

106TH CONGRESS
2D SESSION

S. 2342

To amend the Medicare program under title XVIII of the Social Security Act to make Medicare more competitive and efficient, to provide for a prescription drug benefit, and for other purposes.

IN THE SENATE OF THE UNITED STATES

APRIL 4, 2000

Mr. MOYNIHAN (by request) introduced the following bill; which was read twice and referred to the Committee on finance

A BILL

To amend the Medicare program under title XVIII of the Social Security Act to make Medicare more competitive and efficient, to provide for a prescription drug benefit, and for other purposes.

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

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

5 (a) **SHORT TITLE.**—This Act may be cited as the
6 “Medicare Modernization Act of 2000”.

7 (b) **REFERENCES.**—Except where otherwise specifi-
8 cally provided, references in this Act shall be considered

1 to be made to the Social Security Act, or to a section or
 2 other provision thereof.

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

TITLE I—MAKING MEDICARE MORE COMPETITIVE AND
EFFICIENT

PART A—COMPETITIVE DEFINED BENEFIT

Sec. 101. Competitive defined benefit.

PART B—PRIVATE SECTOR PURCHASING AND QUALITY IMPROVEMENT
TOOLS FOR TRADITIONAL MEDICARE

- Sec. 111. Care coordination services.
- Sec. 112. Disease management services.
- Sec. 113. Competitive acquisition of items and services.
- Sec. 114. Provider and physician collaborations.
- Sec. 115. Preferred participants.
- Sec. 116. Centers of excellence.
- Sec. 117. Demonstration of bonus payments for health care groups.
- Sec. 118. Administration of certain private sector purchasing and quality improvement programs.
- Sec. 119. Reports to Congress on private sector purchasing and quality improvement programs.
- Sec. 120. Increased flexibility in contracting for Medicare claims processing.
- Sec. 121. Special provisions for funding of activities related to certain overpayment recoveries and provider enrollment and reverification of eligibility.

TITLE II—MODERNIZING MEDICARE BENEFITS

PART A—PRESCRIPTION DRUG BENEFIT

- Sec. 201. Prescription drug benefit.
- Sec. 202. Medicaid buy-in of Medicare prescription drug coverage for certain low-income individuals.

PART B—IMPROVING PREVENTIVE BENEFITS AND ELIMINATING COST
SHARING

- Sec. 221. Elimination of cost sharing for preventive benefits.
- Sec. 222. Information campaign on prevention.
- Sec. 223. Smoking cessation demonstration.

PART C—RATIONALIZING COST SHARING AND MEDIGAP

- Sec. 231. Deductibles and coinsurance for clinical laboratory services.
- Sec. 232. Indexing deductible to inflation.
- Sec. 233. Updating and expanding Medigap plan options.
- Sec. 234. Report to Congress on options for improving Medicare supplemental coverage.
- Sec. 235. Increasing access to Medigap.

Sec. 236. Removal of sunset date for cost-sharing in Medicare part B premiums for certain qualifying individuals.

TITLE III—PROTECTING AND EXTENDING MEDICARE SOLVENCY

Sec. 301. Transfers to extend solvency.

Sec. 302. Catastrophic prescription drug coverage reserve.

Sec. 303. Medicare solvency debt reduction reserve.

Sec. 304. Protection of Medicare solvency debt reduction reserve.

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

4 **PART A—COMPETITIVE DEFINED BENEFIT**

5 **SEC. 101. COMPETITIVE DEFINED BENEFIT.**

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

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

19 (2) ANNUAL DETERMINATION AND ANNOUNCE-
 20 MENT OF PAYMENT FACTORS.—

1 (A) IN GENERAL.—Section 1853(b) (42
2 U.S.C. 1395w-23(b)) is amended—

3 (i) in paragraph (1), by striking “the
4 calendar year concerned” and all that fol-
5 lows and inserting “the calendar year con-
6 cerned, the following factors, as defined in
7 paragraph (4):

8 “(A) national monthly per capita costs,

9 “(B) the benchmark amount for each pay-
10 ment area, and

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

14 (ii) in paragraph (3), by striking
15 “monthly adjusted” and all that follows
16 and inserting “such estimates, factors, and
17 amounts”; and

18 (iii) by adding at the end the fol-
19 lowing new paragraphs:

20 “(4) FACTORS USED IN ADJUSTING BIDS FOR
21 MEDICARE+CHOICE ORGANIZATIONS AND IN DETER-
22 MINING ENROLLEE PREMIUMS.—

23 “(A) IN GENERAL.—Subject to paragraph
24 (5), the Secretary shall use, for purposes of ad-
25 justing plan bids and determining enrollee pre-

1 miums under this part, the factors specified in
2 this paragraph, which factors—

3 “(i) shall be calculated separately for
4 benefits under parts A and B combined,
5 and under part D; and

6 “(ii) shall be calculated separately
7 for—

8 “(I) beneficiaries who are aged or
9 disabled; and

10 “(II) beneficiaries who have end
11 stage renal disease until such time as
12 the Secretary establishes an inte-
13 grated risk adjustment system for the
14 groups specified in subclauses (I) and
15 (II).

16 “(B) NATIONAL MONTHLY PER CAPITA
17 COSTS.—

18 “(i) IN GENERAL.—The term ‘na-
19 tional monthly per capita costs’ means
20 (subject to clause (ii)) the projected na-
21 tional, monthly, per capita costs of benefits
22 under this title and associated claims proc-
23 essing costs for individuals entitled to ben-
24 efits under part A and individuals enrolled

1 in the program under part B who are not
2 enrolled in a plan under this part.

3 “(ii) EXCLUSION OF DSH AND GME
4 COSTS.—The calculation of costs under
5 clause (i) shall not take into account any
6 amounts attributable to—

7 “(I) payment adjustments under
8 section 1886(d)(5)(F) for hospitals
9 serving a significantly dispropor-
10 tionate number of low income pa-
11 tients;

12 “(II) payments for costs of grad-
13 uate medical education under section
14 1886(h); or

15 “(III) payments for indirect costs
16 of medical education under section
17 1886(d)(5)(B).

18 “(C) BENCHMARK AMOUNT.—

19 “(i) The term ‘benchmark amount’
20 means, for a payment area, an amount
21 equal to the greater of—

22 “(I) except as provided in clause
23 (ii), $\frac{1}{12}$ of the annual
24 Medicare+Choice capitation rate that
25 would have applied in that payment

1 area under section 1853(c) (as in ef-
2 fect prior to the enactment of the
3 Medicare Modernization Act of 2000);
4 or

5 “(II) the product of 96 percent
6 of national monthly per capita costs
7 and the ratio, for a previous period,
8 of—

9 “(aa) monthly per capita
10 costs of Medicare benefits for in-
11 dividuals entitled to benefits
12 under part A and individuals en-
13 rolled in the program under part
14 B in that payment area (adjusted
15 for relative risk due to health
16 status and demographic adjust-
17 ment factors) to—

18 “(bb) the weighted average
19 for all payment areas of such
20 monthly per capita costs.

21 “(ii) If the amount calculated under
22 clause (i)(I) for a year for all payment
23 areas is equal to either the minimum
24 amount or the blended capitation rate, for
25 all subsequent years the Secretary shall

1 not calculate the rates described in that
2 clause and the amount under such clause
3 instead shall be equal to the product of 96
4 percent of national monthly per capita
5 costs and the ratio of—

6 “(I) the annual Medicare+Choice
7 capitation rate for the last year that
8 such rates were calculated under such
9 clause to—

10 “(II) the weighted average of the
11 area-specific Medicare+Choice capita-
12 tion rates for that same year.

13 “(iii) For years prior to 2005, with
14 regard to benefits under part D, the Sec-
15 retary may use 96 percent of national
16 monthly per capita costs as the benchmark
17 amount for all payment areas or provide
18 for regional rather than payment area-spe-
19 cific determinations of the benchmark
20 amounts.

21 “(D) HEALTH STATUS AND DEMOGRAPHIC
22 ADJUSTMENT FACTORS.—The term ‘health sta-
23 tus and demographic adjustment factors’ means
24 health status and such other risk factors as
25 age, disability status, gender, institutional sta-

1 tus, and such other factors as the Secretary de-
 2 termines to be appropriate, so as to ensure ac-
 3 tual equivalence. The Secretary may add to,
 4 modify, or substitute for such factors, if such
 5 changes will improve the determination of actu-
 6 arial equivalence, and in that event will make
 7 comparable adjustments to the benchmark
 8 amounts. For years prior to 2005, with regard
 9 to part D benefits, the Secretary shall not be
 10 required to include health status in the factors
 11 described in this subparagraph.”.

12 (B) CONFORMING AMENDMENT.—Section
 13 1853(c)(7) is relocated and redesignated as sec-
 14 tion 1853(b)(5), indented accordingly, and
 15 amended by striking all that follows “shall ad-
 16 just appropriately” and inserting “national
 17 monthly per capita costs for the following
 18 year”.

19 (3) SUBMISSION OF BIDS BY
 20 MEDICARE+CHOICE ORGANIZATIONS.—

21 (A) IN GENERAL.—Section 1853 (42
 22 U.S.C. 1395w-23) is amended by striking sub-
 23 section (c) and inserting the following new sub-
 24 section:

1 “(c) SUBMISSION OF BIDS BY MEDICARE+CHOICE
2 ORGANIZATIONS.—

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

8 “(A) by April 1, notice of such intent and
9 information on the service area and plan type
10 for each plan; and

11 “(B) by July 1—

12 “(i) the information described in para-
13 graph (2) for the type of plan involved;
14 and

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

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

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

24 “(B) The actuarial value of the reduction
25 in cost-sharing for Medicare benefits included

1 in each plan bid (which value shall not exceed
2 15 percent of the value of the balance of the
3 bid).

4 “(C) A description of the cost-sharing for
5 Medicare benefits that will apply and the actu-
6 arial value of such cost-sharing.

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

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

15 “(i) enrolled individuals who are aged
16 or disabled; and

17 “(ii) enrolled individuals who have
18 end-stage renal disease.”.

19 (B) CONFORMING AMENDMENTS.—

20 (i) Paragraphs (3) and (5) of section
21 1854(a) are relocated and redesignated as
22 paragraphs (3) and (4), respectively, of
23 section 1853(c), as amended.

1 (ii) Section 1853(c)(3)(B) (42 U.S.C.
2 1395w-23(c)(3)(B)), as redesignated, is
3 amended by striking “beneficiary”.

4 (iii) Section 1853(c)(4)(B) (42 U.S.C.
5 1395w-23(c)(3)(B)), as redesignated, is
6 amended by striking “or subparagraphs
7 (A)(ii) and (B) of paragraph (4)”.

8 (4) SECRETARY’S DETERMINATION OF PAY-
9 MENT AMOUNT.—Section 1853 is further
10 amended—

11 (A) by redesignating subsections (d)
12 through (h) as subsections (e) through (i), re-
13 spectively; and

14 (B) by adding after subsection (c) the fol-
15 lowing new subsection:

16 “(d) SECRETARY’S DETERMINATION OF PAYMENT
17 AMOUNT.—

18 “(1) CONVERSION TO NORMALIZED BIDS.—

19 “(A) NORMALIZED BIDS.—Subject to sub-
20 paragraph (B), the Secretary shall adjust each
21 monthly plan bid submitted under subsection
22 (c) for the relative risk of enrollees in such plan
23 based on health status and demographic adjust-
24 ment factors.

1 “(B) SPECIAL RULE FOR PLAN BIDS FOR
2 PART D BENEFITS BEFORE 2005.—The Sec-
3 retary is not required, for years before 2005, to
4 make the adjustments described in subpara-
5 graph (A) with respect to plans for part D ben-
6 efits.

7 “(2) COMPARISON TO PLAN BENCHMARK
8 AMOUNT.—

9 “(A) DETERMINATION OF PLAN BENCH-
10 MARK.—The Secretary shall determine, using
11 the plan enrollment assumptions included in the
12 organization’s bid, a plan benchmark amount
13 for each plan equal to—

14 “(i) (until such time as the Secretary
15 establishes an integrated risk adjustment
16 system for individuals who are aged or dis-
17 abled and for individuals who have end-
18 stage renal disease)—

19 “(I) the product of the weighted
20 average of the benchmark amounts for
21 the payment areas included in the
22 plan’s service area for individuals who
23 are aged or disabled and the number
24 of such individuals in the plan, plus

1 “(II) the product of the weighted
2 average of the benchmark amounts for
3 the payment areas included in the
4 plan’s service area for individuals who
5 have end-stage renal disease and the
6 number of such individuals in the
7 plan, divided by the total number of
8 individuals in subclauses (I) and (II);
9 and

10 “(ii) (after such time) the weighted
11 average of the benchmark amounts for the
12 payment areas included in the plan’s serv-
13 ice area.

14 “(B) COMPARISON TO BENCHMARK; DE-
15 TERMINATION OF PAYMENT AMOUNT.—The
16 monthly payment to a Medicare+Choice organi-
17 zation with respect to each individual enrolled
18 in a plan shall be set as follows:

19 “(i) IF BID DOES NOT EXCEED
20 BENCHMARK.—If the normalized bid deter-
21 mined under paragraph (1) does not ex-
22 ceed the plan benchmark amount deter-
23 mined under subparagraph (A), the month-
24 ly payment shall be the normalized bid, ad-
25 justed to account for the health status and

1 demographic adjustment factors of the in-
 2 dividual enrollee.

3 “(ii) IF BID EXCEEDS BENCHMARK.—
 4 If the normalized bid determined under
 5 paragraph (1) exceeds the plan benchmark
 6 amount determined under subparagraph
 7 (B), the monthly payment shall be the nor-
 8 malized bid, adjusted as described in
 9 clause (i), minus the monthly excess pre-
 10 mium determined under section 1854.”.

11 (b) PREMIUMS.—

12 (1) DETERMINATION OF PREMIUM AMOUNT.—

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

14 (A) by striking subsection (a) and redesign-
 15 ating subsections (b) and (c) as subsections
 16 (a) and (b);

17 (B) by adding after subsection (b) the fol-
 18 lowing new subsection:

19 “(c) DETERMINATION OF MEDICARE PREMIUM RE-
 20 Duction AND EXCESS PREMIUM.—

21 “(1) IN GENERAL.—Subject to paragraph (2),
 22 the Secretary shall subtract the normalized bid (de-
 23 termined under section 1853(d)(1)) from the plan’s
 24 benchmark amount (determined under section
 25 1853(d)(2)) to determine the Medicare premium re-

1 duction or monthly excess premium for plan enroll-
2 ees.

3 “(2) ADJUSTMENT.—If the difference between
4 the normalized bid and the plan’s benchmark
5 amount—

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

8 “(i) the monthly Medicare premium
9 reduction for individuals enrolled in the
10 plan (up to the entire amount of the pre-
11 mium for part B or part D, as applicable);
12 and

13 “(ii) the remainder, if any, under
14 clause (i) shall be equal to the additional
15 reduction in the actuarial value of plan
16 cost-sharing for plan enrollees;

17 “(B) is a negative amount, the absolute
18 value of that amount shall equal the monthly
19 excess premium for individuals enrolled in the
20 plan.

21 (2) LIMITATION ON ENROLLEE LIABILITY.—

22 (A) FOR BASIC BENEFITS.—Section
23 1854(e)(1) (42 U.S.C. 1395w-4(e)(1)) is
24 amended to read as follows:

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

1 “(A) the actuarial value of the deductibles,
2 coinsurance, and copayments applicable on av-
3 erage to individuals enrolled under this part
4 with a Medicare+Choice plan described in sec-
5 tion 1851(a)(2)(A) or (C) of an organization
6 with respect to benefits described in section
7 1852(a)(1);

8 “(B) the reduction in cost sharing included
9 in the plan bid;

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

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

1 (B) FOR SUPPLEMENTAL BENEFITS.—
2 Section 1854(e)(2) (42 U.S.C. 1395w-4(e)(2))
3 is amended—

4 (i) by striking “section
5 1851(a)(2)(A)” and inserting “subpara-
6 graph (A) or (C) of section 1851(a)(2)”;

7 (ii) by striking “(multiplied by 12)”;
8 and

9 (iii) by striking “may not exceed” and
10 inserting “must equal”.

11 (c) OTHER CHANGES IN PLAN DESIGN.—

12 (1) ALLOWING PLANS TO INCLUDE COST SHAR-
13 ING REDUCTION IN THEIR BASIC BENEFITS.—Sec-
14 tion 1852(a)(1) (42 U.S.C. 1395w-22(a)(1)) is
15 amended by striking subparagraph (B) and inserting
16 the following—

17 “(B) at plan option, reduction in cost-shar-
18 ing for part A and part B benefits, or part D
19 benefits, that would otherwise be applicable (the
20 actuarial value of such reduction however shall
21 not exceed 15 percent of the value of the por-
22 tion of the bid related to combined part A and
23 part B benefits, or part D benefits, as applica-
24 ble).”.

1 (2) ELIMINATION OF MANDATORY SUPPLE-
2 MENTAL BENEFITS.—Section 1852(a)(3) (42 U.S.C.
3 1395w–22(a)(3)) is amended by striking subpara-
4 graph (A) and redesignating subparagraphs (B) and
5 (C) and subparagraphs (A) and (B).

6 (d) CONFORMING AMENDMENTS.—

7 (1) PREMIUM REDUCTIONS.—

8 (A) UNDER PART B.—

9 (i) Section 1839(a)(2) (42 U.S.C.
10 1395r(a)(2)) is amended by striking
11 “shall” and all that follows and inserting
12 “shall be the amount determined under
13 paragraph (3), adjusted as required in ac-
14 cordance with subsections (b), (c), and (f),
15 and thereafter further modified as required
16 to comply with section 1854(c)(2)(A).”.

17 (ii) Section 1840 (42 U.S.C. 1395s) is
18 amended by adding at the end the fol-
19 lowing:

20 “(i) The Secretary shall provide for
21 necessary adjustments of the Medicare pre-
22 mium for Medicare+Choice enrollees de-
23 termined under section 1854(c)(2)(A).
24 This premium adjustment may be provided
25 directly or as an adjustment to Social Se-

1 security, Railroad Retirement and Civil Serv-
2 ice Retirement benefits, as appropriate, as
3 the Secretary determines feasible with the
4 concurrence of such agencies.”.

5 (B) UNDER PART D.—

6 (i) Section 1859D(a)(2)(B) is amend-
7 ed by inserting “thereafter further modi-
8 fied as required to comply with section
9 1854(c)(2)(A),” before “and rounded”.

10 (ii) Section 1859(b)(1) is amended by
11 adding at the end the following:

12 “(C) The Secretary shall provide for nec-
13 essary adjustments of the Medicare premium
14 for Medicare+Choice enrollees determined
15 under section 1854(c)(2)(A). This premium ad-
16 justment may be provided directly or as an ad-
17 justment to Social Security, Railroad Retire-
18 ment and Civil Service Retirement benefits, as
19 appropriate, as the Secretary determines fea-
20 sible with the concurrence of such agencies.”.

21 (2) APPROPRIATIONS FOR GOVERNMENT CON-
22 TRIBUTION.—Section 1844(a)(1) (42 U.S.C.
23 1395w(a)(1)) is amended by adding after subpara-
24 graph (B) the following new subparagraph:

1 “(C) an adjustment for the Government
2 contribution to reflect the savings to the Trust
3 Fund from enrollment in Medicare+Choice
4 plans by beneficiaries who receive monthly
5 Medicare premium reductions in accordance
6 with section 1854(c)(2)(A).”.

7 (3) Section 1851(b)(1)(B) (42 U.S.C. 1395w-
8 21(b)(1)(B)) is amended by striking “section
9 1852(a)(1)(A)” and inserting “section 1852(a)(1)”.

10 (4) Section 1851(d)(2)(A) (42 U.S.C. 1395w-
11 21(d)(2)(A)) is amended by striking “At least 15
12 days before” and inserting “Before”.

13 (5) Part C is amended by striking “BENE-
14 FICLARY” each time it appears immediately before
15 “PREMIUM” or “PREMIUMS”, and by striking “bene-
16 ficiary” each time it appears immediately before
17 “premium” or “premiums”.

18 (6) Section 1851(d)(4)(B) (42 U.S.C. 1395w-
19 21(d)(4)(B)) is amended—

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

22 (B) by adding before the period “; and (ii)
23 the reduction in the part B and part D pre-
24 miums, if any”.

1 (7) Section 1851(d)(4)(E) (42 U.S.C. 1395w–
2 21(d)(4)(E)) is amended by striking “includes man-
3 datory supplemental benefits in its base benefit
4 package or”.

5 (8) Section 1852(a)(5) (42 U.S.C. 1395w–
6 22(a)(5)) is amended by striking “the annual
7 Medicare+Choice capitation rate” and inserting
8 “the national monthly per capita costs”.

