERVICING.**

15 “(a) *REQUIREMENT.*—*The State in which a project*
 16 *that receives financial assistance under this title is located*
 17 *may identify a local servicer to assist the Secretary in serv-*
 18 *icing the Federal credit instrument made available under*
 19 *this title.*

20 “(b) *AGENCY; FEES.*—*If a State identifies a local*
 21 *servicer under subsection (a), the local servicer—*

22 “(1) *shall act as the agent for the Secretary; and*

23 “(2) *may receive a servicing fee, subject to ap-*
 24 *proval by the Secretary.*

1 “(c) *LIABILITY.*—A local servicer identified under sub-
 2 section (a) shall not be liable for the obligations of the obli-
 3 gor to the Secretary or any lender.

4 “(d) *ASSISTANCE FROM EXPERT FIRMS.*—The Sec-
 5 retary may retain the services of expert firms in the field
 6 of project finance to assist in the underwriting and serv-
 7 icing of Federal credit instruments.

8 **“SEC. 2206. STATE AND LOCAL PERMITS.**

9 “The provision of financial assistance under this title
 10 with respect to a project shall not—

11 “(1) relieve any recipient of the assistance of any
 12 obligation to obtain any required State or local per-
 13 mit or approval with respect to the project;

14 “(2) limit the right of any unit of State or local
 15 government to approve or regulate any rate of return
 16 on private equity invested in the project; or

17 “(3) otherwise supersede any State or local law
 18 (including any regulation) applicable to the construc-
 19 tion or operation of the project.

20 **“SEC. 2207. REGULATIONS.**

21 “The Secretary may issue such regulations as the Sec-
 22 retary determines appropriate to carry out this title.

23 **“SEC. 2208. FUNDING.**

24 “(a) *FUNDING.*—

1 “(1) *IN GENERAL.*—*There are authorized to be*
 2 *appropriated to carry out this title, \$40,000,000 for*
 3 *each of fiscal years 2004 through 2008.*

4 “(2) *ADMINISTRATIVE COSTS.*—*From funds*
 5 *made available under paragraph (1), the Secretary*
 6 *may use, for the administration of this title, not more*
 7 *than \$2,000,000 for each of fiscal years 2004 through*
 8 *2008.*

9 “(3) *AVAILABILITY.*—*Amounts made available*
 10 *under paragraph (1) shall remain available until ex-*
 11 *pendent and any unexpended amount shall be carried*
 12 *forward to the subsequent fiscal year until fully ex-*
 13 *pendent.*

14 “(b) *CONTRACT AUTHORITY.*—

15 “(1) *IN GENERAL.*—*Notwithstanding any other*
 16 *provision of law, approval by the Secretary of a Fed-*
 17 *eral credit instrument that uses funds made available*
 18 *under this title shall be deemed to be acceptance by*
 19 *the United States of a contractual obligation to fund*
 20 *the Federal credit instrument.*

21 “(2) *AVAILABILITY.*—*Amounts authorized under*
 22 *this section for a fiscal year shall be available for ob-*
 23 *ligation on October 1 of the fiscal year.*

24 “(c) *LIMITATIONS ON CREDIT AMOUNTS.*—*For each of*
 25 *fiscal years 2004 through 2008, principal amounts of Fed-*

1 *eral credit instruments made available under this title shall*
 2 *be limited to the amounts specified in the following table:*

<i>Fiscal year:</i>	<i>Maximum amount of credit:</i>
2004	\$40,000,000
2005	\$40,000,000
2006	\$40,000,000
2007	\$40,000,000
2008	\$40,000,000.

