107TH CONGRESS
1ST SESSION

S. 357

To amend the Social Security Act to preserve and improve the medicare program.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 15, 2001

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

---

A BILL

To amend the Social Security Act to preserve and improve the medicare program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Preservation and Improvement Act of 2001''.

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

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—

(1) Based on the deliberations of the National Bipartisan Commission on the Future of Medicare, the medicare program under title XVIII of the Social Security Act in its current form is unsustainable and is scheduled to become insolvent in 2025.

(2) Medicare's spending, left unchecked, will continue to consume an increasing share of the Federal budget, leaving little room for other priorities, such as defense, education, debt reduction, tax cuts, and domestic spending.

(3) Medicare's current benefit package is outdated in that it does not provide a prescription drug benefit and limits beneficiary access to new technologies.

(4) Medicare only covers 53 percent of a beneficiary's average health care costs and exposes beneficiaries to large out-of-pocket liabilities.

(5) The number of beneficiaries in the medicare program is estimated to more than double by the end of 2030, due to the influx of 77,000,000 baby boomers beginning in 2010.

(6) Each year there are fewer workers paying payroll taxes to fund current Medicare obligations, evidenced by a decrease in the number of workers per retiree from 4.5 in 1960 to 3.9 in 2000. This number is expected to decline further to 2.8 in 2020.

(7) The Balanced Budget Act of 1997, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 underscore the need to fundamentally restructure the medicare program and reduce Government micromanagement of that program.

(b) PURPOSES.—The purposes of this Act are—

(1) to promote high quality, comprehensive, integrated health care to meet the individual needs of each medicare beneficiary;

(2) to assist all medicare beneficiaries, especially those with low incomes, in obtaining comprehensive benefits, including prescription drugs through a health plan;

(3) to increase the flexibility of the medicare program and provide medicare beneficiaries timely access to the latest advances in the practice of medicine and delivery of care;

(4) to end the congressional micromanagement over prices and delivery of benefits currently administered through approximately 130,000 pages of regulations established under the medicare program; and

(5) to improve the existing medicare program by adopting a stable, competitive system based on the proven model of the Federal Employees Health Benefits Plan, thereby providing medicare beneficiaries with better and broader health coverage and a greater variety of reasonably priced health care options from which to choose.

TITLE I—ESTABLISHMENT OF MEDICARE COMPETITIVE PREMIUM SYSTEM

SEC. 101. ESTABLISHMENT OF MEDICARE COMPETITIVE PREMIUM SYSTEM.

The Social Security Act is amended by adding at the end the following:

''TITLE XXII—ESTABLISHMENT OF MEDICARE COMPETITIVE PREMIUM SYSTEM

''SEC. 2200. CONSTRUCTION; REFERENCES; DEFINITIONS.

''(a) CONSTRUCTION OF TITLE.—The provisions of this title shall be construed to modify and supersede the provisions and operation of title XVIII to the extent such provisions are inconsistent with the provisions of this title.

''(b) REFERENCES TO MEDICARE PROVISIONS.—Any reference in any law or regulation to any provision of title XVIII is deemed a reference to such provision as modified through the operation of this title.

''(c) DEFINITIONS RELATING TO MEDICARE PLANS.—As used in this title:

''(1) MEDICARE PLAN.—The term 'Medicare plan' means a health benefits plan which the Medicare Board has approved under section 2223, and includes each HCFA-sponsored plan.

''(2) STANDARD MEDICARE PLAN.—The term 'standard Medicare plan' means a Medicare plan that includes the core benefits under section 2202(a), but is not a high option Medicare plan.

''(3) HIGH OPTION MEDICARE PLAN.—The term 'high option Medicare plan' means a Medicare plan that, in addition to providing coverage for the core benefits under section 2202(a), includes coverage for

outpatient prescription drugs under section 2202(b), and stop-loss coverage under section 2202(c).

''(4) HCFA-SPONSORED PLAN.—The term 'HCFA-sponsored plan' means a standard or high option Medicare plan established under section 2282.