9 (9) Section 1852(c)(1)(F) (42 U.S.C. 1395w–
10 22(c)(1)(F)) is amended by striking clause (i) and
11 redesignating clauses (ii) and (iii) as clauses (i) and
12 (ii).

13 (10) Section 1853(a)(1)(B) (42 U.S.C. 1395w–
14 23(a)(1)(B)) is amended by striking the first and
15 second sentences.

16 (11) Section 1853(e)(3)(B) (42 U.S.C. 1395w–
17 23(e)(3)(B)), as redesignated, is amended—

18 (A) in the caption, by striking “BUDGET
19 NEUTRALITY”;

20 (B) by striking “adjust the payment rates”
21 and all that follows through “that would have
22 been made” and inserting “adjust the bench-
23 mark amounts otherwise established under this
24 section for Medicare+Choice payment areas in
25 the State in a manner so that the weighted av-

1 erage of the benchmark amounts under this
2 section in the State equals the weighted average
3 of benchmark amounts that would have been
4 applicable”.

5 (12) Section 1853(i)(2) (42 U.S.C. 1395w-
6 23(i)(2)), as redesignated, is amended—

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

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

11 (C) by striking subparagraph (C).

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

18 (B) Section 1854(a)(2)(B) (42 U.S.C. 1395w-
19 4(a)(2)(B)), as redesignated, is amended—

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

22 (ii) by striking “or (4)(B)”.

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

1 (15)(A) Paragraphs (3) and (4) of section
2 1854(f) (42 U.S.C. 1395w-4(f)) are relocated and
3 redesignated as paragraphs (4) and (5) of subsection
4 (e).

5 (B) Section 1854(e)(4) (42 U.S.C. 1395w-
6 4(e)(4)), as so redesignated, is amended by striking
7 “subject to paragraph (4)” and inserting “subject to
8 paragraph (5)”.

9 (C) Section 1854(f) (42 U.S.C. 1395w-4(f)) is
10 stricken.

11 (16) Section 1858(c), as redesignated by section
12 201, is amended by striking paragraph (3) and re-
13 designating paragraph (4) as paragraph (3).

14 (e) EFFECTIVE DATE.—The amendments made by
15 this section shall be effective for 2003 and succeeding
16 years.

17 **PART B—PRIVATE SECTOR PURCHASING AND**
18 **QUALITY IMPROVEMENT TOOLS FOR ORIGI-**
19 **NAL MEDICARE**

20 **SEC. 111. CARE COORDINATION SERVICES.**

21 (a) PROGRAM AUTHORIZED.—Title XVIII (42 U.S.C.
22 1395 et seq.) is amended by adding after section 1866
23 the following new section:

24 **“SEC. 1866A. CARE COORDINATION SERVICES.**

25 “(a) IN GENERAL.—

1 “(1) PROGRAM AUTHORITY.—The Secretary,
2 beginning in 2002, may implement a care coordina-
3 tion services program in accordance with the provi-
4 sions of this section under which, in appropriate cir-
5 cumstances, eligible individuals may elect to have
6 health care services covered under this title managed
7 and coordinated by a designated care coordinator.

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

12 “(b) ELIGIBILITY CRITERIA; IDENTIFICATION AND
13 NOTIFICATION OF ELIGIBLE INDIVIDUALS.—

14 “(1) INDIVIDUAL ELIGIBILITY CRITERIA.—The
15 Secretary shall specify criteria to be used in making
16 a determination as to whether an individual may ap-
17 propriately be enrolled in the care coordination serv-
18 ices program under this section, which shall include
19 at least a finding by the Secretary that for cohorts
20 of individuals with characteristics identified by the
21 Secretary, professional management and coordina-
22 tion of care can reasonably be expected to improve
23 processes or outcomes of health care and to reduce
24 aggregate costs to the programs under this title.

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

5 “(c) ENROLLMENT OF INDIVIDUALS.—

6 “(1) SECRETARY’S DETERMINATION OF ELIGI-
7 BILITY.—The Secretary shall determine the eligi-
8 bility for services under this section of individuals
9 who are enrolled in the program under this section
10 and who make application for such services in such
11 form and manner as the Secretary may prescribe.

12 “(2) ENROLLMENT PERIOD.—

13 “(A) EFFECTIVE DATE AND DURATION.—
14 Enrollment of an individual in the program
15 under this section shall be effective as of the
16 first day of the month following the month in
17 which the Secretary approves the individual’s
18 application under paragraph (1), shall remain
19 in effect for one month (or such longer period
20 as the Secretary may specify), and shall be
21 automatically renewed for additional periods,
22 unless terminated in accordance with such pro-
23 cedures as the Secretary shall establish by regu-
24 lation.

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

7 “(d) PROGRAM.—The care coordination services pro-
8 gram under this section shall include the following ele-
9 ments:

10 “(1) BASIC CARE COORDINATION SERVICES.—

11 “(A) IN GENERAL.—Subject to the cost-ef-
12 fectiveness criteria specified in subsection
13 (b)(1), except as otherwise provided in this sec-
14 tion, enrolled individuals shall receive services
15 described in section 1905(t)(1) and may receive
16 additional items and services as described in
17 subparagraph (B).

18 “(B) ADDITIONAL BENEFITS.—The Sec-
19 retary may specify additional benefits for which
20 payment would not otherwise be made under
21 this title that may be available to individuals
22 enrolled in the program under this section (sub-
23 ject to an assessment by the care coordinator of
24 an individual’s circumstance and need for such

1 benefits) in order to encourage enrollment in, or
2 to improve the effectiveness of, such program.

3 “(2) CARE COORDINATION REQUIREMENT.—

4 Notwithstanding any other provision of this title, the
5 Secretary may provide that an individual enrolled in
6 the program under this section may be entitled to
7 payment under this title for any specified health
8 care items or services only if the items or services
9 have been furnished by the care coordinator, or co-
10 ordinated through the care coordination services pro-
11 gram. Under such provision, the Secretary shall pre-
12 scribe exceptions for emergency medical services as
13 described in section 1852(d)(3), and other excep-
14 tions determined by the Secretary for the delivery of
15 timely and needed care.

16 “(3) REDUCTION OR ELIMINATION OF COST
17 SHARING.—Notwithstanding any other provision of
18 law, subject to the cost-effectiveness criteria speci-
19 fied in subsection (b)(1), the Secretary may provide
20 for the reduction or elimination of beneficiary cost
21 sharing (such as deductibles, copayments, and coin-
22 surance) with respect to any of the items or services
23 furnished under this title (other than the care co-
24 ordination services and other benefits described in

1 paragraph (1)) and may limit such reduction or
2 elimination to particular service areas.

3 “(e) CARE COORDINATORS.—

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

7 “(A) be a health care professional or entity
8 (which may include physicians, physician group
9 practices, or other health care professionals or
10 entities the Secretary may find appropriate)
11 meeting such conditions as the Secretary may
12 specify;

13 “(B) have entered into a care coordination
14 agreement; and

15 “(C) meet such criteria as the Secretary
16 may establish (which may include experience in
17 the provision of care coordination or primary
18 care physician’s services).

19 “(2) AGREEMENT TERM; PAYMENT.—

20 “(A) DURATION AND RENEWAL.—A care
21 coordination agreement under this subsection
22 shall be for one year and may be renewed if the
23 Secretary is satisfied that the care coordinator
24 continues to meet the conditions of participa-
25 tion specified in paragraph (1).

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

5 “(C) TERMS.—In addition to such other
 6 terms as the Secretary may require, an agree-
 7 ment under this section shall include the terms
 8 specified in subparagraphs (A) through (C) of
 9 section 1905(t)(3).”.

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

12 (1) IN GENERAL.—Section 1861(s) (42 U.S.C.
 13 1395x(s)) is amended—

14 (A) in the second sentence, by redesign-
 15 ating paragraphs (16) and (17) as clauses (i)
 16 and (ii); and

17 (B) in the first sentence—

18 (i) by striking “and” at the end of
 19 paragraph (14);

20 (ii) by striking the period at the end
 21 of paragraph (15) and inserting “; and”;
 22 and

23 (iii) by adding after paragraph (15)
 24 the following new paragraph:

1 “(16) care coordination services furnished in
2 accordance with section 1866A.”.

3 (2) PART B COINSURANCE AND DEDUCTIBLE
4 NOT APPLICABLE TO CARE COORDINATION SERV-
5 ICES.—

6 (A) COINSURANCE.—Section 1833(a)(1) is
7 amended—

8 (i) by striking “and” at the end of
9 subparagraph (R); and

10 (ii) by inserting before the final semi-
11 colon “, and (T) with respect to care co-
12 ordination services described in section
13 1861(s)(16), the amounts paid shall be
14 100 percent of the payment amount estab-
15 lished under section 1866C”.

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

18 (i) by striking “and” at the end of
19 paragraph (5); and

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

1 **SEC. 112. DISEASE MANAGEMENT SERVICES.**

2 (a) PROGRAM AUTHORIZED.—Title XVIII (42 U.S.C.
3 1395 et seq.), as previously amended by this part, is fur-
4 ther amended by adding after section 1866A the following
5 new section:

6 **“SEC. 1866B. DISEASE MANAGEMENT SERVICES.**

7 “(a) IN GENERAL.—

8 “(1) PROGRAM AUTHORITY.—The Secretary,
9 beginning in 2002, may implement a program in ac-
10 cordance with the provisions of this section under
11 which certain eligible individuals may, in appropriate
12 circumstances, receive disease management services
13 from entities designated by the Secretary with re-
14 spect to diagnoses that the Secretary determines are
15 amenable to such management.

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

20 “(b) INDIVIDUALS WHO MAY RECEIVE DISEASE
21 MANAGEMENT SERVICES.—No individual shall be eligible
22 for enrollment in a disease management program under
23 this section unless the Secretary finds the following with
24 respect to the individual:

25 “(1) DIAGNOSIS AND RELATED CHARACTERIS-
26 TICS.—

1 “(A) IN GENERAL.—The individual has
2 been diagnosed with congestive heart failure,
3 chronic obstructive pulmonary disease, diabetes,
4 or any other diagnosis, if the Secretary has de-
5 termined with respect to such diagnoses that
6 there is evidence that the provision of disease
7 management services, over clinically relevant
8 time-periods, to cohorts of individuals with such
9 diagnoses can reasonably be expected to im-
10 prove processes or outcomes of health care for
11 the Medicare population and to reduce aggre-
12 gate costs to the programs under this title.

13 “(B) ADDITIONAL FACTORS.—Where re-
14 quired by the Secretary, the individual also has
15 certain clinical characteristics or conditions, ex-
16 hibits certain patterns of utilization, or mani-
17 fests other factors indicating the need for and
18 potential effectiveness of disease management.

19 “(2) REFERRAL BY QUALIFIED INDIVIDUAL OR
20 ENTITY.—The individual has been referred for con-
21 sideration for such services by an individual or entity
22 furnishing health care items or services, or by an en-
23 tity administering benefits under this title.

24 “(c) PROCEDURES TO FACILITATE ENROLLMENT.—
25 The Secretary shall develop and implement procedures de-

1 signed to facilitate enrollment of eligible individuals in the
2 program under this section.

3 “(d) ENROLLMENT OF INDIVIDUALS WITH DISEASE
4 MANAGEMENT ORGANIZATIONS.—

5 “(1) EFFECTIVE DATE AND DURATION.—En-
6 rollment of an individual in the program under this
7 section shall remain in effect for one month (or such
8 longer period as the Secretary may specify), and
9 shall be automatically renewed for additional peri-
10 ods, unless terminated in accordance with such pro-
11 cedures as the Secretary shall establish by regula-
12 tion.

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

18 “(e) DISEASE MANAGEMENT REQUIREMENT.—Not-
19 withstanding any other provision of this title, the Sec-
20 retary may provide that an individual enrolled in the pro-
21 gram under this section may be entitled to payment under
22 this title for any specified health care items or services
23 only if the items or services have been furnished by the
24 disease management organization, or coordinated through
25 the disease management services program. Under such

1 provision, the Secretary shall prescribe exceptions for
2 emergency medical services as described in section
3 1852(d)(3), and other exceptions determined by the Sec-
4 retary for the delivery of timely and needed care.

5 “(f) DISEASE MANAGEMENT SERVICES.—

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

10 “(A) initial and periodic health screening
11 and assessment;

12 “(B) management (including coordination
13 with other providers) of, and referral for, med-
14 ical and other health services related to the
15 managed diagnosis (which may include referral
16 for provision of such services by the disease
17 management organization);

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

21 “(D) patient education and counseling;

22 “(E) nursing or other health professional
23 home visits, as appropriate;

24 “(F) providing access for consultations by
25 telephone with physicians or other appropriate

1 medical professionals, including 24-hour avail-
2 ability for emergency consultations;

3 “(G) managing and facilitating the transi-
4 tion to other care arrangements in preparation
5 for termination of the disease management en-
6 rollment; and

7 “(H) such other services for which pay-
8 ment would not otherwise be made under this
9 title as the Secretary shall determine to be ap-
10 propriate.

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

19 “(3) REDUCTION OR ELIMINATION OF COST
20 SHARING.—Notwithstanding any other provision of
21 law, subject to the cost-effectiveness criteria speci-
22 fied in subsection (b)(1), the Secretary may provide
23 for the reduction or elimination of beneficiary cost
24 sharing (such as deductibles, copayments, and coin-
25 surance) with respect to any of the items or services

1 furnished under this title (other than those fur-
2 nished under a service package developed under
3 paragraph (2)), and may limit such reduction or
4 elimination to particular service areas.

5 “(g) AGREEMENTS WITH DISEASE MANAGEMENT
6 ORGANIZATIONS.—

7 “(1) ENTITIES ELIGIBLE.—Entities qualified to
8 enter into agreements with the Secretary for the
9 provision of disease management services under this
10 section include entities that have demonstrated the
11 ability to meet the performance standards and other
12 criteria established by the Secretary with respect
13 to—

14 “(A) the management of each diagnosis
15 and condition with respect to which the entity,
16 if designated, would furnish disease manage-
17 ment services under this section; and

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

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

24 “(A) have in effect an agreement with the
25 Secretary setting forth such obligations of the

1 entity as a disease management organization
2 under this section as the Secretary shall pre-
3 scribe;

4 “(B) meet the standards established by the
5 Secretary under subsection (h); and

6 “(C) meet such other conditions as the
7 Secretary may establish.

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

13 “(h) STANDARDS.—

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

18 “(A) performance standards with respect
19 to the processes or outcomes of health care or
20 the health status of enrolled individuals, includ-
21 ing procedures for establishing a baseline and
22 measuring changes in health care processes or
23 health outcomes with respect to managed dis-
24 eases or health conditions;

1 “(B) a requirement that the organization
2 meet such licensure and other accreditation
3 standards as the Secretary may find appro-
4 priate; and

5 “(C) such other quality standards, includ-
6 ing patient satisfaction, as the Secretary may
7 find appropriate.

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

16 “(i) PAYMENT.—

17 “(1) TERMS OF PAYMENT.—The Secretary may
18 negotiate or otherwise establish payment terms and
19 rates for service packages developed under sub-
20 section (f)(2).

21 “(2) WITHHOLDING OF PAYMENTS.—An agree-
22 ment under subsection (g) may provide that the Sec-
23 retary may withhold up to ten percent of the amount
24 due a disease management organization under the
25 basis of payment established under paragraph (1)

1 until such time as such organization meets a stand-
2 ard or standards specified in such agreement.

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

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

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

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

11 (C) by adding after paragraph (16) the fol-
12 lowing new paragraph:

13 “(17) disease management services furnished in
14 accordance with section 1866B.”.

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

18 (A) COINSURANCE.—Section
19 1833(a)(1)(T) (42 U.S.C. 1395l(a)(1)(T)), as
20 added by section 111(b)(2)(A), is amended to
21 read as follows: “(T) with respect to care co-
22 ordination services described in section
23 1861(s)(16) and disease management services
24 described in section 1861(s)(17), the amounts
25 paid shall be 100 percent of the payment

1 amounts established under sections 1866A and
2 1866B, respectively;”.

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

9 **SEC. 113. COMPETITIVE ACQUISITION OF ITEMS AND SERV-**
10 **ICES.**

11 (a) PROGRAM AUTHORIZED.—Title XVIII (42 U.S.C.
12 1395 et seq.), as previously amended by this part, is fur-
13 ther amended by adding after section 1866B the following
14 new section:

15 **“SEC. 1866C. COMPETITIVE ACQUISITION OF ITEMS AND**
16 **SERVICES.**

17 “(a) IN GENERAL.—

18 “(1) PROGRAM AUTHORITY.—The Secretary
19 shall implement a program to purchase, on behalf of
20 individuals enrolled under this part certain competi-
21 tively priced items and services for which payment
22 may be made under part B.

23 “(2) ADMINISTRATION BY CONTRACT.—Except
24 as otherwise specifically provided, the Secretary may

1 administer the program under this section in accord-
2 ance with section 1866M.

3 “(b) ESTABLISHMENT OF COMPETITIVE ACQUISI-
4 TION AREAS.—

5 “(1) IN GENERAL.—The Secretary shall estab-
6 lish competitive acquisition areas for agreement
7 award purposes for the furnishing under part B of
8 the items and services described in subsection (d)
9 after 2002. The Secretary may establish different
10 competitive acquisition areas under this subsection
11 for different classes of items and services.

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

20 “(c) AWARDING OF AGREEMENTS IN COMPETITIVE
21 ACQUISITION AREAS.—

22 “(1) IN GENERAL.—The Secretary shall con-
23 duct a competition among individuals and entities
24 supplying items and services described in subsection
25 (d) for each competitive acquisition area established

1 under subsection (b) for each class of items and
2 services.

3 “(2) CONDITIONS FOR AWARDING AGREEMENT.—The Secretary may not enter an agreement
4 with any entity under the competition conducted
5 pursuant to paragraph (1) to furnish an item or
6 service unless the Secretary finds that the entity
7 meets quality standards specified by the Secretary,
8 and that the aggregate amounts to be paid under
9 the agreement are expected to be less than the ag-
10 gregate amounts that would otherwise be paid.
11

12 “(3) TERMS OF AGREEMENT.—An agree-
13 ment entered into with an entity under the
14 competition conducted pursuant to paragraph
15 (1) is subject to terms and conditions that the
16 Secretary may specify.

17 “(d) SERVICES DESCRIBED.—The items and services
18 to which this section applies are all items and services de-
19 scribed in paragraphs (3) and (5) through (9) of section
20 1861(s) (other than custom fabricated prostheses, as de-
21 fined by the Secretary), and such other items or services
22 as the Secretary may specify.”.

23 (b) ITEMS AND SERVICES TO BE FURNISHED ONLY
24 THROUGH COMPETITIVE ACQUISITION.—Section 1862(a)
25 (42 U.S.C. 1395y(a)) is amended—

1 (1) by striking “or” at the end of paragraph
2 (20),

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

5 (3) by adding after paragraph (21) the fol-
6 lowing:

7 “(22) where the expenses are for an item or
8 service furnished in a competitive acquisition area
9 (as established by the Secretary under section
10 1866C(a)) by an entity other than an entity with
11 which the Secretary has entered into an agreement
12 under section 1866C(e) for the furnishing of such an
13 item or service in that area, except in such cases of
14 emergency or urgent need as the Secretary shall pre-
15 scribe.

16 (c) EFFECTIVE DATE.—The amendments made by
17 subsections (a) and (b) apply to items and services fur-
18 nished after 2002.

19 **SEC. 114. PROVIDER AND PHYSICIAN COLLABORATIONS.**

20 Title XVIII (42 U.S.C. 1395 et seq.), as previously
21 amended by this part, is further amended by adding after
22 section 1866C the following new section:

23 **“SEC. 1866D. PROVIDER AND PHYSICIAN COLLABORATIONS.**

24 “(a) IN GENERAL.—

1 “(1) PROGRAM AUTHORITY.—The Secretary
2 may enter into agreements with specific providers,
3 suppliers, or other individuals or entities for the fur-
4 nishing of bundled items and services in selected
5 sites of service or related to specific medical condi-
6 tions or needs for an episode of care. The services
7 may include any items or services covered under this
8 title that the Secretary determines to be appropriate,
9 including post-hospital services.

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

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

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

1 the Secretary would have otherwise made for the items
2 and services.

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

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

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

20 **SEC. 115. PREFERRED PARTICIPANTS.**

21 (a) **IN GENERAL.**—Title XVIII (42 U.S.C. 1395 et
22 seq.), as previously amended by this part, is further
23 amended by adding after section 1866D the following new
24 section:

1 **“SEC. 1866E. PREFERRED PARTICIPANTS.**

2 “(a) PROGRAM AUTHORITY.—

3 “(1) IN GENERAL.—The Secretary shall imple-
4 ment beginning in 2002, a preferred participant pro-
5 gram, under which the Secretary enters into agree-
6 ments for the furnishing of health care items and
7 services by individuals and entities participating in
8 the program under part A or B of this title that pro-
9 vide high-quality, efficient health care.