3 ***“SEC. 2209. REPORT TO CONGRESS.***

4 *“Not later than 4 years after the date of enactment*
 5 *of this title, the Secretary shall submit to Congress a report*
 6 *summarizing the financial performance of the projects that*
 7 *are receiving, or have received, assistance under this title,*
 8 *including a recommendation as to whether the objectives of*
 9 *this title are best served—*

10 *“(1) by continuing the program under the au-*
 11 *thority of the Secretary;*

12 *“(2) by establishing a Government corporation*
 13 *or Government-sponsored enterprise to administer the*
 14 *program; or*

15 *“(3) by phasing out the program and relying on*
 16 *the capital markets to fund the types of infrastructure*
 17 *investments assisted by this title without Federal par-*
 18 *ticipation.”.*

1 **SEC. 609. CAPITAL INFRASTRUCTURE REVOLVING LOAN**
 2 **PROGRAM.**

3 (a) *IN GENERAL.*—*Part A of title XVI of the Public*
 4 *Health Service Act (42 U.S.C. 300q et seq.) is amended by*
 5 *adding at the end the following new section:*

6 “*CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM*

7 “*SEC. 1603. (a) AUTHORITY TO MAKE AND GUAR-*
 8 *ANTEE LOANS.*—

9 “*(1) AUTHORITY TO MAKE LOANS.*—*The Sec-*
 10 *retary may make loans from the fund established*
 11 *under section 1602(d) to any rural entity for projects*
 12 *for capital improvements, including—*

13 “*(A) the acquisition of land necessary for*
 14 *the capital improvements;*

15 “*(B) the renovation or modernization of*
 16 *any building;*

17 “*(C) the acquisition or repair of fixed or*
 18 *major movable equipment; and*

19 “*(D) such other project expenses as the Sec-*
 20 *retary determines appropriate.*

21 “*(2) AUTHORITY TO GUARANTEE LOANS.*—

22 “*(A) IN GENERAL.*—*The Secretary may*
 23 *guarantee the payment of principal and interest*
 24 *for loans made to rural entities for projects for*
 25 *any capital improvement described in paragraph*
 26 *(1) to any non-Federal lender.*

1 “(B) *INTEREST SUBSIDIES.*—*In the case of*
 2 *a guarantee of any loan made to a rural entity*
 3 *under subparagraph (A), the Secretary may pay*
 4 *to the holder of such loan, for and on behalf of*
 5 *the project for which the loan was made,*
 6 *amounts sufficient to reduce (by not more than*
 7 *3 percent) the net effective interest rate otherwise*
 8 *payable on such loan.*

9 “(b) *AMOUNT OF LOAN.*—*The principal amount of a*
 10 *loan directly made or guaranteed under subsection (a) for*
 11 *a project for capital improvement may not exceed*
 12 *\$5,000,000.*

13 “(c) *FUNDING LIMITATIONS.*—

14 “(1) *GOVERNMENT CREDIT SUBSIDY EXPO-*
 15 *SURE.*—*The total of the Government credit subsidy*
 16 *exposure under the Credit Reform Act of 1990 scoring*
 17 *protocol with respect to the loans outstanding at any*
 18 *time with respect to which guarantees have been*
 19 *issued, or which have been directly made, under sub-*
 20 *section (a) may not exceed \$50,000,000 per year.*

21 “(2) *TOTAL AMOUNTS.*—*Subject to paragraph*
 22 *(1), the total of the principal amount of all loans di-*
 23 *rectly made or guaranteed under subsection (a) may*
 24 *not exceed \$250,000,000 per year.*

25 “(d) *CAPITAL ASSESSMENT AND PLANNING GRANTS.*—

1 “(1) *NONREPAYABLE GRANTS.*—Subject to para-
 2 graph (2), the Secretary may make a grant to a rural
 3 entity, in an amount not to exceed \$50,000, for pur-
 4 poses of capital assessment and business planning.

5 “(2) *LIMITATION.*—The cumulative total of
 6 grants awarded under this subsection may not exceed
 7 \$2,500,000 per year.

8 “(e) *TERMINATION OF AUTHORITY.*—The Secretary
 9 may not directly make or guarantee any loan under sub-
 10 section (a) or make a grant under subsection (d) after Sep-
 11 tember 30, 2008.”.