''(d) OTHER DEFINITIONS.—As used in this title:

''(1) CORE BENEFITS.—The term 'core benefits' means the items and services described in section 2202(a).

''(2) HCFA.—The term 'HCFA' means the Health Care Financing Administration, acting through the Administrator of such Administration.

''(3) MEDICARE BENEFICIARY.—The term 'Medicare beneficiary' means an individual entitled to benefits under title XVIII.

''(4) MEDICARE BOARD; BOARD.—The terms 'Medicare Board' and 'Board' mean the Board established under section 2241.

''(5) MEDICARE+CHOICE ORGANIZATION; MEDICARE+CHOICE PLAN.—The terms 'Medicare+Choice organization' and 'Medicare+Choice plan' have the meanings given such terms in subsections (a)(1) and (b)(1), respec-

tively, of section 1859 (relating to definitions relating to Medicare+Choice organizations).

''(6) MEDICARE TRUST FUND.—The term 'Medicare Trust Fund' means the Trust Fund established under section 2261.

''PART A—MEDICARE PLANS; COMBINING PARTS A AND B

''SEC. 2201. ELECTION OF COVERAGE THROUGH A MEDICARE PLAN AND CONSOLIDATED MEDICARE ELIGIBILITY.

''(a) CONTINUED ENTITLEMENT TO MEDICARE BENEFITS.—Beginning on January 1, 2004, Medicare beneficiaries shall continue to be entitled to receive benefits under title XVIII and shall receive such benefits through enrollment in a Medicare plan.

''(b) CONSOLIDATED MEDICARE ELIGIBILITY.—Beginning January 1, 2004, an individual may receive benefits under title XVIII only if such individual is entitled under part A (or enrolled under such part) and enrolled under part B of such title.

''(c) ENROLLMENT PROCESS.—

''(1) IN GENERAL.—The Medicare Board shall establish a process for the enrollment of Medicare beneficiaries under Medicare plans that is based, except as the Board may provide, upon the process for

enrollment with Medicare+Choice plans under part C of title XVIII, including the provision of information and open enrollment and disenrollment opportunities.

''(2) TRANSITIONAL ENROLLMENT.—The Medicare Board shall provide for such general enrollment period before January 1, 2004, as may be appropriate to permit all individuals who are eligible to receive benefits under part A or part B of title XVIII, but not both, to become eligible to receive benefits under such other part.

''(3) STUDY AND REPORT TO CONGRESS REGARDING TRANSITION PERIOD.—

''(A) STUDY.—The Medicare Board shall conduct a study on the need for—

''(i) establishing a period after January 1, 2004, in which an individual, notwithstanding subsection (a), may receive benefits under part A of title XVIII without being enrolled under part B of such title or may receive benefits under part B of such title without being entitled under part A of such title; and

''(ii) adjusting the amount of the beneficiary obligation and drug discount com-

puted under section 2227 during the period described in subparagraph (A).

''(B) REPORT.—Not later than January 1, 2003, the Medicare Board shall submit a report to Congress on the study conducted under subparagraph (A), together with any recommendations for legislation that the Board determines to be appropriate as a result of such study.

''(4) STUDY AND REPORT TO CONGRESS REGARDING SPECIAL RULES FOR END-STAGE RENAL DISEASE.—

''(A) STUDY.—The Medicare Board shall conduct a study on the need for a special rule for individuals medically determined to have end-stage renal disease, similar to the special rule established under section 1851(a)(3)(B) (relating to Medicare+Choice eligible individuals).

''(B) REPORT.—Not later than January 1, 2003, the Medicare Board shall submit a report to Congress on the study conducted under subparagraph (A), together with any recommendations for legislation that the Board determines to be appropriate as a result of such study.

''(5) STUDY AND REPORT ON ONE-TIME ENROLLMENT.—

''(A) STUDY.—The Medicare Board shall conduct a study on the need for rules relating to a one-time enrollment of Medicare beneficiaries in high option Medicare plans, including HCFA-sponsored high option plans, similar to the rules established under section 1882(s) (relating to guaranteed issuance of Medicare supplemental policies).