10 “(2) LIMITATION.—The Secretary shall not im-
11 plement the program under this section with respect
12 to a service area, or with respect to a category of in-
13 dividuals and entities furnishing items and services
14 in such service area, unless the Secretary estimates
15 that to do so will reduce the cost and improve the
16 quality of the programs under this title.

17 “(3) ADMINISTRATION BY CONTRACT.—Except
18 as otherwise specifically provided, the Secretary shall
19 administer the program under this section in accord-
20 ance with section 1866M.

21 “(b) PREFERRED PARTICIPANT AGREEMENT.—

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

1 “(A) PARTICIPATION CRITERIA.—The indi-
2 vidual or entity shall meet the criteria estab-
3 lished by the Secretary under section
4 1866M(b)(5) (relating to quality, cost-effective-
5 ness, categories of participants in service area,
6 and such other standards or criteria as the Sec-
7 retary may establish).

8 “(B) PAYMENT RATE.—The individual or
9 entity shall agree to accept payment, for cov-
10 ered health care items and services furnished
11 during the term of the agreement, at the rates
12 established under this section (which may in-
13 clude rates in effect under part A or B, dis-
14 counted rates, or such other rates as the Sec-
15 retary may find appropriate).

16 “(2) DURATION.—A preferred participant agreement
17 under this section shall be for a calendar year (or,
18 in the case of an agreement commencing after the
19 first day of January (or such later date as the Sec-
20 retary may specify), for the remainder of such cal-
21 endar year), and shall be annually renewable, at the
22 option of the participant, while the participant con-
23 tinues to meet all applicable conditions of participa-
24 tion.

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

5 “(1) provide for the reduction or elimination of
 6 beneficiary cost sharing (such as deductibles, copay-
 7 ments, and coinsurance) with respect to any of the
 8 items or services furnished under this section, and
 9 may limit such reduction or elimination to particular
 10 service areas; and

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

14 (b) DEFINITIONS.—Section 1861 (42 U.S.C. 1395x)
 15 is amended by adding at the end the following new sub-
 16 section:

17 “(uu) PREFERRED PARTICIPANT.—The term ‘pre-
 18 ferred participant’ means an individual or entity that fur-
 19 nishes health care items or services under part A or B
 20 and that has in effect an agreement under section
 21 1866E(b).”.

22 **SEC. 116. CENTERS OF EXCELLENCE.**

23 Title XVIII (42 U.S.C. 1395 et seq.), as previously
 24 amended by this part, is further amended by adding after
 25 section 1866E the following new section:

1 **“SEC. 1866F. CENTERS OF EXCELLENCE.**

2 “(a) IN GENERAL.—

3 “(1) COMPETITION TO FURNISH BUNDLED
4 ITEMS AND SERVICES.—The Secretary, beginning in
5 2002, shall use a competitive process to enter into
6 agreements with specific hospitals or other entities
7 for the furnishing of bundled groups of items and
8 services related to certain surgical procedures, and
9 of other bundled groups of items and services (unre-
10 lated to surgical procedures) specified by the Sec-
11 retary furnished during an episode of care (as de-
12 fined by the Secretary). Such items and services may
13 include any items or services covered under this title
14 that the Secretary determines to be appropriate.

15 “(2) ADMINISTRATION BY CONTRACT.—Except
16 as otherwise specifically provided, the Secretary may
17 administer the program under this section in accord-
18 ance with section 1866M.

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

21 “(1) meet quality standards established by the
22 Secretary;

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

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

1 “(c) PAYMENT.—

2 “(1) IN GENERAL.—The Secretary shall estab-
3 lish criteria for identifying the health care items and
4 services furnished by a center with an agreement
5 under this section during an episode of care that are
6 to be bundled together and for which payment shall
7 be made on the basis of an all-inclusive rate.

8 “(2) PAYMENT LIMITATION.—

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

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

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

1 “(e) INCENTIVES FOR USE OF CENTERS.—Notwith-
 2 standing any other provision of law, the Secretary may
 3 permit entities under an agreement under this section to
 4 furnish additional services or to waive part or all bene-
 5 ficiary cost sharing (such as deductibles, copayments, and
 6 coinsurance) with respect to any of the items or services
 7 furnished under this section.

8 “(f) BENEFICIARY ELECTION.—Notwithstanding any
 9 other provision of this title, an individual who voluntarily
 10 elects to receive items and services under an arrangement
 11 described in subsection (a)(1) with respect to an episode
 12 of care shall not be entitled to payment under this title
 13 for any such item or service furnished with respect to such
 14 episode of care other than through such arrangement, sub-
 15 ject to such exceptions as the Secretary may prescribe for
 16 emergency medical services as described in section
 17 1852(d)(3) and other cases of urgent need.”.

18 **SEC. 117. DEMONSTRATION OF BONUS PAYMENTS FOR**
 19 **HEALTH CARE GROUPS.**

20 Title XVIII (42 U.S.C. 1395 et seq.), as previously
 21 amended by this part, is further amended by adding after
 22 section 1866F the following new section:

23 **“SEC. 1866G. DEMONSTRATION OF BONUS PAYMENTS FOR**
 24 **HEALTH CARE GROUPS.**

25 “(a) DEMONSTRATION PROGRAM AUTHORIZED.—

1 “(1) IN GENERAL.—The Secretary shall con-
2 duct demonstration projects to test and, if proven ef-
3 fective, expand the use of incentives to health care
4 groups participating in the program under this title
5 that—

6 “(A) encourage coordination of the care
7 furnished to individuals under the programs
8 under parts A and B by institutional and other
9 providers, practitioners, and suppliers of health
10 care items and services;

11 “(B) encourage investment in administra-
12 tive structures and processes to ensure efficient
13 service delivery; and

14 “(C) reward physicians for improving
15 health outcomes.

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

20 “(3) DEFINITIONS.—For purposes of this sec-
21 tion, terms have the following meanings:

22 “(A) PHYSICIAN.—Except as the Secretary
23 may otherwise provide, the term ‘physician’
24 means any individual who furnishes services

1 which may be paid for as physicians' services
2 under this title .

3 “(B) HEALTH CARE GROUP.—The term
4 ‘health care group’ means a group of physicians
5 (as defined in subparagraph (A)) organized at
6 least in part for the purpose of providing physi-
7 cians’ services under this title. As the Secretary
8 finds appropriate, a health care group may in-
9 clude a hospital and any other individual or en-
10 tity furnishing items or services for which pay-
11 ment may be made under this title that is affili-
12 ated with the health care group under an ar-
13 rangement structured so that such individual or
14 entity participates in a demonstration under
15 this section and will share in any bonus earned
16 under subsection (d).

17 “(b) ELIGIBILITY CRITERIA.—

18 “(1) IN GENERAL.—The Secretary is authorized
19 to establish criteria for health care groups eligible to
20 participate in a demonstration under this section, in-
21 cluding criteria relating to numbers of health care
22 professionals in, and of patients served by, the
23 group, scope of services provided, and quality of
24 care.

1 “(2) PAYMENT METHOD.—A health care group
2 participating in the demonstration under this section
3 shall agree with respect to services furnished to
4 beneficiaries within the scope of the demonstration
5 (as determined under subsection (c))—

6 “(A) to be paid on a fee-for-service basis;
7 and

8 “(B) that payment with respect to all such
9 services furnished by members of the health
10 care group to such beneficiaries shall (where de-
11 termined appropriate by the Secretary) be made
12 to a single entity.

13 “(3) DATA REPORTING.—A health care group
14 participating in a demonstration under this section
15 shall report to the Secretary such data, at such
16 times and in such format as the Secretary require,
17 for purposes of monitoring and evaluation of the
18 demonstration under this section.

19 “(c) PATIENTS WITHIN SCOPE OF DEMONSTRA-
20 TION.—

21 “(1) IN GENERAL.—The Secretary shall specify,
22 in accordance with this subsection, the criteria for
23 identifying those patients of a health care group who
24 shall be considered within the scope of the dem-
25 onstration under this section for purposes of applica-

1 tion of subsection (d) and for assessment of the ef-
2 fectiveness of the group in achieving the objectives
3 of this section.

4 “(2) OTHER CRITERIA.—The Secretary may es-
5 tablish additional criteria for inclusion of bene-
6 ficiaries within a demonstration under this section,
7 which may include frequency of contact with physi-
8 cians in the group or other factors or criteria that
9 the Secretary finds to be appropriate.

10 “(3) NOTICE REQUIREMENTS.—In the case of
11 each beneficiary determined to be within the scope
12 of a demonstration under this section with respect to
13 a specific health care group, the Secretary shall en-
14 sure that such beneficiary is notified of the incen-
15 tives, and of any waivers of coverage or payment
16 rules, applicable to such group under such dem-
17 onstration.

18 “(d) INCENTIVES.—

19 “(1) PERFORMANCE TARGET.—The Secretary
20 shall establish for each health care group partici-
21 pating in a demonstration under this section—

22 “(A) a base expenditure amount, equal to
23 the average total payments under parts A, B,
24 and D for patients served by the health care

1 group on a fee-for-service basis in a base period
2 determined by the Secretary; and

3 “(B) an annual per capita expenditure tar-
4 get for patients determined to be within the
5 scope of the demonstration, reflecting the base
6 expenditure amount adjusted for risk and ex-
7 pected growth rates.

8 “(2) INCENTIVE BONUS.—The Secretary shall
9 pay to each participating health care group (subject
10 to paragraph (4)) a bonus for each year under the
11 demonstration equal to a portion of the Medicare
12 savings realized for such year relative to the per-
13 formance target.

14 “(3) ADDITIONAL BONUS FOR PROCESS AND
15 OUTCOME IMPROVEMENTS.—At such time as the
16 Secretary has established appropriate criteria based
17 on evidence the Secretary determines to be suffi-
18 cient, the Secretary shall also pay to a participating
19 health care group (subject to paragraph (4)) an ad-
20 ditional bonus for a year, equal to such portion as
21 the Secretary may designate of the saving to the
22 Medicare program resulting from process improve-
23 ments made by and patient outcome improvements
24 attributable to activities of the group.

1 “(4) LIMITATION.—The Secretary shall limit
2 bonus payments under this section as necessary to
3 ensure that the aggregate expenditures under this
4 title (inclusive of bonus payments) with respect to
5 patients within the scope of the demonstration do
6 not exceed the amount which the Secretary esti-
7 mates would be expended if the demonstration
8 projects under this section were not implemented.

9 “(e) SELECTION OF DEMONSTRATION PROJECTS.—
10 The Secretary shall implement up to ten demonstrations
11 under this section, selected competitively on the basis of
12 criteria determined by the Secretary.”.

13 **SEC. 118. ADMINISTRATION OF CERTAIN PRIVATE SECTOR**
14 **PURCHASING AND QUALITY IMPROVEMENT**
15 **PROGRAMS.**

16 Title XVIII (42 U.S.C. 1395 et seq.) is amended by
17 adding after section 1866F the following new section:

18 **“SEC. 1866M. GENERAL PROVISIONS FOR ADMINISTRATION**
19 **OF CERTAIN PRIVATE SECTOR PURCHASING**
20 **AND QUALITY IMPROVEMENT PROGRAMS.**

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

24 “(1) section 1866A (care coordination services);

1 “(2) section 1866B (disease management serv-
2 ices);

3 “(3) section 1866C (competitive acquisition of
4 items and services);

5 “(4) section 1866D (provider and physician col-
6 laborations); and

7 “(5) section 1866E (preferred participants);

8 “(6) section 1866F (centers of excellence);

9 “(7) section 1866G (demonstration of bonus
10 payments for health care groups).

11 “(b) PROVISIONS GENERALLY APPLICABLE TO DES-
12 IGNATED PROGRAMS.—The following provisions apply to
13 programs specified in subsection (a), except as otherwise
14 specifically provided:

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

19 “(A) is enrolled in under the program
20 under part B;

21 “(B) is not enrolled in a Medicare+Choice
22 plan under part C, an eligible organization
23 under a contract under section 1876 (or a simi-
24 lar organization operating under a demonstra-
25 tion project authority), an organization with an

1 agreement under section 1833(a)(1)(A), or a
2 PACE program under section 1894; and

3 “(C) in the case of the programs specified
4 in paragraphs (1), (2), (4), (6), and (7) of sub-
5 section (a), is entitled to benefits under part A.

6 “(2) SECRETARY’S DISCRETION AS TO SCOPE
7 OF PROGRAM.—The Secretary may limit the imple-
8 mentation of a program specified in subsection (a)
9 to—

10 “(A) a geographic area (or areas) that the
11 Secretary designates for purposes of the pro-
12 gram, based upon such criteria as the Secretary
13 finds appropriate;

14 “(B) a subgroup (or subgroups) of bene-
15 ficiaries or individuals and entities furnishing
16 items or services (otherwise eligible to partici-
17 pate in the program), selected on the basis of
18 the number of such participants that the Sec-
19 retary finds consistent with the effective and ef-
20 ficient implementation of the program;

21 “(C) an element (or elements) of the pro-
22 gram that the Secretary determines to be suit-
23 able for implementation; or

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

1 “(3) VOLUNTARY RECEIPT OF ITEMS AND
2 SERVICES.—Except as provided in the authority for
3 the program specified in subsection (a)(3), items and
4 services shall be furnished to an individual under the
5 programs specified in subsection (a) only at the indi-
6 vidual’s election.

7 “(4) AGREEMENTS.—The Secretary is author-
8 ized to enter into agreements with individuals and
9 entities to furnish health care items and services to
10 beneficiaries under the programs specified in sub-
11 section (a).

12 “(5) PROGRAM STANDARDS AND CRITERIA.—
13 The Secretary shall establish performance standards
14 for the programs specified in subsection (a) includ-
15 ing, as applicable, standards for quality of health
16 care items and services, cost-effectiveness, bene-
17 ficiary satisfaction, and such other factors as the
18 Secretary finds appropriate. The eligibility of indi-
19 viduals or entities for the initial award, continuation,
20 and renewal of agreements to provide health care
21 items and services under the program shall be condi-
22 tioned, at a minimum, on performance that meets or
23 exceeds such standards.

24 “(6) ADMINISTRATIVE REVIEW OF ADVERSE
25 DECISION.—

1 “(A) DECISIONS AFFECTING INDIVIDUALS
2 AND ENTITIES FURNISHING SERVICES UNDER
3 PROGRAMS.—An individual or entity furnishing
4 services under a program specified in subsection
5 (a) shall be entitled to a review by the program
6 administrator (or, if the Secretary has not con-
7 tracted with a program administrator, by the
8 Secretary) of a decision not to enter into, or to
9 terminate, or not to renew, an agreement with
10 the individual or entity to provide health care
11 items or services under such program.

12 “(B) DECISIONS AFFECTING BENE-
13 FICIARIES UNDER CARE COORDINATION SERV-
14 ICES OR DISEASE MANAGEMENT SERVICES PRO-
15 GRAMS.—

16 “(i) DETERMINATION OF INELIGI-
17 BILITY.—An individual shall be entitled to
18 a review by the program administrator (or,
19 if the Secretary has not contracted with a
20 program administrator, by the Secretary)
21 of a determination that the individual does
22 not meet the criteria for eligibility to par-
23 ticipate in a program specified in para-
24 graph (1) or (2) of subsection (a).

1 “(ii) DENIAL OF PAYMENT FOR ITEMS
2 OR SERVICES.—A beneficiary shall be enti-
3 tled to a reconsideration or appeal of a de-
4 nial of payment under section 1866A(d)(2)
5 or 1866B(e)(2) in accordance with the pro-
6 visions of section 1852(g), as if such sec-
7 tion applied to this clause. In applying
8 such section 1852(g), any reference to a
9 Medicare+Choice organization is construed
10 to refer to the program administrator or, if
11 the Secretary has not contracted with a
12 program administrator, to the Secretary.

13 “(7) SECRETARY’S REVIEW OF MARKETING MA-
14 TERIALS.—An agreement with an individual or enti-
15 ty furnishing services under a program specified in
16 subsection (a) shall require the individual or entity
17 to guarantee that it will not distribute materials
18 marketing items or services under such program
19 without the Secretary’s prior review and approval;

20 “(8) PAYMENT IN FULL.—

21 “(A) IN GENERAL.—Except as provided in
22 subparagraph (B), an individual or entity re-
23 ceiving payment from the Secretary under a
24 contract or agreement under a program speci-
25 fied in subsection (a) shall agree to accept such

1 payment as payment in full, and such payment
2 shall be in lieu of any payments to which the
3 individual or entity would otherwise be entitled
4 under this title.

5 “(B) COLLECTION OF DEDUCTIBLES AND
6 COINSURANCE.—Such individual or entity may
7 collect any applicable deductible or coinsurance
8 amount from a beneficiary.

9 “(c) CONTRACTS FOR PROGRAM ADMINISTRATION.—

10 “(1) IN GENERAL.—The Secretary may admin-
11 ister a program specified in subsection (a) through
12 a contract with a program administrator in accord-
13 ance with the provisions of this subsection.

14 “(2) SCOPE OF PROGRAM ADMINISTRATOR CON-
15 TRACTS.—A contract under this subsection may, at
16 the Secretary’s discretion, relate to administration of
17 any or all of the programs specified in subsection
18 (a). The Secretary may enter into such contracts for
19 a limited geographic area, or on a regional or na-
20 tional basis.

21 “(3) ELIGIBLE CONTRACTORS.—The Secretary
22 may contract for the administration of the program
23 with—

24 “(A) an entity that, under a contract
25 under section 1816 or 1842, determines the

1 amount of and makes payments for health care
2 items and services furnished under this title; or

3 “(B) any other entity with substantial ex-
4 perience in managing the type of program con-
5 cerned.

6 “(4) CONTRACT AWARD, DURATION, AND RE-
7 NEWAL.—

8 “(A) IN GENERAL.—A contract under this
9 subsection shall be for an initial term of up to
10 three years, renewable for additional terms of
11 up to three years.

12 “(B) NONCOMPETITIVE AWARD AND RE-
13 NEWAL FOR ENTITIES ADMINISTERING PART A
14 OR PART B PAYMENTS.—The Secretary may
15 enter or renew a contract under this subsection
16 with an entity described in paragraph (3)(A)
17 without regard to the requirements of section 5
18 of title 41, United States Code.

19 “(5) APPLICABILITY OF FEDERAL ACQUISITION
20 REGULATION.—The Federal Acquisition Regulation
21 shall apply to program administration contracts
22 under this subsection.

23 “(6) PERFORMANCE STANDARDS.—The Sec-
24 retary shall establish performance standards for the
25 program administrator including, as applicable,

1 standards for the quality and cost-effectiveness of
2 the program administered, and such other factors as
3 the Secretary finds appropriate. The eligibility of en-
4 tities for the initial award, continuation, and renewal
5 of program administration contracts shall be condi-
6 tioned, at a minimum, on performance that meets or
7 exceeds such standards.

8 “(7) FUNCTIONS OF PROGRAM ADMINIS-
9 TRATOR.—A program administrator shall perform
10 any or all of the following functions, as specified by
11 the Secretary:

12 “(A) AGREEMENTS WITH INDIVIDUALS OR
13 ENTITIES FURNISHING HEALTH CARE ITEMS
14 AND SERVICES.—Determine the qualifications
15 of individuals or entities seeking to enter or
16 renew agreements to provide services under a
17 program specified in subsection (a), and as ap-
18 propriate enter or renew (or refuse to enter or
19 renew) such agreements on behalf of the Sec-
20 retary.

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

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

4 “(D) PAYMENT OF BONUSES.—Using such
5 guidelines as the Secretary shall establish, and
6 subject to the approval of the Secretary, make
7 bonus payments as described in subsection
8 (d)(2)(A)(ii) to individuals and entities fur-
9 nishing items or services for which payment
10 may be made under any such program.

11 “(E) LIST OF PROGRAM PARTICIPANTS.—
12 Maintain and regularly update a list of individ-
13 uals or entities with agreements to provide
14 health care items and services under any such
15 program, and ensure that such list, in electronic
16 and hard copy formats, is readily available, as
17 applicable, to—

18 “(i) individuals residing in the service
19 area who are entitled to benefits under
20 part A or enrolled in the program under
21 part B;

22 “(ii) the entities responsible under
23 sections 1816 and 1842 for administering
24 payments for health care items and serv-
25 ices furnished; and

1 “(iii) individuals and entities pro-
2 viding health care items and services in the
3 service area.

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

15 “(G) OVERSIGHT.—Monitor the compli-
16 ance of individuals and entities with agreements
17 under any such program with the conditions of
18 participation.