12 (b) *RURAL ENTITY DEFINED.*—Section 1624 of the
 13 Public Health Service Act (42 U.S.C. 300s–3) is amended
 14 by adding at the end the following new paragraph:

15 “(14)(A) The term ‘rural entity’ includes—

16 “(i) a rural health clinic, as defined in sec-
 17 tion 1861(aa)(2) of the Social Security Act;

18 “(ii) any medical facility with at least 1
 19 bed, but with less than 50 beds, that is located
 20 in—

21 “(I) a county that is not part of a met-
 22 ropolitan statistical area; or

23 “(II) a rural census tract of a metro-
 24 politan statistical area (as determined
 25 under the most recent modification of the

1 *Goldsmith Modification, originally pub-*
 2 *lished in the Federal Register on February*
 3 *27, 1992 (57 Fed. Reg. 6725));*

4 *“(iii) a hospital that is classified as a*
 5 *rural, regional, or national referral center under*
 6 *section 1886(d)(5)(C) of the Social Security Act;*
 7 *and*

8 *“(iv) a hospital that is a sole community*
 9 *hospital (as defined in section 1886(d)(5)(D)(iii)*
 10 *of the Social Security Act).*

11 *“(B) For purposes of subparagraph (A), the fact*
 12 *that a clinic, facility, or hospital has been geographi-*
 13 *cally reclassified under the medicare program under*
 14 *title XVIII of the Social Security Act shall not pre-*
 15 *clude a hospital from being considered a rural entity*
 16 *under clause (i) or (ii) of subparagraph (A).”.*

17 *(c) CONFORMING AMENDMENTS.—Section 1602 of the*
 18 *Public Health Service Act (42 U.S.C. 300q–2) is amend-*
 19 *ed—*

20 *(1) in subsection (b)(2)(D), by inserting “or*
 21 *1603(a)(2)(B)” after “1601(a)(2)(B)”;* and

22 *(2) in subsection (d)—*

23 *(A) in paragraph (1)(C), by striking “sec-*
 24 *tion 1601(a)(2)(B)” and inserting “sections*
 25 *1601(a)(2)(B) and 1603(a)(2)(B)”;* and

1 (B) in paragraph (2)(A), by inserting “or
 2 1603(a)(2)(B)” after “1601(a)(2)(B)”.

3 **SEC. 610. FEDERAL REIMBURSEMENT OF EMERGENCY**
 4 **HEALTH SERVICES FURNISHED TO UNDOCU-**
 5 **MENTED ALIENS.**

6 (a) *TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.*—
 7 *There is appropriated, out of any funds in the Treasury*
 8 *not otherwise appropriated, \$250,000,000 for each of fiscal*
 9 *years 2005 through 2008, for the purpose of making allot-*
 10 *ments under this section to States described in paragraph*
 11 *(1) or (2) of subsection (b). Funds appropriated under the*
 12 *preceding sentence shall remain available until expended.*

13 (b) *STATE ALLOTMENTS.*—

14 (1) *BASED ON PERCENTAGE OF UNDOCUMENTED*
 15 *ALIENS.*—

16 (A) *IN GENERAL.*—*Out of the amount ap-*
 17 *propriated under subsection (a) for a fiscal year,*
 18 *the Secretary shall use \$167,000,000 of such*
 19 *amount to make allotments for such fiscal year*
 20 *in accordance with subparagraph (B).*

21 (B) *FORMULA.*—*The amount of the allot-*
 22 *ment for each State for a fiscal year shall be*
 23 *equal to the product of—*

1 (i) the total amount available for allot-
2 ments under this paragraph for the fiscal
3 year; and

4 (ii) the percentage of undocumented
5 aliens residing in the State with respect to
6 the total number of such aliens residing in
7 all States, as determined by the Statistics
8 Division of the Immigration and Natu-
9 ralization Service, as of January 2003,
10 based on the 2000 decennial census.

11 (2) *BASED ON NUMBER OF UNDOCUMENTED*
12 *ALIEN APPREHENSION STATES.—*

13 (A) *IN GENERAL.—*Out of the amount ap-
14 propriated under subsection (a) for a fiscal year,
15 the Secretary shall use \$83,000,000 of such
16 amount to make allotments for such fiscal year
17 for each of the 6 States with the highest number
18 of undocumented alien apprehensions for such
19 fiscal year.