''(B) REPORT.—Not later than January 1, 2003, the Medicare Board shall submit a report to Congress on the study conducted under subparagraph (A), together with any recommendations for legislation that the Board determines to be appropriate as a result of such study.

''SEC. 2202. HEALTH BENEFITS COVERAGE.

''(a) CORE BENEFITS.—Each Medicare plan shall provide those items and services for which benefits are available under parts A and B of title XVIII to Medicare beneficiaries enrolled in the plan.

''(b) OUTPATIENT PRESCRIPTION DRUG BENEFIT.—

''(1) IN GENERAL.—Each high option Medicare plan shall provide a benefit for outpatient prescription drugs—

"(A) during 2004, that is actuarially equivalent to an amount equal to $850 on January 1, 2004; and

"(B) during a subsequent year, that is actuarially equivalent to the amount for each Medicare beneficiary during the previous year, adjusted for any increase in the reasonable cost of outpatient prescription drugs during such previous year.

"(2) COST CONTROL MECHANISMS.—In providing the outpatient prescription drug benefit under paragraph (1), the entity offering each Medicare plan (including a private entity with a contract under section 2283) may use cost control mechanisms that are customarily used in employer sponsored plans, including the use of formularies, tiered copayments, selective contracting with providers of outpatient prescription drugs, and mail order pharmacies.

"(c) STOP-LOSS COVERAGE.—Each high option Medicare plan shall provide a benefit for stop-loss coverage that is designed to limit Medicare beneficiary cost-sharing for core benefits during a year after the Medicare beneficiary incurs out-of-pocket expenditures in excess of—

''(1) during 2004, $2,000 for the core benefits; and

''(2) for any subsequent calendar year, the amount for the previous year for the core benefits increased by the average annual percentage increase in expenditures per beneficiary under title XVIII during the previous year, as estimated by the Medicare Board.

''SEC. 2203. CONTINUATION OF BENEFICIARY PROTECTIONS AND OTHER QUALIFICATIONS FOR MEDICARE PLANS.

''In order to be offered as a Medicare plan under this part, except as otherwise provided in this title, the plan and the entity offering the plan shall meet the requirements applicable to Medicare+Choice plans and Medicare+Choice organizations under part C of title XVIII, including—

''(1) the offering of Medicare benefits; and

''(2) protections for Medicare beneficiaries enrolled in the plans.

''SEC. 2204. EXCLUSIVE PAYMENT METHODOLOGY.

''(a) IN GENERAL.—Except as provided in this title, for items and services furnished on or after January 1, 2004—

''(1) payment to an entity offering a Medicare plan in the amounts provided under this part shall be instead of any amounts that may be otherwise payable under title XVIII; and

''(2) only the entity offering the Medicare plan is eligible to receive payment for items and services under such title.

''(b) EXCEPTIONS.—Under rules established by the Medicare Board, the Board may provide for exceptions to subsection (a) under circumstances that are similar to the circumstances provided for under section 1851(i) (relating to effect of election of Medicare+Choice plan option).

''PART B—COMPETITIVE PREMIUM SYSTEM

''SEC. 2221. PUBLICATION OF GEOGRAPHIC AND RISK ADJUSTERS.

''(a) PUBLICATION.—Not later than April 15 of each year (beginning in 2003), the Medicare Board shall publish the geographic and risk adjusters established under subsection (b) to be used in determining the amount of payment to Medicare plans computed under section 2226.

''(b) ESTABLISHMENT OF GEOGRAPHIC AND RISK ADJUSTERS.—

''(1) IN GENERAL.—Subject to paragraph (2), the Medicare Board shall establish an appropriate methodology for adjusting the amount of payment to

Medicare plans computed under section 2226 to take into account, in a budget neutral manner, appropriate variation in costs for core benefits—

"(A) based on the provision of items and services in different geographic areas; and

"(B) based on the differences in actuarial risk of different enrollees being served.