19 “(H) ADMINISTRATIVE REVIEW.—Conduct
20 reviews of adverse determinations specified in
21 subparagraph (A) and in subsection (b)(6).

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

1 “(J) ADDITIONAL FUNCTIONS.—Perform
2 such other functions as the Secretary may
3 specify.

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

9 “(9) INFORMATION SHARING.—Notwithstanding
10 section 1106 and section 552a of title 5, United
11 States Code, the Secretary is authorized to disclose
12 to an entity with a program administration contract
13 under this subsection such information (including
14 medical information) on individuals receiving health
15 care items and services under the program as the
16 entity may require to carry out its responsibilities
17 under the contract.

18 “(d) RULES APPLICABLE TO BOTH PROGRAM
19 AGREEMENTS AND PROGRAM ADMINISTRATION CON-
20 TRACTS.—

21 “(1) RECORDS, REPORTS, AND AUDITS.—The
22 Secretary is authorized to require individuals and
23 entities with agreements to provide health care items
24 or services under programs specified under sub-
25 section (a), and entities with program administration

1 contracts under subsection (c), to maintain adequate
2 records, to afford the Secretary access to such
3 records (including for audit purposes), and to fur-
4 nish such reports and other materials (including au-
5 dited financial statements and performance data) as
6 the Secretary may require for purposes of implemen-
7 tation, oversight, and evaluation of such program
8 and of individuals' and entities' effectiveness in per-
9 formance of such agreements or contracts.

10 “(2) BONUSSES.—Notwithstanding any other
11 provision of law, but subject to subparagraph
12 (B)(ii), the Secretary may make bonus payments
13 under a program specified in subsection (a) from the
14 Health Insurance and Supplementary Medical Insur-
15 ance Trust Funds in amounts that do not exceed
16 50 percent of the savings to such Trust Funds at-
17 tributable to such programs (or in the case of the
18 program specified in subsection (a)(7), in amounts
19 authorized under such program), in accordance with
20 the following:

21 “(A) PAYMENTS TO PROGRAM ADMINIS-
22 TRATORS.—The Secretary may make bonus
23 payments under each program specified in sub-
24 section (a) to program administrators.

1 “(B) PAYMENTS TO INDIVIDUALS AND EN-
2 TITIES FURNISHING SERVICES.—

3 “(i) IN GENERAL.—Subject to clause
4 (ii), the Secretary may make bonus pay-
5 ments to individuals or entities furnishing
6 items or services for which payment may
7 be made under the programs specified in
8 paragraphs (1), (2), (5), and (7) of sub-
9 section (a), or may authorize a program
10 administrator to make such bonus pay-
11 ments in accordance with such guidelines
12 as the Secretary shall establish and subject
13 to the Secretary’s approval.

14 “(ii) LIMITATIONS.—The Secretary
15 may limit bonus payments under clause (i)
16 to particular service areas, types of individ-
17 uals or entities furnishing items or services
18 under a program, or kinds of items or
19 services, and may condition such payments
20 on the achievement of such standards re-
21 lated to efficiency, improvement in proc-
22 esses or outcomes of care, or such other
23 factors as the Secretary determines to be
24 appropriate.

25 “(3) ANTIDISCRIMINATION LIMITATION.—

1 “(A) IN GENERAL.—The Secretary shall
2 not enter into an agreement with an individual
3 or entity to provide health care items or serv-
4 ices under a program specified under subsection
5 (a), or with an entity to administer such a pro-
6 gram, unless such individual or entity guaran-
7 tees that it will not deny, limit, or condition the
8 coverage or provision of benefits under such
9 program, for individuals eligible to be enrolled
10 under such program, based on any health sta-
11 tus-related factor described in section
12 2702(a)(1) of the Public Health Service Act.

13 “(B) CONSTRUCTION.—Subparagraph (A)
14 shall not be construed to prohibit such indi-
15 vidual or entity from taking any action explic-
16 itly authorized by the provisions of section
17 1866A (care coordination services) or section
18 1866B (disease management services).

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

23 “(1) limiting the implementation of a program
24 under subsection (b)(2);

1 “(2) establishment of program participation
2 standards under subsection (b)(5); or the denial or
3 termination of, or refusal to renew, an agreement
4 with an individual or entity to provide health care
5 items and services under the program;

6 “(3) determination of a beneficiary’s eligibility
7 under subsection (b)(6)(B);

8 “(4) establishment of program administration
9 contract performance standards under subsection
10 (c)(6); or the refusal to renew a program adminis-
11 tration contract; or the noncompetitive award or re-
12 newal of a program administration contract under
13 subsection (c)(4)(B);

14 “(5) the establishment of payment rates,
15 through negotiation or otherwise, under a program
16 agreement or a program administration contract;

17 “(6) a determination with respect to a program
18 (where specifically authorized by the program au-
19 thority or by subsection (d)(2))—

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

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

24 “(C) as to whether to reduce or eliminate
25 beneficiary cost-sharing.

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

5 (b) EXCEPTION TO LIMITS ON PHYSICIAN REFER-
6 RALS.—Section 1877(b) (42 U.S.C. 1395nn(b)) is
7 amended—

8 (1) by redesignating paragraph (4) as para-
9 graph (5); and

10 (2) by adding after paragraph (3) the following
11 new paragraph:

12 “(4) PRIVATE SECTOR PURCHASING AND QUAL-
13 ITY IMPROVEMENT TOOLS FOR ORIGINAL MEDI-
14 CARE.—In the case of a designated health service, if
15 the designated health service is—

16 “(A) included in the services under section
17 1866A, 1866B, 1866D, or 1866F; and

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

1 **SEC. 119. REPORTS TO CONGRESS ON PRIVATE SECTOR**
2 **PURCHASING AND QUALITY IMPROVEMENT**
3 **PROGRAMS.**

4 Not later than two years after the date of enactment
5 of the Medicare Modernization Act of 2000, and biennially
6 thereafter for six years, the Secretary shall report to the
7 Congress on the use of authorities enacted by sections 111
8 through 117 of this Act. Each report shall address the
9 impact of the use of those authorities on expenditures, ac-
10 cess, and quality under the programs under title XVIII
11 of the Social Security Act.

12 **SEC. 120. INCREASED FLEXIBILITY IN CONTRACTING FOR**
13 **MEDICARE CLAIMS PROCESSING.**

14 (a) CARRIERS TO INCLUDE ENTITIES THAT ARE
15 NOT INSURANCE COMPANIES.—

16 (1) The matter in section 1842(a) (42 U.S.C.
17 1395u(a)) preceding paragraph (1) is amended by
18 striking “with carriers” and inserting “with agencies
19 and organizations (referred to as carriers)”.

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

22 (b) SECRETARIAL FLEXIBILITY IN CONTRACTING
23 FOR AND IN ASSIGNING FISCAL INTERMEDIARY AND CAR-
24 RIER FUNCTIONS.—

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

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

9 “(A) determine (subject to the provisions of sec-
10 tion 1878 and to such review by the Secretary as
11 may be provided for by the contracts) the amount of
12 the payments required pursuant to this part to be
13 made to providers of services,

14 “(B) make payments described in subparagraph
15 (A),

16 “(C) provide consultative services to institutions
17 or agencies to enable them to establish and maintain
18 fiscal records necessary for purposes of this part and
19 otherwise to qualify as providers of services,

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

1 from individuals entitled to benefits under this part
2 and from providers of services to the Secretary,

3 “(E) make such audits of the records of pro-
4 viders of services as may be necessary to insure that
5 proper payments are made under this part,

6 “(F) perform the functions described by sub-
7 section (d), and

8 “(G) perform such other functions as are nec-
9 essary to carry out the purposes of this part.

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

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

15 “(d) Each provider of services shall have a fiscal
16 intermediary that—

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

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

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

1 “(e) The Secretary, in evaluating the performance of
2 a fiscal intermediary, may solicit comments from providers
3 of services.”.

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

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

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

20 (C) The second sentence of section
21 1842(b)(2)(A) (42 U.S.C. 1395u(b)(2)(A)) is
22 amended to read as follows: “The Secretary may
23 consult with Medicare+Choice organizations under
24 part C of this title, providers of services and other
25 persons who furnish items or services for which pay-

1 ment may be made under this title, and organiza-
2 tions and agencies performing functions necessary to
3 carry out the purposes of this part with respect to
4 performance requirements for contracts under sub-
5 section (a).”.

6 (D) Section 1842(b)(2)(A) (42 U.S.C.
7 1395u(b)(2)(A)) is amended by striking the third
8 sentence.

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

14 (F) Section 1842(b)(2)(D) (42 U.S.C.
15 1395u(b)(2)(D)) is amended by striking “standards
16 and criteria” each place it occurs and inserting
17 “contract performance requirements”.

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

22 (B) Paragraphs (1)(B) and (2)(A) of section
23 1816(b) (42 U.S.C. 1395h(b)) are each amended by
24 striking “agreement” and inserting “contract”.

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

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

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

11 (F) Section 1816(c)(3)(A) (42 U.S.C.
12 1395h(c)(3)(A)) is amended by striking “agree-
13 ment” and inserting “contract”.

14 (G) Section 1816(h) (42 U.S.C. 1395h(h)) is
15 amended—

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

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

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

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

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

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

7 (L) The matter in section 1842(a) (42 U.S.C.
8 1395u(a)) preceding paragraph (1) is amended by
9 striking “agreements” and inserting “contracts”.

10 (M) Section 1842(h)(3)(A) (42 U.S.C.
11 1395u(h)(3)(A)) is amended by striking “an agree-
12 ment” and inserting “a contract”.

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

17 (B) Section 1816(c)(3)(A) (42 U.S.C.
18 1395h(c)(3)(A)) is amended by inserting “that pro-
19 vides for making payments under this part” after
20 “this section”.

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

24 (D) The matter in section 1842(a) (42 U.S.C.
25 1395u(a)) preceding paragraph (1) is amended by

1 striking “some or all of the following functions” and
2 inserting “any or all of the following functions, or
3 parts of those functions”.

4 (E) The first sentence of section 1842(b)(2)(C)
5 (42 U.S.C. 1395u(b)(2)(C)) is amended by inserting
6 “(as appropriate)” after “carriers”.

7 (F) The matter preceding subparagraph (A) in
8 the first sentence of section 1842(b)(3) (42 U.S.C.
9 1395u(b)(3)) is amended by inserting “(as appro-
10 priate)” after “contract”.

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

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

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

22 (J) Section 1842(h)(5)(A) (42 U.S.C.
23 1395u(h)(5)(A)) is amended by inserting “(as ap-
24 propriate)” after “carriers”.

1 (6)(A) Section 1816(e)(2)(C) (42 U.S.C.
2 1395h(e)(2)(C)) is amended by striking “hospital,
3 rural primary care hospital, skilled nursing facility,
4 home health agency, hospice program, comprehen-
5 sive outpatient rehabilitation facility, or rehabilita-
6 tion agency” and inserting “provider of services”.

7 (B) The matter in section 1816(j) (42 U.S.C.
8 1395h(j)) preceding paragraph (1) is amended by
9 striking “for home health services, extended care
10 services, or post-hospital extended care services”.

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

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

23 (c) ELIMINATION OF SPECIAL PROVISIONS FOR TER-
24 MINATIONS OF CONTRACTS.—

1 (1) The matter in section 1816(b) (42 U.S.C.
2 1395h(b)) preceding paragraph (1) is amended by
3 striking “or renew”.

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

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

9 (4) The last sentence of section 1842(b)(2)(A)
10 (42 U.S.C. 1395u(b)(2)(A)) is amended by striking
11 “or renewing”.

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

14 (d) REPEAL OF FISCAL INTERMEDIARY REQUIRE-
15 MENTS THAT ARE NOT COST-EFFECTIVE.—Section
16 1816(f)(2) (42 U.S.C. 1395h(f)(2)) is amended to read
17 as follows:

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

1 (e) REPEAL OF COST REIMBURSEMENT REQUIRE-
2 MENTS.—

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

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

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

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

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

14 (A) by striking “shall provide” the first
15 place it occurs and inserting “may provide”,
16 and

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

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

22 (5) Section 2326(a) of the Deficit Reduction
23 Act of 1984 (42 U.S.C. 1395h nt) is repealed.

1 (f) SECRETARIAL FLEXIBILITY WITH RESPECT TO
2 RENEWING CONTRACTS AND TRANSFER OF FUNC-
3 TIONS.—

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

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

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

18 “(ii) Functions may be transferred among fiscal
19 intermediaries without regard to any provision of
20 law requiring competition. However, the Secretary
21 shall ensure that performance quality is considered
22 in such transfers.”.

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

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

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

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

15 (g) WAIVER OF COMPETITIVE REQUIREMENTS FOR
16 INITIAL CONTRACTS.—

17 (1) Contracts under section 1816(a) (42 U.S.C.
18 1395h(a)) or 1842(a) (42 U.S.C. 1395u(a)) whose
19 periods begin before or during the one year period
20 that begins on the first day of the fourth calendar
21 month that begins after the date of enactment of
22 this section may be entered into without regard to
23 any provision of law requiring competition.

24 (2) The amendments made by subsection (f)
25 apply to contracts whose periods begin after the end

1 of the one year period specified in paragraph (1) of
2 this subsection.

3 (h) EFFECTIVE DATES.—

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

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

12 **SEC. 121. SPECIAL PROVISIONS FOR FUNDING OF ACTIVI-**
13 **TIES RELATED TO CERTAIN OVERPAYMENT**
14 **RECOVERIES AND PROVIDER ENROLLMENT**
15 **AND REVERIFICATION OF ELIGIBILITY.**

16 (a) FUNDING AVAILABLE UNDER THE MEDICARE IN-
17 TEGRITY PROGRAM (MIP) APPROPRIATION FOR PRO-
18 VIDER ENROLLMENT ACTIVITIES PERFORMED BY FISCAL
19 INTERMEDIARIES AND CARRIERS.—Section 1817(k)(4)
20 (42 U.S.C. 1395i(k)(4)) is amended—

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

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

3 “(C)(i) Of the amounts appropriated under
4 subparagraph (A), the amounts specified in
5 clause (iii) shall be available to the Secretary
6 for payment of the costs of the activities de-
7 scribed in clause (ii) which are performed by
8 entities with contracts under section 1816 or
9 1842.

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

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

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

24 “(iii) For purposes of clause (i), the
25 amount specified under this clause is the lesser

1 of the amounts necessary to perform the activi-
2 ties described in clause (ii) or—

3 “(I) for fiscal year 2001,
4 \$14,000,000; and

5 “(II) for fiscal years 2002 and 2003,
6 the amount for the preceding year, in-
7 creased by 30 percent of the difference be-
8 tween the maximum amount specified in
9 subparagraph (B) for such year and the
10 maximum amount so specified for the pre-
11 ceding year.

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

17 (b) ADDITIONAL FUNCTIONS TO BE PERFORMED BY
18 MIP CONTRACTORS.—

19 (1) REVERIFICATION OF ELIGIBILITY FUNC-
20 TION.—Section 1893(b) (42 U.S.C. 1395ddd(b)) is
21 amended by adding at the end the following new
22 paragraph:

23 “(6) activities related to reverifying the eligi-
24 bility of individuals and entities described in para-

1 graph (1) to participate under the program under
2 this title, and related activities.

3 (2) PROVIDER ENROLLMENT AND OVERPAY-
4 MENT RECOVERY FUNCTIONS ADDED AS MIP CON-
5 TRACTOR FUNCTIONS AFTER PHASE-IN PERIOD.—

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

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

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

19 (3) EFFECTIVE DATES.—The amendment made
20 by paragraph (1) shall be effective on and after Oc-
21 tober 1, 2000. The amendment made by paragraph
22 (2) shall be effective on and after October 1, 2003.

1 **TITLE II—MODERNIZING**
2 **MEDICARE BENEFITS**

3 **PART A—PRESCRIPTION DRUG BENEFIT**

4 **SEC. 201. PRESCRIPTION DRUG BENEFIT.**

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

7 (1) by redesignating section 1859 and part D
8 as section 1858 and part F, respectively; and

9 (2) by adding after section 1858, as so redesign-
10 nated, the following new part:

11 **“PART D—PRESCRIPTION DRUG BENEFIT FOR**
12 **THE AGED AND DISABLED**

13 **“SEC. 1859. ESTABLISHMENT OF PRESCRIPTION DRUG BEN-**
14 **EFIT PROGRAM FOR THE AGED AND DIS-**
15 **ABLED.**

16 “There is hereby established a voluntary insurance
17 program to provide prescription drug benefits in accord-
18 ance with the provisions of this part for individuals who
19 are aged or disabled or have end stage renal disease and
20 who elect to enroll under such program, to be financed
21 from premium payments by enrollees together with con-
22 tributions from funds appropriated by the Federal Govern-
23 ment.

1 **“SEC. 1859A. SCOPE OF BENEFITS.**

2 “(a) IN GENERAL.—The benefits provided to an indi-
3 vidual enrolled in the insurance program under this part
4 shall consist of—

5 “(1) payments made, in accordance with the
6 provisions of this part, for covered prescription
7 drugs (as specified in subsection (b)) dispensed by
8 any pharmacy participating in the program under
9 this part (and, in circumstances designated by the
10 benefit manager, by a non-participating pharmacy),
11 including any specifically named drug prescribed for
12 the individual by a qualified health care professional
13 regardless of whether the drug is included in a for-
14 mulary established by the benefit manager if such
15 drug is certified as medically necessary by such
16 health care professional, up to the benefit limits
17 specified in section 1859B; and

18 “(2) charging by participating pharmacies of—

19 “(A) the negotiated price for all covered
20 prescription drugs, without regard to such ben-
21 efit limit; and

22 “(B) the negotiated price (if any) estab-
23 lished with respect to any drugs or classes of
24 drugs described in subparagraphs (A) through
25 (D) or (F) of section 1927(d)(2) that are avail-

1 able to individuals receiving benefits under this
2 title.

3 “(b) COVERED PRESCRIPTION DRUGS.—

4 “(1) IN GENERAL.—Covered prescription drugs,
5 for purposes of this part, include all prescription
6 drugs (as defined in section 1859J(1)), including
7 smoking cessation agents, except as otherwise pro-
8 vided in this subsection.

9 “(2) EXCLUSIONS FROM COVERAGE.—Covered
10 prescription drugs shall not include drugs or classes
11 of drugs described in subparagraphs (A) through
12 (D) and (F) through (H) of section 1927(d)(2) (ex-
13 cept to the extent otherwise specifically provided by
14 the Secretary with respect to a drug in any of such
15 classes).

16 “(3) EXCLUSION OF PRESCRIPTION DRUGS TO
17 THE EXTENT COVERED UNDER PART A OR B.—A
18 drug prescribed for an individual that would other-
19 wise be a covered prescription drug under this part
20 shall not be so considered to the extent that pay-
21 ment for such drug is available under part A or B
22 (but shall be so considered to the extent that such
23 payment is not available because benefits under part
24 A or B have been exhausted).

1 **“SEC. 1859B. PAYMENT OF BENEFITS; BENEFIT LIMITS.**

2 “(a) PAYMENTS.—There shall be paid from the Pre-
 3 scription Drug Insurance Account within the Supple-
 4 mentary Medical Insurance Trust Fund (hereafter in this
 5 part referred to as the ‘Prescription Drug Insurance Ac-
 6 count’ or ‘the Insurance Account’), in the case of each in-
 7 dividual who is enrolled in the insurance program under
 8 this part and who purchases covered prescription drugs
 9 in a calendar year, an amount (not exceeding 50 percent
 10 of the applicable limit under subsection (b)) equal to 50
 11 percent of the negotiated price for each such covered pre-
 12 scription drug or such higher percentage as is proposed
 13 by a benefit manager pursuant to section 1859G(d)(8),
 14 if the Secretary finds that such percentage will not in-
 15 crease aggregate costs to the Insurance Account.

16 “(b) LIMIT.—

17 “(1) FOR 2003 THROUGH 2009.—For purposes
 18 of subsection (a), the limit under this subsection for
 19 2003 through 2009 is—

20 “(A) \$2,000 for each of calendar years
 21 2003 and 2004;

22 “(B) \$3,000 for each of calendar years
 23 2005 and 2006;

24 “(C) \$4,000 for each of calendar years
 25 2007 and 2008; and

26 “(D) \$5,000 for calendar year 2009.

1 “(2) FOR 2010 AND SUBSEQUENT YEARS.—For
2 purposes of subsection (a), the limit under this sub-
3 section for 2010 and each subsequent year is equal
4 to the greater of the limit for the preceding year ad-
5 justed by the percentage change in the consumer
6 price index for all urban consumers (U.S. urban av-
7 erage) for the 12-month period ending with June of
8 the preceding year; or the limit for the preceding
9 year.