20 (B) *DETERMINATION OF ALLOTMENTS.—*The
21 amount of the allotment for each State described
22 in subparagraph (A) for a fiscal year shall bear
23 the same ratio to the total amount available for
24 allotments under this paragraph for the fiscal
25 year as the ratio of the number of undocumented

1 *alien apprehensions in the State in that fiscal*
 2 *year bears to the total of such numbers for all*
 3 *such States for such fiscal year.*

4 *(C) DATA.—For purposes of this paragraph,*
 5 *the highest number of undocumented alien ap-*
 6 *prehensions for a fiscal year shall be based on*
 7 *the 4 most recent quarterly apprehension rates*
 8 *for undocumented aliens in such States, as re-*
 9 *ported by the Immigration and Naturalization*
 10 *Service.*

11 *(3) RULE OF CONSTRUCTION.—Nothing in this*
 12 *section shall be construed as prohibiting a State that*
 13 *is described in both of paragraphs (1) and (2) from*
 14 *receiving an allotment under both paragraphs for a*
 15 *fiscal year.*

16 *(c) USE OF FUNDS.—*

17 *(1) AUTHORITY TO MAKE PAYMENTS.—From the*
 18 *allotments made for a State under subsection (b) for*
 19 *a fiscal year, the Secretary shall pay directly to local*
 20 *governments, hospitals, or other providers located in*
 21 *the State (including providers of services received*
 22 *through an Indian Health Service facility whether*
 23 *operated by the Indian Health Service or by an In-*
 24 *dian tribe or tribal organization) that provide un-*
 25 *compensated emergency health services furnished to*

1 *undocumented aliens during that fiscal year, and to*
 2 *the State, such amounts (subject to the total amount*
 3 *available from such allotments) as the local govern-*
 4 *ments, hospitals, providers, or State demonstrate were*
 5 *incurred for the provision of such services during that*
 6 *fiscal year.*

7 (2) *LIMITATION ON STATE USE OF FUNDS.—*
 8 *Funds paid to a State from allotments made under*
 9 *subsection (b) for a fiscal year may only be used for*
 10 *making payments to local governments, hospitals, or*
 11 *other providers for costs incurred in providing emer-*
 12 *gency health services to undocumented aliens or for*
 13 *State costs incurred with respect to the provision of*
 14 *emergency health services to such aliens.*

15 (3) *INCLUSION OF COSTS INCURRED WITH RE-*
 16 *SPECT TO CERTAIN ALIENS.—Uncompensated emer-*
 17 *gency health services furnished to aliens who have*
 18 *been allowed to enter the United States for the sole*
 19 *purpose of receiving emergency health services may be*
 20 *included in the determination of costs incurred by a*
 21 *State, local government, hospital, or other provider*
 22 *with respect to the provision of such services.*

23 (d) *APPLICATIONS; ADVANCE PAYMENTS.—*

24 (1) *DEADLINE FOR ESTABLISHMENT OF APPLICA-*
 25 *TION PROCESS.—*

1 (A) *IN GENERAL.*—Not later than Sep-
2 tember 1, 2004, the Secretary shall establish a
3 process under which States, local governments,
4 hospitals, or other providers located in the State
5 may apply for payments from allotments made
6 under subsection (b) for a fiscal year for uncom-
7 pensated emergency health services furnished to
8 undocumented aliens during that fiscal year.

9 (B) *INCLUSION OF MEASURES TO COMBAT*
10 *FRAUD.*—The Secretary shall include in the
11 process established under subparagraph (A)
12 measures to ensure that fraudulent payments are
13 not made from the allotments determined under
14 subsection (b).

15 (2) *ADVANCE PAYMENT; RETROSPECTIVE ADJUST-*
16 *MENT.*—The process established under paragraph (1)
17 shall allow for making payments under this section
18 for each quarter of a fiscal year on the basis of ad-
19 vance estimates of expenditures submitted by appli-
20 cants for such payments and such other investigation
21 as the Secretary may find necessary, and for making
22 reductions or increases in the payments as necessary
23 to adjust for any overpayment or underpayment for
24 prior quarters of such fiscal year.

25 (e) *DEFINITIONS.*—In this section:

1 (1) *HOSPITAL*.—The term “hospital” has the
 2 meaning given such term in section 1861(e) of the So-
 3 cial Security Act (42 U.S.C. 1395x(e)).

4 (2) *INDIAN TRIBE; TRIBAL ORGANIZATION*.—The
 5 terms “Indian tribe” and “tribal organization” have
 6 the meanings given such terms in section 4 of the In-
 7 dian Health Care Improvement Act (25 U.S.C. 1603).