"(2) CONSIDERATIONS.—In establishing an appropriate methodology under this subsection, the Medicare Board—

"(A)(i) subject to clause (ii), may take into account the similar methodologies used under section 1853 (relating to payments to Medicare+Choice organizations); and

"(ii) shall limit the geographic adjustment to variations based on input costs of providing covered items and services in different areas;

"(B) may provide for the risk adjustment to be effected through a pooling arrangement in which unfavorable risks are shared among the entities offering Medicare plans in an area, rather than through risk adjustment of payment made with respect to Medicare beneficiaries;

"(C) may establish other risk adjusters, such as those based on the length of time a Medicare beneficiary has been continuously enrolled in a Medicare plan;

"(D) may phase-in geographic and risk adjusters established under this section during the transition from the medicare program under title XVIII of the Social Security Act in effect on the date of enactment of this title as necessary to prevent large changes in the obligation of Medicare beneficiaries during a year; and

"(E) shall consider the interrelationship of all adjustments to the amount paid to Medicare plans and obligations of Medicare beneficiaries under this section, to ensure that all Medicare plans have an incentive to provide efficient care.

"SEC. 2222. SUBMISSION OF PROPOSED MEDICARE PLANS.

"(a) IN GENERAL.—Each entity that intends to offer a Medicare plan in a year (beginning with 2004) shall submit to the Medicare Board, at such time and in such manner as the Board may specify, such information as the Board may require to carry out title XVIII, including the information described in subsection (b) and taking into ac-

count the geographic and risk adjusters published under section 2221.

''(b) INFORMATION DESCRIBED.—The information described in this paragraph includes information on each of the following:

''(1) BENEFITS.—A description of the benefits under the plan.

''(2) PREMIUM BID.—The premium proposed to be charged for enrollment under the plan.

''(3) SERVICE AREA.—The service area for the plan.

''SEC. 2223. BOARD APPROVAL OF PROPOSED MEDICARE PLANS.

''(a) APPROVAL OF MEDICARE PLANS BY MEDICARE BOARD.—

''(1) IN GENERAL.—Subject to paragraph (2), the Medicare Board shall approve Medicare plans—

''(A) in accordance with the requirements established under subsection (b) and, in the case of a high option Medicare plan, subsection (c); and

''(B) subject to the terms and conditions established under subsection (d).

''(2) HIGH OPTION MEDICARE PLAN REQUIRED.—The Medicare Board may approve the of-

fering of a standard Medicare plan by an entity under this title in a service area only if the entity also offers a Medicare plan that has been approved as a high option Medicare plan in accordance with the requirements established under subsection (c) in that service area.

''(b) REQUIREMENTS FOR ALL MEDICARE PLANS.—The Medicare Board may approve a Medicare plan only if such plan meets the following requirements:

''(1) BENEFITS.—

''(A) IN GENERAL.—The Board may approve a Medicare plan submitted under section 2222 only if the benefits under such plan—

''(i) include the core benefits under section 2202(a); and

''(ii) are not designed in such a manner that the Board finds that it is likely to result in favorable selection of Medicare beneficiaries.

''(B) VARIATION IN COST-SHARING.—

''(i) IN GENERAL.—Except for the HCFA-sponsored plans established under section 2202, for purposes of approving a Medicare plan, the Medicare Board may permit reasonable variation in cost-sharing

so long as the actuarial equivalence of total cost-sharing for the core benefits is maintained.

''(ii) RULE OF CONSTRUCTION.—Nothing in this subparagraph shall be construed as preventing a Medicare plan from providing, as an additional benefit, a lower level of cost-sharing from that otherwise described in title XVIII.

''(2) PREMIUM BID.—The Board may approve a premium bid submitted under section 2222 only if the Board finds that the premium rates are adequate in terms of actuarial soundness to assure the financial solvency of the entity offering the plan.