10 **“SEC. 1859C. ELIGIBILITY AND ENROLLMENT.**

11 “(a) ELIGIBILITY.—Every individual who, in or after
12 2003, is entitled to hospital insurance benefits under part
13 A or enrolled in the medical insurance program under part
14 B is eligible to enroll, in accordance with the provisions
15 of this section, in the insurance program under this part,
16 during an enrollment period prescribed in or under this
17 section, in such manner and form as may be prescribed
18 by regulations.

19 “(b) ENROLLMENT.—

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

1 “(2) ENROLLMENT PERIOD.—Except as pro-
2 vided in section 1859E or 1859H, or as otherwise
3 explicitly provided, no individual shall be entitled to
4 enroll in the program under this part at any time
5 after the initial enrollment period.

6 “(3) SPECIAL ENROLLMENT PERIOD FOR
7 2003.—

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

11 “(i) enroll in the program under this
12 part; and

13 “(ii) enroll or re-enroll in such pro-
14 gram after having previously declined or
15 terminated enrollment in such program.

16 “(B) EFFECTIVE DATE OF COVERAGE.—
17 An individual who enrolls under the program
18 under this part pursuant to subparagraph (A)
19 shall be entitled to benefits under this part be-
20 ginning on the first day of the month following
21 the month in which such enrollment occurs.

22 “(e) PERIOD OF COVERAGE.—

23 “(1) IN GENERAL.—Except as otherwise pro-
24 vided in this part, an individual’s coverage under the
25 program under this part shall be effective for the pe-

1 riod provided in section 1838, as if that section ap-
 2 plied to the program under this part.

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

5 In addition to the causes of termination specified in
 6 section 1838, an individual’s coverage under this
 7 part shall be terminated when the individual retains
 8 coverage under neither the program under part A
 9 nor the program under part B, effective on the effec-
 10 tive date of termination of coverage under part A or
 11 (if later) under part B.

12 **“SEC. 1859D. PREMIUMS.**

13 “(a) ANNUAL ESTABLISHMENT OF MONTHLY PRE-
 14 MIUM RATES.—

15 “(1) IN GENERAL.—The Secretary shall, during
 16 September of 2002 and of each succeeding year, de-
 17 termine and promulgate a monthly premium rate for
 18 the succeeding year in accordance with the provi-
 19 sions of this subsection.

20 “(2) ACTUARIAL DETERMINATIONS.—

21 “(A) DETERMINATION OF ANNUAL BEN-
 22 EFIT COSTS.—The Secretary shall estimate an-
 23 nually for the succeeding year the amount equal
 24 to the total of the benefits that will be payable
 25 from the Insurance Account for prescription

1 drugs dispensed in such calendar year with re-
2 spect to enrollees in the program under this
3 part. In calculating such amount, the Secretary
4 shall include an appropriate amount for a con-
5 tingency margin.

6 “(B) DETERMINATION OF MONTHLY PRE-
7 MIUM RATES.—

8 “(i) IN GENERAL.—The Secretary
9 shall determine the monthly premium rate
10 with respect to such enrollees for such suc-
11 ceeding year, which shall be one-twelfth of
12 the share specified in clause (ii) of the
13 amount determined under subparagraph
14 (A), divided by the total number of such
15 enrollees, and rounded (if such rate is not
16 a multiple of 10 cents) to the nearest mul-
17 tiple of 10 cents.

18 “(ii) ENROLLEE AND EMPLOYER PER-
19 CENTAGE SHARES.—The share specified in
20 this clause, for purposes of clause (i), shall
21 be—

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

1 “(II) two-thirds, in the case of
2 premiums paid for such an individual
3 by a former employer (as defined in
4 section 1859H(f)(2)).

5 “(3) PUBLICATION OF ASSUMPTIONS.—The
6 Secretary shall publish, together with the promulga-
7 tion of the monthly premium rates for the suc-
8 ceeding year, a statement setting forth the actuarial
9 assumptions and bases employed in arriving at the
10 amounts and rates determined under paragraphs (1)
11 and (2).

12 “(b) PAYMENT OF PREMIUMS.—

13 “(1) PAYMENTS BY DEDUCTION FROM SOCIAL
14 SECURITY, RAILROAD RETIREMENT BENEFITS, OR
15 BENEFITS ADMINISTERED BY OPM.—

16 “(A) DEDUCTION FROM BENEFITS.—In
17 the case of an individual who is entitled to or
18 receiving benefits as described in subsection (a),
19 (b), or (d) of section 1840, premiums payable
20 under this part shall be collected by deduction
21 from such benefits at the same time and in the
22 same manner as premiums payable under part
23 B are collected pursuant to section 1840.

24 “(B) TRANSFERS TO INSURANCE AC-
25 COUNT.—The Secretary of the Treasury shall,

1 from time to time, but not less often than quar-
2 terly, transfer premiums collected pursuant to
3 subparagraph (A) to the Insurance Account
4 from the appropriate funds and accounts de-
5 scribed in subsections (a)(2), (b)(2), and (d)(2)
6 of section 1840, on the basis of the certifi-
7 cations described in such subsections. The
8 amounts of such transfers shall be appro-
9 priately adjusted to the extent that prior trans-
10 fers were too great or too small.

11 “(2) DIRECT PAYMENTS TO SECRETARY.—

12 “(A) ADDITIONAL PAYMENT BY EN-
13 ROLLEE.—An individual to whom paragraph
14 (1) applies (other than an individual receiving
15 benefits as described in section 1840(d)) and
16 who estimates that the amount that will be
17 available for deduction under such paragraph
18 for any premium payment period will be less
19 than the amount of the monthly premiums for
20 such period may (under regulations) pay to the
21 Secretary the estimated balance, or such great-
22 er portion of the monthly premium as the indi-
23 vidual chooses.

24 “(B) PAYMENTS BY OTHER ENROLLEES.—

25 An individual enrolled in the insurance program

1 under this part with respect to whom none of
2 the preceding provisions of this subsection ap-
3 plies (or to whom section 1840(c) applies) shall
4 pay premiums to the Secretary at such times
5 and in such manner as the Secretary shall by
6 regulations prescribe.

7 “(C) DEPOSIT OF PREMIUMS.—Amounts
8 paid to the Secretary under this paragraph
9 shall be deposited in the Treasury to the credit
10 of the Prescription Drug Insurance Account in
11 the Supplementary Medical Insurance Trust
12 Fund.

13 “(d) CERTAIN LOW-INCOME INDIVIDUALS.—For
14 rules concerning premiums for certain low-income individ-
15 uals, see section 1859E.

16 **“SEC. 1859F. PRESCRIPTION DRUG INSURANCE ACCOUNT.**

17 “(a) IN GENERAL.—There is created within the Fed-
18 eral Supplemental Medical Insurance Trust Fund estab-
19 lished by section 1841 an account to be known as the ‘Pre-
20 scription Drug Insurance Account’ (hereafter in this sec-
21 tion referred to as the ‘Account’). The Account shall con-
22 sist of such gifts and bequests as may be made as provided
23 in section 201(i)(1), and such amounts as may be depos-
24 ited in, or appropriated to, such fund as provided in this
25 part. Funds provided under this part to the Account shall

1 be kept separate from all other funds within the Federal
2 Supplemental Medical Insurance Trust Fund.

3 “(b) PAYMENTS FROM ACCOUNT.—The Managing
4 Trustee shall pay from time to time from the Account such
5 amounts as the Secretary of Health and Human Services
6 certifies are necessary to make the payments provided for
7 by this part, and the payments with respect to administra-
8 tive expenses in accordance with section 201(g).

9 **“SEC. 1859G. ADMINISTRATION OF BENEFITS.**

10 “(a) IN GENERAL.—The Secretary shall provide for
11 administration of the benefits under this part through a
12 contract with a benefit manager designated in accordance
13 with subsection (c), for enrolled individuals residing in
14 each service area designated pursuant to subsection (b)
15 (other than such individuals enrolled in a
16 Medicare+Choice program under part C), in accordance
17 with the provisions of this section.

18 “(b) DESIGNATION OF SERVICE AREAS.—

19 “(1) IN GENERAL.—The Secretary shall divide
20 the total geographic area served by the programs
21 under this title into at least fifteen service areas for
22 purposes of administration of benefits under this
23 part. Such division shall not be subject to adminis-
24 trative or judicial review.

1 “(2) CONSIDERATIONS.—In determining or ad-
2 justing the number and boundaries of service areas
3 under this subsection, the Secretary shall seek to en-
4 sure that—

5 “(A) there is a reasonable expectation of a
6 meaningful level of competition among entities
7 eligible to contract to provide the benefit man-
8 agement services under this section for each
9 area; and

10 “(B) the designation of areas is consistent
11 with the goal of securing contracts under this
12 section with respect to the maximum feasible
13 number of areas so designated.

14 “(c) DESIGNATION OF BENEFIT MANAGER.—

15 “(1) AWARD AND DURATION OF CONTRACT.—
16 The following shall apply to the award of a contract
17 under this subsection with respect to a service area:

18 “(A) COMPETITIVE AWARD.—Each con-
19 tract shall be awarded competitively in accord-
20 ance with section 5 of title 41, United States
21 Code, for a period (subject to subparagraph
22 (B)) of not less than three nor more than five
23 years.

24 “(B) NONCOMPETITIVE EXTENSION.—The
25 second and each succeeding contract for a serv-

1 ice area may be extended noncompetitively, at
2 the discretion of the Secretary, for a total con-
3 tract period not to exceed five years.

4 “(2) ELIGIBLE ENTITIES.—An entity eligi-
5 ble for consideration as a benefit manager for
6 a service area shall meet at least the following
7 criteria:

8 “(A) TYPE.—The entity shall be any entity
9 that the Secretary determines is capable of ad-
10 ministering a prescription drug benefit pro-
11 gram.

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

16 “(C) INTEGRITY; FISCAL SOUNDNESS.—
17 The entity and its officers, directors, agents,
18 and managing employees shall have a satisfac-
19 tory record of professional competence and pro-
20 fessional and financial integrity, and the entity
21 shall have financial resources the Secretary de-
22 termines to be adequate to perform services
23 under the contract without risk of insolvency.

1 “(3) PROPOSAL REQUIREMENTS.—An entity’s
2 proposal for award or renewal of a contract under
3 this section shall—

4 “(A) include a cost proposal setting forth
5 the entity’s proposed charges for administration
6 of the prescription drug benefit;

7 “(B) include a proposal for the prices of
8 drugs and annual increases in such prices, in-
9 cluding differentials between formulary and
10 non-formulary prices, if applicable (and at the
11 entity’s election, include a proposal described in
12 subsection (d)(8));

13 “(C) specify details of proposed cost and
14 utilization management, error reduction, and
15 quality assurance measures;

16 “(D) be accompanied by such information
17 as the Secretary may require on the entity’s
18 past performance;

19 “(E) disclose ownership and shared finan-
20 cial interests with other entities involved in the
21 delivery of the benefit as proposed;

22 “(F) include a proposal for working with
23 the Secretary to deter medical errors related to
24 prescription drugs; and

1 “(G) include such other material and infor-
2 mation as the Secretary may require.

3 “(4) CRITERIA FOR COMPETITIVE SELEC-
4 TION.—In awarding a contract competitively, the
5 Secretary shall consider the comparative merits of
6 each of the applications by eligible entities, as deter-
7 mined on the basis of the entities’ past performance
8 and other relevant factors, with respect to the fol-
9 lowing:

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

17 “(B) prior experience in administering a
18 prescription drug benefit program;

19 “(C) effectiveness in containing costs
20 through pricing incentives and utilization man-
21 agement;

22 “(D) the quality and efficiency of benefit
23 management services with respect to such mat-
24 ters as claims processing and benefits coordina-
25 tion; record-keeping and reporting; and drug

1 utilization review, patient information, and
2 other activities supporting quality of care; and

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

6 “(5) EXCEPTIONS TO CONFLICT OF INTEREST
7 RULES.—In awarding contracts under this sub-
8 section, the Secretary may waive conflict of interest
9 rules generally applicable to Federal acquisitions
10 (subject to such safeguards as the Secretary may
11 find necessary to impose) in circumstances where the
12 Secretary finds that such waiver—

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

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

20 “(6) MAXIMIZING COMPETITION.—In awarding
21 contracts under this section, the Secretary shall give
22 consideration to the need to maintain sufficient
23 numbers of entities eligible and willing to administer
24 benefits under this part to ensure vigorous competi-
25 tion for such contracts.

1 “(d) FUNCTIONS OF BENEFIT MANAGER.—The ben-
2 efit manager for a service area shall (or in the case of
3 the function described in paragraph (8), may) perform
4 some or all of the following functions, as specified by the
5 Secretary:

6 “(1) PARTICIPATION AGREEMENTS, PRICES,
7 AND FEES.—

8 “(A) SCHEDULE OF COVERED DRUG
9 PRICES.—Establish, through negotiations with
10 drug manufacturers and wholesalers and phar-
11 macies, a schedule of prices for covered pre-
12 scription drugs. Such negotiated prices shall not
13 be subject to administrative or judicial review.

14 “(B) AGREEMENTS WITH PHARMACIES.—
15 Enter into participation agreements under sub-
16 section (e) with qualifying pharmacies, on terms
17 that—

18 “(i) secure the participation of suffi-
19 cient numbers of pharmacies to ensure
20 convenient access (including adequate
21 emergency access); and

22 “(ii) permit the participation of any
23 pharmacy in the service area that meets
24 the participation requirements described in
25 subsection (e).

1 “(C) LISTS OF PRICES AND PARTICIPATING
2 PHARMACIES.—Ensure that the negotiated
3 prices established under subparagraph (A) and
4 the list of pharmacies with agreements under
5 subsection (e) are regularly updated and readily
6 available in the service area to health care pro-
7 fessionals authorized to prescribe drugs, partici-
8 pating pharmacies, and enrolled individuals.

9 “(2) TRACKING OF COVERED ENROLLED INDI-
10 VIDUALS.—Maintain accurate, updated records of all
11 enrolled individuals residing in the service area
12 (other than individuals enrolled in a plan under part
13 C).

14 “(3) PAYMENT AND COORDINATION OF BENE-
15 FITS.—

16 “(A) IN GENERAL.—Administer claims for
17 payment of benefits under this part; determine
18 amounts of benefit payments to be made; and
19 receive, disburse, and account for funds used in
20 making such payments, including through the
21 activities specified in the provisions of this
22 paragraph.

23 “(B) COORDINATION AND PAYMENT OF
24 BENEFITS.—Coordinate with the Secretary,
25 other benefit managers, pharmacies and other

1 relevant entities as necessary to ensure appro-
2 priate coordination of benefits with respect to
3 enrolled individuals, including coordination of
4 access to and payment for covered prescription
5 drugs according to an individual's in-service
6 area plan provisions, when such individual is
7 traveling outside the home service area, and
8 under such other circumstances as the Sec-
9 retary may specify.

10 “(C) EXPLANATION OF BENEFITS.—Fur-
11 nish to enrolled individuals an explanation of
12 benefits in accordance with section 1806(a),
13 and a notice of the balance of benefits remain-
14 ing for the current year, whenever prescription
15 drug benefits are provided under this part (ex-
16 cept that such notice need not be provided more
17 often than monthly).

18 “(4) COST AND UTILIZATION MANAGEMENT;
19 QUALITY ASSURANCE.—Have in place effective cost
20 and utilization management, quality assurance meas-
21 ures, and systems to reduce medical errors, includ-
22 ing at least the following, together with such addi-
23 tional measures as the Secretary may specify:

24 “(A) DRUG UTILIZATION REVIEW.—A drug
25 utilization review program conforming to the

1 standards provided in section 1927(g)(2) (with
2 such modifications as the Secretary finds ap-
3 propriate for operation of such program by an
4 entity other than a State).

5 “(B) FRAUD AND ABUSE CONTROL.—Ac-
6 tivities to control fraud, abuse, and waste.

7 “(5) EDUCATION AND INFORMATION ACTIVI-
8 TIES.—Have in place mechanisms for disseminating
9 educational and informational materials to enrolled
10 individuals and health care providers designed to en-
11 courage effective and cost-effective use of prescrip-
12 tion drug benefits and to ensure that enrolled indi-
13 viduals understand their rights and obligations
14 under the program.

15 “(6) BENEFICIARY PROTECTIONS.—

16 “(A) CONFIDENTIALITY OF HEALTH IN-
17 FORMATION.—Have in effect systems to safe-
18 guard the confidentiality of health care infor-
19 mation on enrolled individuals, which comply
20 with section 1106 and with section 552a of title
21 5, United States Code, and meet such addi-
22 tional standards as the Secretary may pre-
23 scribe.

24 “(B) GRIEVANCE AND APPEAL PROCE-
25 DURES.—Have in place such procedures as the

1 Secretary may specify for hearing and resolving
2 grievances and appeals brought by enrolled in-
3 dividuals against the benefit manager or a
4 pharmacy concerning benefits under this part,
5 which shall, to the extent the Secretary finds
6 necessary and appropriate, include procedures
7 equivalent to those specified in subsections (f)
8 and (g) of section 1852.

9 “(7) RECORDS, REPORTS, AND AUDITS OF BEN-
10 EFIT MANAGERS.—

11 “(A) RECORDS AND AUDITS.—Maintain
12 adequate records, and afford the Secretary ac-
13 cess to such records (including for audit pur-
14 poses).

15 “(B) REPORTS.—Make such reports and
16 submissions of financial and utilization data as
17 the Secretary may require taking into account
18 standard commercial practices.

19 “(8) PROPOSAL FOR ALTERNATIVE COINSUR-
20 ANCE AMOUNT.—At the benefit manager’s election,
21 provide a proposal for increased Government cost
22 sharing for generic prescription drugs, prescription
23 drugs on the benefit manager’s formulary, or pre-
24 scription drugs obtained through mail order phar-
25 macies, which includes evidence that such increased

1 cost sharing would not result in an increase in ag-
2 gregate costs to the Account including an analysis of
3 differences in projected drug utilization patterns by
4 beneficiaries whose cost sharing would be reduced
5 under the proposal and those making the cost-shar-
6 ing payments that would otherwise apply.

7 “(9) OTHER REQUIREMENTS.—Meet such other
8 requirements as the Secretary may specify.

9 “(e) PHARMACY PARTICIPATION AGREEMENTS.—

10 “(1) IN GENERAL.—A pharmacy that meets the
11 requirements of this subsection shall be eligible to
12 enter an agreement with a benefit manager to fur-
13 nish covered prescription drugs to enrolled individ-
14 uals residing in the service area.

15 “(2) TERMS OF AGREEMENT.—An agreement
16 under this subsection shall include the following
17 terms and requirements:

18 “(A) LICENSING.—The pharmacy shall
19 meet (and throughout the contract period will
20 continue to meet) all applicable State and local
21 licensing requirements.

22 “(B) ACCESS AND QUALITY STANDARDS.—
23 The pharmacy shall comply with such standards
24 as the Secretary and the benefit manager shall
25 establish concerning the quality of, and enrolled

1 individuals' access to, pharmacy services under
2 this part.

3 “(C) ADHERENCE TO ESTABLISHED
4 PRICES.—The total charge for each drug dis-
5 pensed to an enrolled individual, without regard
6 to whether such individual is financially respon-
7 sible for any or all of such charge, shall not ex-
8 ceed the negotiated price for the drug, as estab-
9 lished under subsection (d)(1)(A) with respect
10 to the service area in which the enrolled indi-
11 vidual resides.

12 “(D) MANAGEMENT SYSTEMS AND PROCE-
13 DURES.—The pharmacy shall—

14 “(i) have in effect management sys-
15 tems (including electronic systems) and
16 procedures for carrying out functions
17 under the agreement; and

18 “(ii) maintain adequate records, af-
19 ford the benefit manager access to such
20 records for audit purposes, and make such
21 reports as the benefit manager may require
22 to meet its responsibilities under this sec-
23 tion.

24 “(E) COST AND UTILIZATION MANAGE-
25 MENT; QUALITY ASSURANCE.—The pharmacy

1 shall implement effective measures for quality
2 assurance, cost management, and reduction of
3 medical errors with respect to drugs dispensed
4 under the agreement, including maintenance of
5 utilization records and participation in the drug
6 utilization review program described in sub-
7 section (d)(4)(A).

8 “(F) CONFIDENTIALITY PROTECTIONS.—
9 The pharmacy shall have in effect systems to
10 ensure compliance with the confidentiality
11 standards applicable under subsection
12 (d)(6)(A).

13 “(G) OTHER REQUIREMENTS.—The phar-
14 macy shall meet such other requirements as the
15 Secretary may impose.

16 (f) LIMITATION OF LIABILITY.—The provisions of
17 section 1157(b) shall apply with respect to activities of
18 benefit managers and their officers, employees, and agents
19 under a contract under this section.