8 (3) *PROVIDER*.—The term “provider” includes a
 9 physician, any other health care professional licensed
 10 under State law, and any other entity that furnishes
 11 emergency health services, including ambulance serv-
 12 ices.

13 (4) *SECRETARY*.—The term “Secretary” means
 14 the Secretary of Health and Human Services.

15 (5) *STATE*.—The term “State” means the 50
 16 States and the District of Columbia.

17 **SEC. 611. INCREASE IN APPROPRIATION TO THE HEALTH**
 18 **CARE FRAUD AND ABUSE CONTROL AC-**
 19 **COUNT.**

20 Section 1817(k)(3)(A) (42 U.S.C. 1395i(k)(3)(A)) is
 21 amended—

22 (1) in clause (i)—

23 (A) in subclause (II), by striking “and” at
 24 the end; and

1 (B) by striking subclause (III), and insert-
2 ing the following new subclauses:

3 “(III) for fiscal year 2004, the
4 limit for fiscal year 2003 increased by
5 \$10,000,000;

6 “(IV) for fiscal year 2005, the
7 limit for fiscal year 2003 increased by
8 \$15,000,000;

9 “(V) for fiscal year 2006, the
10 limit for fiscal year 2003 increased by
11 \$25,000,000; and

12 “(VI) for each fiscal year after fis-
13 cal year 2006, the limit for fiscal year
14 2003.”; and

15 (2) in clause (ii)—

16 (A) in subclause (VI), by striking “and” at
17 the end;

18 (B) in subclause (VII)—

19 (i) by striking “each fiscal year after
20 fiscal year 2002” and inserting “fiscal year
21 2003”; and

22 (ii) by striking the period and insert-
23 ing a semicolon; and

24 (3) by adding at the end the following:

1 “(VIII) for fiscal year 2004,
 2 \$170,000,000;
 3 “(IX) for fiscal year 2005,
 4 \$175,000,000;
 5 “(X) for fiscal year 2006,
 6 \$185,000,000; and
 7 “(XI) for each fiscal year after fis-
 8 cal year 2006, not less than
 9 \$150,000,000 and not more than
 10 \$160,000,000.”.

11 **SEC. 612. INCREASE IN CIVIL PENALTIES UNDER THE FALSE**
 12 **CLAIMS ACT.**

13 (a) *IN GENERAL.*—Section 3729(a) of title 31, United
 14 States Code, is amended—

15 (1) by striking “\$5,000” and inserting “\$7,500”;
 16 and
 17 (2) by striking “\$10,000” and inserting
 18 “\$15,000”.

19 (b) *EFFECTIVE DATE.*—The amendments made by sub-
 20 section (a) shall apply to violations occurring on or after
 21 January 1, 2004.

1 **SEC. 613. INCREASE IN CIVIL MONETARY PENALTIES**
 2 **UNDER THE SOCIAL SECURITY ACT.**

3 (a) *IN GENERAL.*—Section 1128A(a) (42 U.S.C.
 4 1320a–7a(a)), in the matter following paragraph (7), is
 5 amended—

6 (1) by striking “\$10,000” each place it appears
 7 and inserting “\$12,500”;

8 (2) by striking “\$15,000” and inserting
 9 “\$18,750”; and

10 (3) striking “\$50,000” and inserting “\$62,500”.

11 (b) *EFFECTIVE DATE.*—The amendments made by sub-
 12 section (a) shall apply to violations occurring on or after
 13 January 1, 2004.

14 **SEC. 614. EXTENSION OF CUSTOMS USER FEES.**

15 Section 13031(j)(3) of the Consolidated Omnibus
 16 Budget Reconciliation Act of 1985 (19 U.S.C. 58c(j)(3)) is
 17 amended by striking “September 30, 2003” and inserting
 18 “September 30, 2013”.

Amend the title so as to read: “A bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the medicare program and to strengthen and improve the medicare program, and for other purposes.”.

Calendar No. 138

108TH CONGRESS
1ST SESSION

S. 1

A BILL

To amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

JUNE 13, 2001

Reported with an amendment and an amendment to the
title