''(3) SERVICE AREA.—The Board may approve a service area submitted under section 2222 only if the Board finds that—

''(A) the use of such an area is consistent with the purposes of this title; and

''(B) the service area for the plan is not designed so as to discriminate based on the health status, economic status, or prior receipt of health care of Medicare beneficiaries.

''(c) SPECIAL REQUIREMENTS FOR HIGH OPTION MEDICARE PLANS.—The Medicare Board may approve a

Medicare plan as a high option Medicare plan only if such plan includes, in addition to the core benefits under section 2202(a), coverage for outpatient prescription drugs under section 2202(b), and stop-loss coverage under 2202(c).

''(d) TERMS AND CONDITIONS.—

''(1) IN GENERAL.—Medicare plans approved under this section shall be subject to such additional terms and conditions as the Board may specify.

''(2) NEGOTIATION.—

''(A) IN GENERAL.—Subject to subparagraph (B), for purposes of specifying the terms and conditions under paragraph (1), the Board may negotiate with any entity offering a Medicare plan regarding the terms and conditions of such plan.

''(B) LIMITATION.—The Medicare Board may approve a Medicare plan only if the Board finds that the negotiated terms and conditions are consistent with the requirements of this title.

''SEC. 2224. COMPUTATION OF CORE BENEFIT PREMIUMS.

''(a) IN GENERAL.—For each year (beginning with 2004), the Medicare Board shall compute a core benefit premium for each Medicare plan approved under section

2223 that reflects only the actuarial value of the core benefits offered under the Medicare plan.

''(b) DE MINIMIS BENEFITS INCLUDED.—For purposes of computing the core-benefit premium under subsection (a), the Board may include de minimis benefits that are not core benefits.

''SEC. 2225. COMPUTATION OF NATIONAL AVERAGE PREMIUM.

''(a) COMPUTATION.—

''(1) IN GENERAL.—For each year (beginning with 2004) the Medicare Board shall compute a national average premium equal to the average of the core benefit premium for each Medicare plan (as computed under section 2224).

''(2) WEIGHTED AVERAGE.—The national average premium computed under paragraph (1) shall be a weighted average, with the weight for each plan being equal to the average number of beneficiaries enrolled under such plan in the previous year.

''(b) SPECIAL RULE FOR 2004.—For purposes of applying subsection (a) in 2004, Medicare beneficiaries who obtained benefits—

''(1) under the original fee-for-service program under parts A and B of title XVIII as in effect on the date of enactment of this title are deemed to

have been enrolled in the HCFA-sponsored standard plan; and

''(2) through enrollment in a Medicare+Choice plan (or similar plan) are deemed to have been enrolled in the Medicare plan the Board determines is most comparable to the Medicare+Choice plan (or similar plan) in which the individual was enrolled on such date.

''SEC. 2226. PAYMENT OF FULL AMOUNT OF MEDICARE PLAN PREMIUMS.

''(a) IN GENERAL.—Subject to subsection (b), for each year (beginning with 2004), the Board shall pay to each Medicare plan in which a Medicare beneficiary is enrolled an amount equal to—

''(1) the full amount of the premium approved under section 2223(b)(2) on behalf of each Medicare beneficiary enrolled in such plan for the year, as adjusted using the geographic and risk adjusters that apply to the core benefits published under section 2221; minus

''(2) the amount of any fees (as computed under section 2246(b)).

''(b) PAYMENT TERMS.—Payment under this section to an entity offering a Medicare plan shall be made in a manner determined by the Medicare Board and based

upon the manner in which payments are under section 1853(a) (relating to payments to Medicare+Choice organizations).

"SEC. 2227. COMPUTATION OF BENEFICIARY OBLIGATION AND DRUG DISCOUNTS FOR BENEFICIARIES ENROLLED IN HIGH OPTION MEDICARE PLANS.

''(a) COMPUTATION OF BENEFICIARY OBLIGATION.—Subject to subsection (b), the annual beneficiary obligation for enrollment in a Medicare plan for a year shall be determined as follows:

''(1) MEDICARE PLAN PREMIUMS OF LESS THAN 85 PERCENT OF THE NATIONAL AVERAGE.—If the amount of the premium approved by the Board under section 2223 for the Medicare plan does not exceed 85 percent of the national average premium (as computed under section 2225) the obligation of the Medicare beneficiary shall be zero.