20 (g) INCENTIVES FOR COST AND UTILIZATION MAN-
21 AGEMENT AND QUALITY IMPROVEMENT.—The Secretary
22 is authorized to include in a contract awarded under sub-
23 section (c)(4) such incentives for cost and utilization man-
24 agement and quality improvement as the Secretary may
25 deem appropriate, including—

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

3 “(2) incentives under which benefit managers
4 share in any benefit savings achieved;

5 “(3) risk sharing arrangements related to ben-
6 efit payments; and

7 “(4) any other incentive that the Secretary
8 deems appropriate and likely to be effective in man-
9 aging costs or utilization.

10 “(h) FLEXIBILITY IN ASSIGNING WORKLOAD AMONG
11 BENEFIT MANAGERS.—During the period after the Sec-
12 retary has given notice of intent to terminate a contract
13 under subsection (c)(4), the Secretary may transfer re-
14 sponsibilities of the benefit manager under such contract
15 to another benefit manager.

16 “(i) NONINTERFERENCE.—Nothing in this section or
17 in this part shall be construed as authorizing the Secretary
18 to authorize a particular formulary or to institute a price
19 structure for benefits, or to otherwise interfere with the
20 competitive nature of providing a prescription drug benefit
21 through benefit managers.

1 **“SEC. 1859H. EMPLOYER INCENTIVE PROGRAM FOR EM-**
2 **PLOYMENT-BASED RETIREE DRUG COV-**
3 **ERAGE.**

4 “(a) PROGRAM AUTHORITY.—The Secretary is au-
5 thorized to develop and implement a program under this
6 section called the Employer Incentive Program that en-
7 courages employers and other sponsors of employment-
8 based health care coverage to provide adequate prescrip-
9 tion drug benefits to retired individuals by subsidizing, in
10 part, the sponsor’s cost of providing coverage under quali-
11 fying plans.

12 “(b) SPONSOR REQUIREMENTS.—In order to be eligi-
13 ble to receive an incentive payment under this section with
14 respect to coverage of an individual under a qualified re-
15 tiree prescription drug plan (as defined in subsection
16 (f)(3)), a sponsor shall meet the following requirements:

17 “(1) ASSURANCES.—The sponsor shall—

18 “(A) annually attest, and provide such as-
19 surances as the Secretary may require, that the
20 coverage offered by the sponsor is a qualified
21 retiree prescription drug plan, and will remain
22 such a plan for the duration of the sponsor’s
23 participation in the program under this section;
24 and

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

1 “(i) at least 120 days before termi-
2 nating its plan, and

3 “(ii) immediately upon determining
4 that the actuarial value of the prescription
5 drug benefit under the plan falls below the
6 actuarial value of the insurance benefit
7 under this part.

8 “(2) BENEFICIARY INFORMATION.—The spon-
9 sor shall report to the Secretary, for each calendar
10 quarter for which it seeks an incentive payment
11 under this section the names and social security
12 numbers of all retirees (and their spouses and de-
13 pendents) covered under such plan during such
14 quarter and the dates (if less than the full quarter)
15 during which each such individual was covered.

16 “(3) AUDITS.—The sponsor and the employ-
17 ment-based retiree health coverage plan seeking in-
18 centive payments under this section shall agree to
19 maintain, and to afford the Secretary access to, such
20 records as the Secretary may require for purposes of
21 audits and other oversight activities necessary to en-
22 sure the adequacy of prescription drug coverage, the
23 accuracy of incentive payments made, and such
24 other matters as may be appropriate.

1 “(4) OTHER REQUIREMENTS.—The sponsor
2 shall provide such other information, and comply
3 with such other requirements, as the Secretary may
4 find necessary to administer the program under this
5 section.

6 “(c) INCENTIVE PAYMENT.—

7 “(1) IN GENERAL.—A sponsor that meets the
8 requirements of subsection (b) with respect to a
9 quarter in a calendar year shall be entitled to have
10 payment made on a quarterly basis (to the sponsor
11 or, at the sponsor’s direction, to the appropriate em-
12 ployment-based health plan) of an incentive pay-
13 ment, in the amount determined as described in
14 paragraph (2), for each retired individual (or
15 spouse) who—

16 “(A) was covered under the sponsor’s
17 qualified retiree prescription drug plan during
18 such quarter; and

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

21 “(2) AMOUNT OF INCENTIVE.—The payment
22 under this section with respect to each individual de-
23 scribed in paragraph (1) for a month shall be equal
24 to two-thirds of the monthly premium amount pay-

1 able by an enrolled individual, as set for the cal-
2 endar year pursuant to section 1859D(a)(2).

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

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

16 “(e) PART D ENROLLMENT FOR CERTAIN INDIVID-
17 UALS COVERED BY EMPLOYMENT-BASED RETIREE
18 HEALTH COVERAGE PLANS.—

19 “(1) ELIGIBLE INDIVIDUALS.—An individual
20 shall be given the opportunity to enroll in the pro-
21 gram under this part during the period specified in
22 paragraph (2) if—

23 “(A) the individual declined enrollment in
24 the program under this part at the time the in-
25 dividual first satisfied section 1859C(a);

1 “(B) at that time, the individual was cov-
2 ered under a qualified retiree prescription drug
3 plan for which an incentive payment was paid
4 under this section; and

5 “(C)(i) the sponsor subsequently ceased to
6 offer such plan; or

7 “(ii) the value of prescription drug cov-
8 erage under such plan became less than the
9 value of the coverage under the program under
10 this part.

11 “(2) SPECIAL ENROLLMENT PERIOD.—An indi-
12 vidual described in paragraph (1) shall be eligible to
13 enroll in the program under this part during the six-
14 month period beginning on the first day of the
15 month in which—

16 “(A) the individual receives a notice that
17 coverage under such plan has terminated (in
18 the circumstance described in paragraph
19 (1)(C)(i)) or notice that a claim has been de-
20 nied because of such a termination; or

21 “(B) the individual received notice of the
22 change in benefits (in the circumstance de-
23 scribed in subparagraph (1)(C)(ii)).

24 “(f) DEFINITIONS.—As used in this section, terms
25 have the following meanings:

1 “(1) EMPLOYMENT-BASED RETIREE HEALTH
2 COVERAGE.—The term ‘employment-based retiree
3 health coverage’ means health insurance or other
4 coverage of health care costs for retired individuals
5 (or for such individuals and their spouses and de-
6 pendents) based on their status as former employees
7 or labor union members.

8 “(2) EMPLOYER.—The term ‘employer’ has the
9 meaning given such term by section 3(5) of the Em-
10 ployee Retirement Income Security Act of 1974 (ex-
11 cept that such term shall include only employers of
12 two or more employees).

13 “(3) QUALIFIED RETIREE PRESCRIPTION DRUG
14 PLAN.—The term ‘qualified retiree prescription drug
15 plan’ means health insurance coverage included in
16 employment-based retiree health coverage that—

17 “(A) provides coverage of the cost of pre-
18 scription drugs whose actuarial value (as de-
19 fined by the Secretary) to each retired bene-
20 ficiary equals or exceeds the actuarial value of
21 the benefits provided to an individual enrolled
22 in the program under this part; and

23 “(B) does not deny, limit, or condition the
24 coverage or provision of prescription drug bene-
25 fits for retired individuals based on age or any

1 health status-related factor described in section
2 2702(a)(1) of the Public Health Service Act.

3 “(4) SPONSOR.—The term ‘sponsor’ means
4 plan sponsor as defined in section 3(16) of the Em-
5 ployer Retirement Income Security Act of 1974.

6 (g) APPROPRIATIONS TO COVER INCENTIVES FOR
7 EMPLOYMENT-BASED RETIREE DRUG COVERAGE.—
8 There are authorized to be appropriated from time to
9 time, out of any moneys in the Treasury not otherwise
10 appropriated such sums as may be necessary for payment
11 of incentive payments under subsection (c).

12 **“SEC. 1859I. APPROPRIATIONS TO COVER GOVERNMENT**
13 **CONTRIBUTIONS.**

14 “There are authorized to be appropriated from time
15 to time, out of any moneys in the Treasury not otherwise
16 appropriated, to the Prescription Drug Insurance Ac-
17 count, a Government contribution equal to—

18 “(1) the aggregate premiums payable for a
19 month pursuant to section 1859D(a)(2) by individ-
20 uals enrolled in the program under this part, plus

21 “(2) one-half the aggregate premiums payable
22 for a month pursuant to such section for such indi-
23 viduals by former employers.

1 **“SEC. 1859J. DEFINITION.**

2 “As used in this part, the term ‘prescription drug’
3 means—

4 “(1) a drug that may be dispensed only upon
5 a prescription, and that is described in subpara-
6 graph (A)(i), (A)(ii), or (B) of section 1927(k)(2);
7 and

8 “(2) insulin certified under section 506 of the
9 Federal Food, Drug, and Cosmetic Act, and needles,
10 syringes, and disposable pumps for the administra-
11 tion of such insulin.”.

12 (b) **STUDY OF ANNUAL OPEN ENROLLMENT.**—Dur-
13 ing 2003 and 2004, the Secretary shall study the feasi-
14 bility and advisability of establishing an annual open en-
15 rollment period for the program under part D (as added
16 by subsection (a)). Such study shall reflect data reported
17 by benefit managers administering benefits under such
18 part and shall include:

19 (1) a review of the costs, effectiveness, and ad-
20 ministrative feasibility of an annual open enrollment
21 period for beneficiaries who previously declined en-
22 rollment or who previously disenrolled and desire to
23 re-enroll;

24 (2) an evaluation of a premium penalty for late
25 enrollment based on actuarially determined costs to
26 the program of late enrollment; and

1 (3) a projection of the costs to the program
2 under such part through 2010 of an annual open en-
3 rollment period.

4 The Secretary shall prepare a report setting forth the out-
5 come of the study, and may include in the report a rec-
6 ommendation as to whether an annual open enrollment pe-
7 riod should be implemented under such part.

8 (c) CONFORMING AMENDMENTS.—

9 (1) AMENDMENTS TO FEDERAL SUPPLE-
10 MENTARY HEALTH INSURANCE TRUST FUND.—Sec-
11 tion 1841 (42 U.S.C. 1395t) is amended—

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

13 (i) by striking “and such amounts”
14 and replacing it with “such amounts”; and

15 (ii) by adding the following before the
16 period: “and such amounts as may be de-
17 posited in, or appropriated to, the Pre-
18 scription Drug Insurance Account estab-
19 lished by section 1859F”;

20 (B) in subsection (g), by inserting after
21 “by this part,” the following: “the payments
22 provided for under part D (in which case the
23 payments shall come from the Prescription
24 Drug Insurance Account in the Supplementary
25 Medical Insurance Trust Fund),”;

1 (C) in subsection (h), by adding at the end
 2 of the first sentence: “and section 1859D(b)(4)
 3 (in which case the payments shall come from
 4 the Prescription Drug Insurance Account in the
 5 Supplementary Medical Insurance Trust
 6 Fund)”;

7 (D) in subsection (i), by inserting after
 8 “section 1840(b)(1)” the following: “, section
 9 1859D(b)(2) (in which case the payments shall
 10 come from the Prescription Drug Insurance Ac-
 11 count in the Supplementary Medical Insurance
 12 Trust Fund),”.

13 (2) PRESCRIPTION DRUG OPTION UNDER
 14 MEDICARE+CHOICE PLANS.—

15 (A) Section 1851 (42 U.S.C. 1395w-21) is
 16 amended—

17 (i) in subsection (a)(1)(A), by striking
 18 “parts A and B” and inserting “parts A,
 19 B, and D”; and

20 (ii) in subsection (i), by striking
 21 “parts A and B” and inserting “parts A,
 22 B, and D”.

23 (B) Section 1852(a)(1)(A) (42 U.S.C.
 24 1395w-22(a)(1)(A)) is amended by inserting

1 “(and under part D to individuals also enrolled
2 under that part)” after “parts A and B”.

3 (C) Section 1852(d)(1) (42 U.S.C.
4 1395(d)(1)) is amended—

5 (i) by striking “and” at the end of
6 subparagraph (D);

7 (ii) by striking the period at the end
8 of subparagraph (E) and inserting “; and”
9 and

10 (iii) by adding at the end the fol-
11 lowing new subparagraph:

12 “(F) the plan for part D benefits guaran-
13 tees coverage of any specifically named covered
14 prescription drug for an enrollee, when pre-
15 scribed by a physician in accordance with the
16 provisions of such part, regardless of whether
17 such drug would otherwise be covered under an
18 applicable formulary or discount arrangement.”.

19 (D) Section 1854(e) (42 U.S.C. 1395w-
20 4(e)) is amended by adding at the end the fol-
21 lowing new paragraph:

22 “(5) SPECIAL RULE FOR PROVISION OF PART D
23 BENEFITS.—In no event may a Medicare+Choice or-
24 ganization include as part of a plan for part D bene-

1 fits a requirement that an enrollee pay a deductible,
2 or a coinsurance percentage that exceeds 50 percent.

3 (E) Section 1857(d) (42 U.S.C. 1395w-
4 27(d)) is amended by adding at the end the fol-
5 lowing new paragraph:

6 “(6) AVAILABILITY OF NEGOTIATED PRICES.—
7 Each contract under this section shall provide that
8 enrollees who exhaust the plan’s prescription drug
9 benefits will continue to have access to prescription
10 drugs at negotiated prices equivalent to the total
11 combined cost of such drugs to the plan and the en-
12 rollee prior to such exhaustion of benefits.”.

13 (3) EXCLUSIONS FROM COVERAGE.—

14 (A) APPLICATION TO PART D.—Section
15 1862(a) (42 U.S.C. 1395y(a)) is amended in
16 the matter preceding paragraph (1) by striking
17 “part A or part B” and inserting “part A, B,
18 or D”.

19 (B) PRESCRIPTION DRUGS NOT EXCLUDED
20 FROM COVERAGE IF APPROPRIATELY PRE-
21 SCRIBED.—Section 1862(a)(1) (42 U.S.C.
22 1395y(a)(1)) is amended—

23 (i) by striking “and” at the end of
24 subparagraph (H);

1 (ii) by striking the semicolon at the
 2 end of subparagraph (I) and inserting “,
 3 and”; and

4 (iii) by adding after subparagraph (I)
 5 the following new subparagraph:

6 “(J) in the case of prescription drugs cov-
 7 ered under part D, which are not prescribed in
 8 accordance with such part;

9 **SEC. 202. MEDICAID BUY-IN OF MEDICARE PRESCRIPTION**
 10 **DRUG COVERAGE FOR CERTAIN LOW-INCOME**
 11 **INDIVIDUALS.**

12 (a) STATE OPTION TO BUY-IN DUALY ELIGIBLE
 13 INDIVIDUALS.—

14 (1) COVERAGE OF PREMIUMS AS MEDICAL AS-
 15 SISTANCE.—Section 1905(a) (42 U.S.C. 1396d(a))
 16 is amended in the fourth sentence by striking
 17 “under part B” the first place it appears and insert-
 18 ing “under parts B and D”.

19 (2) STATE COMMITMENT TO CONTINUE PAR-
 20 TICIPATION IN PART D AFTER BENEFIT LIMIT
 21 REACHED.—Section 1902(a) (42 U.S.C. 1396a(a))
 22 is amended—

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

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

3 (C) by adding after paragraph (65) the fol-
4 lowing new paragraph:

5 “(66) that, in the case of any individual
6 whose eligibility for medical assistance is not
7 limited to Medicare or Medicare drug cost shar-
8 ing and for whom the State elects to pay pre-
9 miums under part D of title XVIII pursuant to
10 section 1859E, the State will purchase all pre-
11 scription drugs for such individual in accord-
12 ance with the provisions of such part D, with-
13 out regard to whether the benefit limit for such
14 individual under section 1859B(b) has been
15 reached.”.

16 (b) MEDICARE COST SHARING REQUIRED FOR
17 QUALIFIED MEDICARE BENEFICIARIES.—Section
18 1905(p)(3) (42 U.S.C. 1396d(p)(3)) is amended—

19 (1) in subparagraph (A)—

20 (A) by striking “and” at the end of clause
21 (i);

22 (B) by inserting “and” at the end of clause
23 (ii); and

24 (C) by adding after clause (ii) the fol-
25 lowing:

1 “(iii) premiums under section
2 1859D,”;

3 (2) in subparagraph (D)—

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

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

6 “(ii) The difference between the
7 amount that is paid under section 1859B
8 and the amount that would be paid under
9 such section if any reference to ‘50 per-
10 cent’ therein were deemed a reference to
11 ‘100 percent’ (or, if the Secretary approves
12 a higher percentage under such section, if
13 any reference to such percentage were
14 deemed to be multiplied by two).

15 (c) MEDICARE DRUG COST SHARING REQUIRED FOR
16 MEDICARE-ELIGIBLE INDIVIDUALS WITH INCOMES BE-
17 TWEEN 100 AND 150 PERCENT OF POVERTY LINE.—

18 (1) DEFINITIONS OF ELIGIBLE BENEFICIARIES
19 AND COVERAGE.—Section 1905 (42 U.S.C. 1396d)
20 is amended by adding at the end the following new
21 subsection:

22 “(v)(1) The term ‘qualified medicare drug bene-
23 ficiary’ means an individual—

24 “(A) who is entitled to hospital insurance bene-
25 fits under part A of title XVIII (including an indi-

1 individual entitled to such benefits pursuant to an en-
2 rollment under section 1818, but not including an
3 individual entitled to such benefits only pursuant to
4 an enrollment under section 1818A),

5 “(B) whose income (as determined under sec-
6 tion 1612 for purposes of the supplemental security
7 income program, except as provided in subsection
8 (p)(2)(D)) is above 100 percent but below 150 per-
9 cent of the official poverty line (as defined by the
10 Office of Management and Budget, and revised an-
11 nually in accordance with section 673(2) of the Om-
12 nibus Budget Reconciliation Act of 1981) applicable
13 to a family of the size involved; and

14 “(C) whose resources (as determined under sec-
15 tion 1613 for purposes of the supplemental security
16 income program) do not exceed twice the maximum
17 amount of resources that an individual may have
18 and obtain benefits under that program.

19 “(2) The term ‘medicare drug cost-sharing’ means
20 the following costs incurred with respect to a qualified
21 medicare drug beneficiary, without regard to whether the
22 costs incurred were for items and services for which med-
23 ical assistance is otherwise available under the plan:

24 “(A) In the case of a qualified medicare drug
25 beneficiary whose income (as determined under

1 paragraph (1)) is less than 135 percent of the offi-
2 cial poverty line—

3 “(i) premiums under section 1859D; and

4 “(ii) the difference between the amount
5 that is paid under section 1859B and the
6 amount that would be paid under such section
7 if any reference to ‘50 percent’ therein were
8 deemed a reference to ‘100 percent’ (or, if the
9 Secretary approves a higher percentage under
10 such section, if any reference to such percent-
11 age were deemed to be multiplied by two).

12 “(B) In the case of a qualified medicare drug
13 beneficiary whose income (as determined under
14 paragraph (1)) is at least 135 percent but less than
15 150 percent of the official poverty line, a percentage
16 of premiums under section 1859D, determined on a
17 linear sliding scale ranging from 100 percent for in-
18 dividuals with incomes at 135 percent of such line
19 to 0 percent for individuals with incomes at 150 per-
20 cent of such line.

21 “(3) In the case of any State which is providing med-
22 ical assistance to its residents under a waiver granted
23 under section 1115, the Secretary shall require the State
24 to meet the requirement of section 1902(a)(10)(E) in the
25 same manner as the State would be required to meet such

1 requirement if the State had in effect a plan approved
2 under this title.”.

3 (2) STATE PLAN REQUIREMENT.—Section
4 1902(a)(10)(E) (42 U.S.C. 1396(a)(10)(E)) is
5 amended—

6 (A) by striking “and” at the end of clause
7 (iii);

8 (B) by adding at the end the following new
9 clause:

10 “(v) for making medical assistance
11 available for medicare drug cost sharing
12 (as defined in section 1905(v)(2)) for
13 qualified medicare drug beneficiaries de-
14 scribed in section 1905(v)(1); and”.

15 (3) 100 PERCENT FEDERAL MATCHING OF
16 STATE MEDICAL ASSISTANCE COSTS FOR MEDICARE
17 DRUG COST SHARING.—Section 1903(a) (42 U.S.C.
18 1396b(a)) is amended—

19 (A) by redesignating paragraph (7) as
20 paragraph (8); and

21 (B) by adding after paragraph (6) the fol-
22 lowing new paragraph:

23 “(7) an amount equal to 100 percent of
24 amounts as expended as medicare drug cost sharing
25 for qualified medicare drug beneficiaries (as defined

1 in section 1905(v)) (except that this paragraph shall
 2 not apply to amounts expended with respect to any
 3 individual whose eligibility for medical assistance is
 4 not limited to medicare or medicare drug cost shar-
 5 ing); and”.

6 (d) MEDICAID DRUG PRICE REBATES UNAVAILABLE
 7 WITH RESPECT TO DRUGS PURCHASED THROUGH MEDI-
 8 CARE BUY-IN.—Section 1927 (42 U.S.C. 1396r–8) is
 9 amended by adding at the end the following new sub-
 10 section:

11 “(l) DRUGS PURCHASED THROUGH MEDICARE
 12 BUY-IN.—The provisions of this section shall not
 13 apply to prescription drugs purchased under part D
 14 of title XVIII pursuant to an agreement with the
 15 Secretary under section 1859E (including any drugs
 16 so purchased after the limit under section 1859B(b)
 17 has been exceeded).”.

18 (e) AMENDMENTS TO MEDICARE PART D.—Part D
 19 of title XVIII, as added by section 201, is amended by
 20 adding after section 1859D the following new section:

21 **“SEC. 1859E. SPECIAL ELIGIBILITY, ENROLLMENT, AND CO-
 22 PAYMENT RULES FOR LOW-INCOME INDIVID-
 23 UALS.**

24 “(a) STATE AGREEMENTS FOR COVERAGE.—

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

8 “(2) ELIGIBILITY GROUPS.—The individuals
9 described in this paragraph, for purposes of para-
10 graph (1), are individuals who satisfy section
11 1859C(a) and who are—

12 “(A)(i) eligible individuals within the
13 meaning of section 1843, and

14 “(ii) in a coverage group or groups per-
15 mitted under section 1843 (as selected by the
16 State and specified in the agreement); or

17 “(B) qualified medicare drug beneficiaries
18 (as defined in section 1905(v)(1)).

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

23 “(A) INDIVIDUALS ELIGIBLE (AT STATE
24 OPTION) FOR PART B BUY-IN.—In the case of
25 an individual described in subsection (a)(2)(A),

1 the coverage period shall be the same period
 2 that applies (or would apply) pursuant to sec-
 3 tion 1843(d).

4 “(B) QUALIFIED MEDICARE DRUG BENE-
 5 FICIARIES.—In the case of an individual de-
 6 scribed in subsection (a)(2)(B)—

7 “(i) the coverage period shall begin on
 8 the latest of—

9 “(I) January 1, 2003,

10 “(II) the first day of the third
 11 month following the month in which
 12 the State agreement is entered into;
 13 or

14 “(III) the first day of the first
 15 month following the month in which
 16 the individual satisfies section
 17 1859C(a); and

18 “(ii) the coverage period shall end on
 19 the last day of the month in which the in-
 20 dividual is determined by the State to have
 21 become ineligible for medicare drug cost-
 22 sharing.

23 “(b) SPECIAL PART D ENROLLMENT OPPORTUNITY
 24 FOR INDIVIDUALS LOSING MEDICAID ELIGIBILITY.—In
 25 the case of an individual who—

1 “(1) satisfies section 1859C(a), and

2 “(2) loses eligibility for benefits under the State
3 plan under title XIX after having been enrolled
4 under such plan or having been determined eligible
5 for such benefits,

6 the Secretary shall provide an opportunity for enrollment
7 under the program under this part during the period that
8 begins on the date that such individual loses such eligi-
9 bility and ends on the date specified by the Secretary.

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

13 PART B—IMPROVING PREVENTIVE BENEFITS AND
14 ELIMINATING COST SHARING

15 **SEC. 221. ELIMINATION OF DEDUCTIBLES AND COINSUR-**
16 **ANCE FOR PREVENTIVE BENEFITS.**

17 (a) IN GENERAL.—Section 1833 (42 U.S.C. 1395l)
18 is amended by adding after subsection (o) the following
19 new subsection:

20 “(p) DEDUCTIBLES AND COINSURANCE WAIVED FOR
21 PREVENTIVE BENEFITS.—Deductibles and coinsurance
22 under subsections (a) and (b) shall not be required of indi-
23 viduals covered under the insurance program under this
24 part for any of the following preventive health care items
25 and services:

1 “(1) blood-testing strips, lancets, and blood glu-
2 cose monitors for individuals with diabetes described
3 in section 1861(n);

4 “(2) diabetes outpatient self-management train-
5 ing services described in section 1861(s)(2)(S);

6 “(3) pneumococcal, influenza, and hepatitis B
7 vaccines and administration described in section
8 1861(s)(10) ;

9 “(4) screening mammography as described in
10 section 1861(s)(13);

11 “(5) screening pap smear and screening pelvic
12 examinations as described in section 1861(s)(14);

13 “(6) bone mass measurement as described in
14 section 1861(s)(15);

15 “(7) prostate cancer screening tests as defined
16 in section 1861(oo); and

17 “(8) colorectal cancer screening as defined in
18 section 1861(pp)(1).”.

19 (b) WAIVER OF COINSURANCE.—Section
20 1833(a)(1)(B) (42 U.S.C. 1395l(a)(1)(B)) is amended by
21 striking “items and services described in section
22 1861(s)(10)(A)” and inserting “preventive care items and
23 services described in subsection (p)”.

24 (c) WAIVER OF DEDUCTIBLE.—Section 1833(b) (42
25 U.S.C. 1395l(b)) is amended in clause (1) to read as fol-

1 lows: “(1) such deductible shall not apply with respect to
2 preventive health care items and services specified in sub-
3 section (p)”.

4 (d) ADDING “LANCET” TO DEFINITION OF DME.—
5 Section 1861(n) (42 U.S.C. 1395x(n)) is amended by
6 striking “blood-testing strips and blood glucose monitors”
7 and inserting “blood-testing strips, lancets, and blood glu-
8 cose monitors ”.

9 (e) CONFORMING AMENDMENTS.—

10 (1) Section 1833(a)(1) (42 U.S.C. 1395l(a)(1))
11 is amended—

12 (A) in subparagraph (B)—

13 (i) by striking “section
14 1861(s)(10)(A)” and inserting “section
15 1833(p)”;

16 (ii) by striking “reasonable charges”
17 and inserting “of the fee schedule or other
18 basis of payment under this title”; and

19 (B) in subparagraphs (1)(D)(i) and
20 (2)(D)(i), by inserting “described in subsection
21 (p) or” after “in the case of such tests”.

22 (2) Section 1834(a)(1)(A) (42 U.S.C.
23 1395m(a)(1)(A)) is amended by inserting “(or 100
24 percent, in the case of such an item described in sec-
25 tion 1833(p))” after “80 percent”.

1 (3) Section 1834(c)(1)(C) (42 U.S.C.
2 1395m(c)(1)(C)) is amended by striking “80 per-
3 cent” and inserting “100 percent”.

4 (4) Section 1834(d) (42 U.S.C. 1395m(d)) is
5 amended—

6 (A) in each of paragraphs (2)(C) and
7 (3)(C)—

8 (i) by striking clause (ii); and

9 (ii) by striking all that precedes “sub-
10 sections (i)(2)(A) and (t)” and inserting
11 the following:

12 “(C) FACILITY PAYMENT LIMIT.—Notwith-
13 standing”, and adjusting margins accordingly;
14 and

15 (B) in paragraph (2)(C), by redesignating
16 subclauses (I) and (II) as clauses (i) and (ii).

17 (f) EFFECTIVE DATE.—The amendments made by
18 this section shall be effective on and after January 1,
19 2003.

20 **SEC. 222. INFORMATION CAMPAIGN ON PREVENTION.**

21 (a) REQUIRED ACTIVITIES.—The Secretary of
22 Health and Human Services shall carry out, during 2002
23 and 2003, a nationwide education campaign to promote
24 preventive health awareness among older Americans and

1 people with disabilities, which shall include the following
2 activities:

3 (1) An information campaign, in collaboration
4 with the Social Security Administration, State health
5 insurance assistance programs, area agencies on
6 aging, and the private sector, designed to educate all
7 Americans over age 50 and individuals with disabil-
8 ities about the importance of preventive health care.

9 (2) Activities designed to encourage Medicare
10 beneficiaries to use Medicare preventive benefits, in-
11 cluding distribution of comprehensive information on
12 Medicare preventive benefits to all Medicare bene-
13 ficiaries.

14 (3) Development and testing of a health status
15 assessment tool with follow-up interventions, to as-
16 sist Medicare beneficiaries and their providers in
17 identifying and mitigating health risks.

18 (4) A nationwide education and awareness cam-
19 paign designed to educate older Americans on ad-
20 justments to behavior and the home environment
21 that can prevent falls.

22 (b) AUTHORIZATION OF APPROPRIATIONS.—Such
23 sums as may be necessary to carry out this section are
24 authorized to be appropriated for fiscal years 2002 and
25 2003.

1 **SEC. 223. SMOKING CESSATION DEMONSTRATION.**

2 (a) IN GENERAL.—The Secretary shall, either di-
3 rectly or through grants, contracts, or cooperative agree-
4 ments, carry out a demonstration project testing a variety
5 of smoking cessation services for Medicare beneficiaries,
6 for the purpose of identifying the most successful and
7 cost-effective approaches.

8 (b) DESIGN OF DEMONSTRATION.—

9 (1) IN GENERAL.—The Secretary shall deter-
10 mine the design, implementation, and evaluation of
11 the demonstration under this section, subject to the
12 provisions of this section.

13 (2) SERVICES INCLUDED.—Services under the
14 demonstration may include an initial patient assess-
15 ment, counseling services, and any pharmacotherapy
16 for smoking cessation approved by the Food and
17 Drug Administration, and such other services as the
18 Secretary may authorize. Services may be furnished
19 by a person or entity that provides other services
20 for which payment may be made under title XVIII
21 of the Social Security Act, as well as by health edu-
22 cators and other professionals in categories des-
23 ignated by the Secretary who meet applicable certifi-
24 cation and licensing requirements of State and local
25 law.

1 (3) SCOPE AND DURATION.—Demonstration
2 projects under this section shall be conducted at a
3 minimum of four sites and shall not exceed five
4 years in duration.

5 (c) Notwithstanding any provision of title XVIII of
6 the Social Security Act (42 U.S.C. 1395 et seq.) or any
7 other provision of law, in the case of smoking cessation
8 items and services furnished to a Medicare beneficiary
9 under a demonstration conducted by the Secretary under
10 this section by an individual or entity authorized by the
11 Secretary to participate in such demonstration—

12 (1) Such items and services shall be deemed to
13 be health care items and services covered under the
14 insurance programs under such title XVIII for pur-
15 poses of payment from the Federal Health Insur-
16 ance and Federal Supplementary Medical Insurance
17 Trust Funds;

18 (2) Persons and entities furnishing smoking
19 cessation items and services under a demonstration
20 under this section shall be entitled to be paid from
21 such Trust Funds an amount equal to the lesser of
22 the actual cost of such items and services or the
23 payment amount prescribed for such items or serv-
24 ices under a fee schedule established by the Sec-
25 retary; and

1 (3) The Secretary shall waive all coinsurance
2 and deductibles under such title XVIII for smoking
3 cessation items and services furnished under such
4 demonstration.

5 (d) WAIVER AUTHORITY.—The Secretary is author-
6 ized to waive the requirements of title XVIII of the Social
7 Security Act (42 U.S.C. 1395 et seq.) to the extent and
8 for the period the Secretary finds necessary to conduct
9 the demonstration under this section.

10 (e) FUNDING.—The Secretary shall provide for the
11 transfer from the Federal Health Insurance and Federal
12 Supplementary Insurance Trust Fund of such funds as
13 are necessary for the costs of carrying out and evaluating
14 the demonstration projects under this section.

15 (f) EVALUATION; REPORT TO CONGRESS.—Upon
16 conclusion of the demonstration, the Secretary shall cause
17 the demonstration to be evaluated and shall submit to
18 Congress a report including the following:

- 19 (1) A description of the demonstration.
- 20 (2) An assessment of—
- 21 (A) patient outcomes, including smoking
22 “quit” rates;
- 23 (B) the cost-effectiveness of the dem-
24 onstration; and

1 (C) the quality of the services furnished
 2 through the demonstration, including measures
 3 of beneficiary and provider satisfaction.

4 (3) A recommendation as to whether the dem-
 5 onstration should be continued or expanded under
 6 part B of such title XVIII, including, if the evalua-
 7 tion has found the demonstration successful, rec-
 8 ommendations as to the individuals who should be
 9 eligible to receive smoking cessation benefits, the
 10 persons and entities that should be authorized to
 11 provide the benefits, the type and scope of benefits,
 12 and appropriate payment methodologies.

13 (4) Any other information that the Secretary
 14 determines to be appropriate.

15 **PART C—RATIONALIZING COST SHARING AND MEDIGAP**

16 **SEC. 231. DEDUCTIBLES AND COINSURANCE FOR CLINICAL**
 17 **LABORATORY SERVICES.**

18 (a) **IN GENERAL.**—Section 1833, as amended by sec-
 19 tion 221, is further amended—

20 (1) in subsection (a)—

21 (A) in paragraph (1)(D)—

22 (i) in clause (i), by striking the open
 23 parenthesis an all that follows through “on
 24 an assignment-related basis)”; and

1 (ii) in clause (ii), by striking “100
2 percent” and inserting “80 percent (or 100
3 percent, in the case of such tests described
4 in subsection (p))”; and

5 (B) in paragraph (2)(D)—

6 (i) in clause (i), by striking the open
7 parenthesis and all that follows through
8 “section 1866” and inserting “such tests
9 described in subsection (p)”; and

10 (ii) in clause (ii), by striking “100
11 percent” and inserting “80 percent (or 100
12 percent, in the case of such tests described
13 in subsection (p))”; and

14 (2) in subsection (b)—

15 (A) by striking subparagraph (3); and

16 (B) by redesignating paragraphs (4)
17 through (6) as paragraphs (3) through (5) re-
18 spectively.

19 (b) EFFECTIVE DATE.—The amendments made by
20 subsection (a) shall apply to tests furnished on or after
21 January 1, 2003.

22 **SEC. 232. INDEXING DEDUCTIBLE TO INFLATION.**

23 Section 1833(b) (42 U.S.C. 1395l(b)) is amended by
24 inserting after “1991 and subsequent years” the following:
25 “, adjusted annually, effective January 1 of each year be-

1 ginning in 2003, by a percentage increase or decrease
 2 equal to the percentage increase or decrease in the con-
 3 sumer price index for all urban consumers (U.S. city aver-
 4 age) for the 12-month period ending with June of the pre-
 5 vious year, rounded to the nearest dollar”.

6 **SEC. 233. UPDATING AND EXPANDING MEDIGAP PLAN OP-**
 7 **TIONS.**

8 (a) REVIEW AND UPDATE OF BENEFIT PACKAGES
 9 FOR MEDIGAP POLICIES.—

10 (1) ESTABLISHMENT OF NEW MEDIGAP
 11 PLAN.—

12 (A) IN GENERAL.—Section 1882(p)(1) (42
 13 U.S.C. 1395ss(p)(1)) is amended by redesignig-
 14 nating subparagraph (E) as subparagraph (F)
 15 and inserting after subparagraph (D) the fol-
 16 lowing new subparagraph:

17 “(E) (i) Within 9 months after enactment
 18 of this subparagraph, the Association may re-
 19 vise the 1991 NAIC Model Regulation to in-
 20 clude a new plan ‘K’ that—

21 “(I) complies with paragraphs (2) and
 22 (3);

23 “(II) except as provided in subclause
 24 (III), requires the beneficiary of the policy
 25 to pay—

1 “(aa) nominal copayments; and
2 “(bb) all or a portion (not to be
3 less than 50 percent) of the part B
4 deductible under section 1833; and
5 “(III) in the case of beneficiaries
6 under the policy who are receiving services
7 under any of the programs specified in
8 paragraphs (1) through (4) of section
9 1866M(a), covers 100 percent of any cost-
10 sharing charges imposed on beneficiaries
11 under such program.

12 If the Association so revises the 1991
13 NAIC Model Regulation, references to the
14 1991 NAIC Model Regulation in this sec-
15 tion shall be interpreted to refer to the
16 1991 NAIC Model Regulation as so re-
17 vised.

18 “(ii) If the Association does not make the
19 changes in the revised NAIC Model Regulation
20 within the 9-month period specified in clause (i)
21 the Secretary shall provide for the establish-
22 ment of a new plan ‘K’ in accordance with the
23 provisions of subparagraph (B), and any re-
24 quirements applicable to a State under subpara-
25 graph (B) shall apply with respect to the estab-

1 lishment of the new plan under this subpara-
2 graph.”.

3 (B) REQUIREMENT THAT ALL ISSUERS
4 OFFER PLAN “K”.—

5 (i) IN GENERAL.—Section
6 1882(p)(9)(A) (42 U.S.C.
7 1395ss(p)(9)(A)) is amended by inserting
8 before the period “and a medicare supple-
9 mental policy described in paragraph
10 (1)(E)”.

11 (ii) PROHIBITION ON STATE RESTRIC-
12 TION.—Section 1882(p)(5)(B) (42 U.S.C.
13 1395ss(p)(5)(B)) is amended by inserting
14 before the period “or a medicare supple-
15 mental policy described in paragraph
16 (1)(E)”.

17 (C) CONFORMING AMENDMENTS.—Section
18 1882(p) (42 U.S.C. 1395ss(p)) is amended in
19 paragraph (2)(C) by striking “shall not exceed
20 10” and inserting “shall not exceed 11”.

21 (2) PERIODIC REVIEW.—Section 1882(p)(1)(F)
22 (42 U.S.C. 1395ss(p)(1)(F)) as redesignated, is
23 amended—

1 (A) by striking all that precedes “the pre-
2 ceding provisions of this paragraph” and insert-
3 ing the following:

4 “(F) The Secretary, in consultation with
5 the Association, shall periodically review stand-
6 ard supplemental packages established pursuant
7 to paragraph (2). If, on the basis of such con-
8 sultation and review, the Secretary determines
9 that changes in the 1991 NAIC Model Regula-
10 tion or 1991 Federal Regulation (including
11 changes in the content or number of packages
12 established pursuant to paragraph (2), and in
13 the provision or scope of drug benefits available
14 under those packages), are needed to better re-
15 flect the needs of beneficiaries under this title
16 (including the need for affordable supplemental
17 insurance options),”; and

18 (B) by adding at the end the following new
19 sentence: “If the Secretary determines that it is
20 necessary to change the benefit packages estab-
21 lished under paragraph (2) to better reflect the
22 needs of beneficiaries as described in this sub-
23 paragraph, the Secretary shall, through a notice
24 in the Federal Register, request the Association

1 to recommend such changes to the benefit pack-
2 age as it considers appropriate.”.

3 (b) IMPROVED INFORMATION ON MEDIGAP.—Section
4 1882(e) (42 U.S.C. 1395ss(e)) is amended by adding at
5 the end the following new paragraph:

6 “(4) The Secretary shall provide to individuals
7 entitled to benefits under this title (and, to the ex-
8 tent feasible, individuals about to become so enti-
9 tled) information allowing easy comparison of the
10 supplemental insurance policies authorized under
11 subsection (p)(2), including the benefits, premiums,
12 and cost-sharing provisions of such policies.”.

13 **SEC. 234. REPORT TO CONGRESS ON OPTIONS FOR IM-**
14 **PROVING MEDICARE SUPPLEMENTAL COV-**
15 **ERAGE.**

16 (a) IN GENERAL.—The Secretary shall prepare and
17 transmit to the Congress, not later than January 1, 2002,
18 a detailed report that may include specific recommenda-
19 tions on policy options for improving Medicare supple-
20 mental coverage, with particular attention to means of
21 limiting out-of-pocket costs for health care items and serv-
22 ices covered under title XVIII of the Social Security Act
23 (42 U.S.C. 1395 et seq.) .

24 (b) CONTENTS OF REPORT.—The report required
25 under this section may—

1 (1) consider effects of beneficiaries' having mul-
2 tiple sources of health care coverage (including du-
3 plication of coverage and incentives for overutiliza-
4 tion of services);

5 (2) compare total cost sharing by Medicare
6 beneficiaries (under Medicare and Medicare supple-
7 mental policies) with cost sharing by beneficiaries of
8 private-sector health insurance;

9 (3) consider means of improving beneficiary in-
10 formation on the comparative cost and quality of
11 Medicare supplemental policies;

12 (4) consider options for structuring, and the
13 feasibility and advisability (including the potential
14 for reducing beneficiaries' out-of-pocket costs and
15 unnecessary utilization) of alternatives including—

16 (A) optional unsubsidized supplemental
17 coverage under Medicare requiring beneficiary
18 cost-sharing; and

19 (B) a Medicare supplemental benefit, re-
20 quiring beneficiary copayments, to be offered by
21 private entities as a supplement to coverage
22 under original Medicare as part of the competi-
23 tive defined benefit program.

1 **SEC. 235. INCREASING ACCESS TO MEDIGAP.**

2 (a) APPLYING MEDIGAP PROTECTIONS TO DISABLED
3 AND ESRD MEDICARE BENEFICIARIES.—

4 (1) OPEN ENROLLMENT PERIOD FOR DISABLED
5 AND ESRD BENEFICIARIES.—

6 (A) IN GENERAL.—Section 1882(s) (42
7 U.S.C. 1395ss(s)) is amended—

8 (i) in paragraph (2)(A), by striking
9 “the 6 month period” and all that follows
10 through the period and inserting “(i) the 6
11 month period beginning with the first
12 month as of the first day on which the in-
13 dividual is first enrolled for benefits under
14 part B of this subchapter; and (ii) if dif-
15 ferent from the period specified in clause
16 (i), the 6 month period beginning with the
17 first month as of the first day on which
18 the individual is 65 years of age or older
19 and is enrolled for benefits under such part
20 B.”;

21 (ii) in paragraph (2)(D), in the mat-
22 ter preceding clause (i)—

23 (I) by striking “the 6-month pe-
24 riod” and inserting “a 6-month pe-
25 riod”; and

1 (II) by striking “who is 65 years
2 of age or older as of the date of
3 issuance and”; and

4 (iii) in paragraph (3)(B)(vi), by strik-
5 ing “at age 65”.

6 (B) INITIAL OPEN ENROLLMENT PE-
7 RIOD.—Section 1882(s)(2) (42 U.S.C.
8 1395ss(s)), as amended by subparagraph (A), is
9 amended by adding at the end the following
10 new subparagraph:

11 “(E) In the case of an individual who, as
12 of the effective date of enactment of this sub-
13 paragraph, is enrolled for benefits under part B
14 on the basis of disability or end-stage renal dis-
15 ease and has not attained age 65, the 6 month
16 period specified in subparagraph (A)(i) shall be
17 deemed to be the 6 month period beginning on
18 such date.”.

19 (2) REQUIREMENT THAT MEDIGAP ISSUERS
20 OFFER POLICIES TO DISABLED AND ESRD BENE-
21 FICIARIES.—Section 1882(s) (42 U.S.C. 1395ss(s))
22 is amended—

23 (A) by redesignating paragraph (4) as
24 paragraph (5); and

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

3 “(4) The issuer of a Medicare supplemental poli-
4 cy that offers such policy to individuals who are 65
5 years of age or older may not decline to offer such
6 policy to individuals entitled to benefits under this
7 title pursuant to section 226(b) or 226A.”.

8 (3) RATING STANDARDS FOR POLICIES ISSUED
9 TO DISABLED AND ESRD BENEFICIARIES.—Section
10 1882(s) (42 U.S.C. 1395ss(s)), as amended by para-
11 graph (2), is amended—

12 (A) by redesignating paragraph (5) as
13 paragraph (6); and

14 (B) by adding after paragraph (4) the fol-
15 lowing new paragraph:

16 “(5)(A) The Secretary shall request the Na-
17 tional Association of Insurance Commissioners (in
18 this paragraph referred to as the ‘Association’) to
19 develop and publish model standards for rating
20 Medicare supplemental policies for individuals who
21 are under age 65. Such standards shall be designed
22 to ensure affordable access to such policies for such
23 individuals while avoiding, to the greatest extent
24 possible, disruptions in the market for Medicare sup-
25 plemental policies.”.

1 (4) EFFECTIVE DATE.—The amendments made
2 by paragraphs (1), (2), and (3) are effective 30 days
3 after enactment of this Act.

4 (b) SPECIAL MEDIGAP ENROLLMENT ANTIDISCRIMI-
5 NATION PROVISION FOR CERTAIN BENEFICIARIES.—

6 (1) DISENROLLMENT WINDOW IN ACCORDANCE
7 WITH BENEFICIARY’S CIRCUMSTANCE.—Section
8 1882(s)(3) is amended—

9 (A) in subparagraph (A), by striking “not
10 later than 63 days after the date of termination
11 of enrollment described in such subparagraph”
12 and inserting “during the period specified in
13 subparagraph (E)”; and

14 (B) by adding at the end the following new
15 subparagraph:

16 “(E) For purposes of subparagraph (A),
17 the time period specified in this subsection in
18 the case of an individual—

19 “(i) described in clause (i) of subpara-
20 graph (B), is the period beginning on the
21 date the individual receives a notice of ter-
22 mination or cessation of all supplemental
23 health benefits or, if no such notice is re-
24 ceived, notice that a claim has been denied

1 because of such a termination or cessation
2 and ending 63 days thereafter;

3 “(ii) described in clause (ii), (iii), (v),
4 or (vi) of subparagraph (B) whose enroll-
5 ment is terminated involuntarily, is the pe-
6 riod beginning on the date that the indi-
7 vidual receives a notice of termination and
8 ending on the date 63 days after the date
9 coverage ends;

10 “(iii) described in clause (iv)(I), is the
11 period beginning on the earlier of (I) the
12 date that the individual receives a notice of
13 termination, a notice of the issuer’s bank-
14 ruptcy or insolvency, or other such similar
15 notice, if any, and (II) the date that cov-
16 erage ends, and ending on the date 63
17 days after the date coverage ends;

18 “(iv) described in clause (ii), (iii),
19 (iv)(II), (iv)(III), (v), or (vi) of subpara-
20 graph (B) who disenrolls voluntarily, is the
21 period beginning on the date 60 days be-
22 fore and ending on the date 63 days after,
23 the effective date of disenrollment; and

24 “(v) described in subparagraph (B),
25 but not described in the preceding provi-

1 sions of this subparagraph, is the period
2 beginning on the effective date of
3 disenrollment and ending on the date 63
4 days thereafter.”.

5 (2) EXTENDED MEDIGAP ACCESS FOR INTER-
6 RUPTED TRIAL PERIODS.—Section 1882(s)(3), as
7 amended by paragraph (1), is further amended by
8 adding at the end the following new subparagraph:

9 “(F) For purposes of this paragraph—

10 “(i) in the case of an individual de-
11 scribed in subparagraph (B)(v) (or deemed
12 to be so described, pursuant to this sub-
13 paragraph) whose enrollment with an orga-
14 nization described in subparagraph
15 (B)(v)(II) is involuntarily terminated with-
16 in the first 12 months of such enrollment,
17 and who, without an intervening enroll-
18 ment, enrolls with another such organiza-
19 tion, such subsequent enrollment shall be
20 deemed to be an initial enrollment de-
21 scribed in such clause (v); and

22 “(ii) in the case of an individual de-
23 scribed in subparagraph (B)(vi) (or
24 deemed to be so described, pursuant to this
25 subparagraph) whose enrollment with a

1 plan described in subparagraph (B)(v)(II)
 2 is involuntarily terminated within the first
 3 12 months of such enrollment, and who,
 4 without an intervening enrollment, enrolls
 5 in another such plan, such subsequent en-
 6 rollment shall be deemed to be an initial
 7 enrollment described in such clause (vi).”.

8 (c) ONE-TIME ADDITIONAL SPECIAL OPEN ENROLL-
 9 MENT FOR BENEFICIARIES LOSING ACCESS TO
 10 MEDICARE+CHOICE PLANS.—

11 (1) IN GENERAL.—An issuer of a medicare sup-
 12 plemental policy must comply with the conditions of
 13 clauses (i) through (iii) of section 1882(s)(3)(A) in
 14 the case of an individual described in paragraph (2)
 15 who seeks to enroll under the policy not later than
 16 92 days after the date of enactment of this section.

17 (2) CONDITIONS OF ELIGIBILITY.—

18 (A) IN GENERAL.—For purposes of para-
 19 graph (1), an individual is described in this
 20 paragraph if—

21 (i) the individual’s enrollment with an
 22 organization—

23 (I) described in clause (i) or (ii)
 24 of subparagraph (B) is terminated be-

1 cause of a circumstance described in
2 section 1851(e)(4)(A); or

3 (II) described in clause (iii) of
4 subparagraph (B) is terminated on or
5 before December 31, 1998 because of
6 such a circumstance;

7 (ii) the individual is not enrolled—

8 (I) with another organization de-
9 scribed in subparagraph (B); or

10 (II) under a medicare supple-
11 mental policy; and

12 (iii) the individual submits evidence of
13 the date of termination or disenrollment
14 along with the application for such medi-
15 care supplemental policy.

16 (B) APPLICABLE ORGANIZATIONS.—For pur-
17 poses of subparagraph (A), an organization de-
18 scribed in this subparagraph is—

19 (i) an eligible organization under a
20 contract under section 1876 or a similar
21 organization operating under a demonstra-
22 tion project authority;

23 (ii) an organization under an agree-
24 ment under section 1833(a)(1)(A); or

1 (iii) a Medicare+Choice organization
2 under a Medicare+Choice plan under part
3 C.

4 (d) GUARANTEED ACCESS FOR CERTAIN MEDICARE
5 BENEFICIARIES TO ALL SUPPLEMENTAL POLICIES.—Sec-
6 tion 1882(s)(3)(C)(iii) (42 U.S.C. 1395ss(s)(3)(C)(iii)) is
7 amended by inserting “or an individual described in sub-
8 paragraph (B)(ii) or (B)(iii) in the case of circumstances
9 permitting discontinuance of the individual’s election
10 under section 1851(e)(4)(A)” after “subpara-
11 graph(B)(vi)”.

12 (e) INCREASED CIVIL MONEY PENALTIES FOR VIO-
13 LATION OF OPEN ENROLLMENT REQUIREMENT.—Section
14 1882(s)(4) (42 U.S.C. 1395ss(s)(4)) is amended by strik-
15 ing “the requirements of this subsection is subject to a
16 civil money penalty of not to exceed \$5,000 for each such
17 failure” and inserting “any requirement of this subsection
18 with respect to any individual is subject to a civil money
19 penalty of not to exceed \$50,000 for each such failure with
20 respect to such individual, plus an additional civil money
21 penalty of not to exceed \$5,000 for each day such failure
22 continues with respect to such individual”.

23 (f) TRANSITION PROVISIONS.—The provisions of sec-
24 tion 4031(e) of the Balanced Budget Act of 1997 shall

1 apply to the amendments made by this section in the same
2 manner as they apply to such section 4031, except that—

3 (1) the reference in such section 4031(e) to “9
4 months after the date of the enactment of this Act”
5 shall be considered to be a reference to 9 months
6 after the effective date of this section;

7 (2) the reference in such section 4031(e) to the
8 “1991 NAIC Model Regulation, as modified pursu-
9 ant to section 171(m)(2) of the Social Security Act
10 Amendments of 1994 (Public Law 103–432) and as
11 modified pursuant to section 1882(d)(3)(A)(vi)(IV)
12 of the Social Security Act, as added by section
13 271(a) of the Health Insurance Portability and Ac-
14 countability Act of 1996 (Public Law 104–191)”
15 shall be considered to be a reference to the 1991
16 NAIC Model Regulation, as modified pursuant to all
17 statutes enacted prior to the enactment of this sec-
18 tion; and

19 (3) any reference to “1999” in such section
20 4031(e) shall be considered to be a reference to
21 2002 for purposes of the amendments made by this
22 section.

1 **SEC. 236. REMOVAL OF SUNSET DATE FOR COST-SHARING**
2 **IN MEDICARE PART B PREMIUMS FOR CER-**
3 **TAIN QUALIFYING INDIVIDUALS.**

4 (a) IN GENERAL.—Section 1902(a)(10)(E)(iv) (42
5 U.S.C. 1396a(a)(10)(E)(iv)) is amended—

6 (1) by striking subclause (II);

7 (2) by amending the text preceding subclause
8 (I) to read as follows:

9 “(iv) subject to section 1905(p)(4),
10 for making medical assistance available”;

11 (3) by striking subclause designation “(I)”, re-
12 locating the remaining text at the end of clause (iv),
13 and indenting appropriately; and

14 (4) by striking “, and” at the end of clause (iv),
15 as so amended, and inserting “; and”.

16 (b) RELOCATION OF PROVISION REQUIRING 100
17 PERCENT FEDERAL MATCHING OF STATE MEDICAL AS-
18 SISTANCE COSTS FOR CERTAIN QUALIFYING INDIVID-
19 UALS.—Section 1903(a) (42 U.S.C. 1395b(a)), as amend-
20 ed by section 202(c)(3), is amended—

21 (1) by redesignating paragraph (8) as para-
22 graph (9); and

23 (2) by adding after paragraph (7) the following
24 new paragraph:

25 “(8) an amount equal to 100 percent of
26 amounts as expended as medicare drug cost sharing

1 for individuals described in section
2 1903(a)(10)(E)(iv);”.

3 (c) REPEAL OF SECTION 1933.—Section 1933 (42
4 U.S.C. 1396u–3) is repealed.

5 (d) EFFECTIVE DATE.—The amendments made by
6 this section shall be effective on and after January 1,
7 2003.

8 **TITLE III—PROTECTING AND EX-**
9 **TENDING MEDICARE SOL-**
10 **VENCY**

11 **SEC. 301. TRANSFERS TO EXTEND MEDICARE SOLVENCY.**

12 Section 1817 (42 U.S.C. 1395i) is amended by add-
13 ing at the end the following new subsection:

14 “(l) Additional Appropriation to Federal Hospital In-
15 surance Trust Fund.—

16 “(1) In addition to any other amounts appro-
17 priated to the Trust Fund, there is hereby appro-
18 priated to the Trust Fund, out of any moneys in the
19 Treasury not otherwise appropriated—

20 “(A) for the fiscal year ending September
21 30, 2001, \$15,400,000,000;

22 “(B) for the fiscal year ending September
23 30, 2002, \$12,600,000,000;

24 “(C) for the fiscal year ending September
25 30, 2006, \$26,000,000,000;

1 “(D) for the fiscal year ending September
2 30, 2007, \$47,000,000,000;

3 “(E) for the fiscal year ending September
4 30, 2008, \$57,000,000,000;

5 “(F) for the fiscal year ending September
6 30, 2009, \$61,000,000,000;

7 “(G) for the fiscal year ending September
8 30, 2010, \$80,000,000,000;

9 “(H) for the fiscal year ending September
10 30, 2011, \$22,400,000,000;

11 “(I) for the fiscal year ending September
12 30, 2012, \$29,500,000,000;

13 “(J) for the fiscal year ending September
14 30, 2013, \$32,000,000,000;

15 “(K) for the fiscal year ending September
16 30, 2014, \$26,200,000,000;

17 “(L) for the fiscal year ending September
18 30, 2015, \$13,800,000,000.

19 “(2) The amounts appropriated for each fiscal
20 year by paragraph (1) shall be transferred from the
21 general fund in the Treasury to the Trust Fund in
22 equal monthly installments on the first business day
23 of each month.”.

1 **SEC. 302. CATASTROPHIC PRESCRIPTION DRUG COVERAGE**

2 **RESERVE.**

3 (a) ESTABLISHMENT OF RESERVE.—There is estab-
4 lished a reserve fund which shall be known as the “Cata-
5 strophic Prescription Drug Coverage Reserve,” as defined
6 in section 3(11) of the Congressional Budget Act of 1974,
7 as amended by this Act.

8 (b) DEFINITION.—Section 3 of the Congressional
9 Budget Act of 1974 is amended by adding at the end the
10 following:

11 “(11) The term ‘Catastrophic Prescription
12 Drug Coverage Reserve’ means—

13 “(A) for fiscal year 2006, \$4,000,000,000;

14 “(B) for fiscal year 2007, \$5,000,000,000;

15 “(C) for fiscal year 2008, \$6,800,000,000;

16 “(D) for fiscal year 2009, \$8,400,000,000;

17 and

18 “(E) for fiscal year 2010,

19 \$10,800,000,000.”.

20 (c) DISPOSITION OF RESERVE FUND.—Beginning
21 with September 30, 2006, any balance remaining in the
22 Catastrophic Prescription Drug Coverage Reserve on the
23 last day of a fiscal year is appropriated to the Federal
24 Hospital Insurance Trust Fund.

1 **SEC. 303. MEDICARE SOLVENCY DEBT REDUCTION RE-**
2 **SERVE.**

3 (a) IN GENERAL.—Both the transfers under section
4 1817(1) of the Social Security Act as well as amounts
5 placed in reserve for catastrophic prescription drug cov-
6 erage under section 3(11) of the Congressional Budget
7 Act shall be known as the Medicare Solvency Debt Reduc-
8 tion Reserve.

9 (b) POINTS OF ORDER TO PROTECT RESERVE.—

10 (1) Section 301 of the Congressional Budget
11 Act of 1974 is amended by adding at the end the
12 following:

13 “(j) POINT OF ORDER TO PROTECT MEDICARE SOL-
14 VENCY DEBT REDUCTION RESERVE.—

15 “(1) IN GENERAL.—It shall not be in order in
16 the House of Representatives or the Senate to con-
17 sider any concurrent resolution on the budget (or
18 amendment, motion, or conference report on the res-
19 olution) that would allocate any amount of, or as-
20 sume a reduction in the Medicare Solvency Debt Re-
21 duction Reserve.

22 “(2) INAPPLICABILITY.—This subsection shall
23 not apply to legislation that appropriates funds from
24 the Catastrophic Prescription Drug Coverage Re-
25 serve for catastrophic prescription drug benefits
26 under the Medicare program.”

1 (2) Section 311(a) of the Congressional Budget
2 Act of 1974 is amended by adding at the end the
3 following:

4 “(4) ENFORCEMENT OF MEDICARE SOLVENCY
5 RESERVE.—

6 “(A) IN GENERAL.—It shall not be in
7 order in the House of Representatives or the
8 Senate to consider any bill, joint resolution,
9 amendment, motion, or conference report that
10 would cause a decrease in the level of the Medi-
11 care Solvency Debt Reduction Reserve.

12 “(B) INAPPLICABILITY.—This paragraph
13 shall not apply to legislation that appropriates
14 a portion of the Medicare Solvency Debt Reduc-
15 tion Reserve for new amounts for Medicare or
16 catastrophic prescription drug benefits under
17 the Medicare program.”.

18 (c) SUPER MAJORITY REQUIREMENT.—

19 (1) Section 904(c)(2) of the Congressional
20 Budget Act of 1974 is amended by inserting
21 “301(j),” after “301(i),”.

22 (2) Section 904(d)(3) of the Congressional
23 Budget Act of 1974 is amended by inserting
24 “301(j),” after “301(i),”.

1 **SEC. 304. PROTECTION OF MEDICARE SOLVENCY DEBT RE-**
2 **DUCTION RESERVE.**

3 (a) REDUCTION OF MEDICARE SOLVENCY TRANS-
4 FERS, OR CATASTROPHIC PRESCRIPTION DRUG RESERVE
5 NOT TO BE COUNTED AS PAY-AS-YOU-GO OFFSET.—
6 Any provision of legislation that would reduce, repeal, or
7 reverse the transfers to the Hospital Insurance Trust
8 Fund under section 1817(1) of the Social Security Act or
9 the amount of the Catastrophic Prescription Drug Cov-
10 erage Reserve under section 3(11) of the Congressional
11 Budget Act, shall not be counted on the pay-as-you-go
12 scorecard and shall not be included in any pay-as-you-go
13 estimates made by the Congressional Budget Office or the
14 Office of Management and Budget under section 252 of
15 the Balanced Budget and Emergency Deficit Control Act
16 of 1985.

17 (b) CONFORMING CHANGE.—Section 252 of the Bal-
18 anced Budget and Emergency Deficit Control Act of 1985
19 is amended, in paragraph (4) of subsection (d), by—

20 (1) striking “and” after subparagraph (A),

21 (2) striking the period after the subparagraph
22 (B) and inserting “; and”, and

23 (3) adding the following:

24 “(C) provisions that reduce, repeal, or re-
25 verse transfers under section 1817(1) of the So-
26 cial Security Act or the amount of the reserve

1 under section 3(11) of the Congressional Budg-
2 et Act.”.

3 (c) MEDICARE SOLVENCY TRANSFERS AND CATA-
4 STROPHIC PRESCRIPTION DRUG RESERVE REDUCE ON-
5 BUDGET SURPLUS.—The transfers under section 1817(1)
6 of the Social Security Act and amounts placed in the re-
7 serve under section 3(11) of the Congressional Budget
8 Act, together known as the “Medicare Solvency Debt Re-
9 duction Reserve”, shall be treated for purposes of the
10 President’s budget under title 31, United States Code, the
11 Balanced Budget and Emergency Deficit Control Act of
12 1985, and the Congressional Budget Act of 1974 as reduc-
13 tions to the on-budget surplus (or increases in the on-
14 budget deficit).

○