''(2) MEDICARE PLAN PREMIUMS BETWEEN 85 AND 100 PERCENT OF THE NATIONAL AVERAGE.—If the amount of the premium approved by the Board under section 2223 for a Medicare plan exceeds 85 percent of the national average premium, but does not exceed 100 percent of the national average premium, the obligation of the Medicare beneficiary

shall be equal to 80 percent of the amount by which the premium for the plan exceeds 85 percent of the national average premium.

''(3) MEDICARE PLAN PREMIUMS EQUAL TO OR GREATER THAN THE NATIONAL AVERAGE.—If the amount of the premium approved by the Board under section 2223 for a Medicare plan equals or exceeds 100 percent of the national average premium the obligation of the Medicare beneficiary shall be equal to the sum of—

''(A) the applicable percent for the year of the national average premium; and

''(B) the amount by which the premium approved by the Board under section 2223 for the Medicare plan exceeds the amount of the national average premium.

In the preceding sentence, the term 'applicable percent' means an amount, (expressed as a percent) as estimated by the Board, determined by dividing the amount of the part B premium for a year (as determined under section 1839 as if the Medicare Preservation and Improvement Act of 2001 had not been enacted) by the total per capita amount of expenditures under the Medicare Trust Fund (under section 2261) for the year.

''(b) DISCOUNTS FOR BENEFICIARIES ENROLLED IN HIGH OPTION MEDICARE PLANS.—

''(1) IN GENERAL.—The beneficiary obligation determined under this section for any Medicare beneficiary enrolled in a high option Medicare plan shall be reduced by the discount determined under paragraph (2).

''(2) DETERMINATION OF DISCOUNT.—The discount determined under this paragraph is the amount equal to the applicable percentage (as determined under paragraph (3)) of the benefit amount for outpatient prescription drugs determined under section 2202(b) for the year.

''(3) APPLICABLE PERCENTAGE.—

''(A) INDIVIDUALS WITH INCOME THAT EXCEEDS 150 PERCENT OF POVERTY.—In the case of a Medicare beneficiary whose income (as determined for purposes of section 1905(p) and without regard to paragraph (4)) exceeds 150 percent of the official poverty line (referred to in paragraph (2)(A) of such section) applicable to a family of the size involved, the applicable percentage shall be 25 percent.

''(B) INDIVIDUALS WITH INCOME BETWEEN 135 AND 150 PERCENT OF POVERTY.—

In the case of a Medicare beneficiary whose income (as so determined) exceeds 135 percent but does not exceed 150 percent of such poverty line, the applicable percentage shall be a percent, equal to 50 percent reduced (but not below 25 percent) by 1.67 percentage points for each percentage point by which such income exceeds 135 percent of such poverty line.

''(4) TAX TREATMENT OF DISCOUNT.—

''(A) IN GENERAL.—For purposes of the Internal Revenue Code of 1986, the discount determined under paragraph (2) for a Medicare beneficiary for a year shall be included in the gross income of the beneficiary for the year.

''(B) STATEMENT OF TAXABLE AMOUNT.—Not later than January 31 of each year (beginning with 2005), the Medicare Board shall provide—

''(i) each Medicare beneficiary with a statement that describes the amount of the discount that is required to be included in the gross income of the beneficiary for the previous year pursuant to subparagraph (A); and

''(ii) the Secretary of the Treasury with the information described in clause (i).

''(5) PUBLICATION OF DISCOUNTED PREMIUMS.—For each year (beginning with 2004), the Medicare Board shall publish in the Board's announcement of the premiums for Medicare plans each year the amount of the beneficiary obligation after applying the discount determined under paragraph (2) for each high option Medicare plan.

''SEC. 2228. COLLECTION OF BENEFICIARY OBLIGATION.

''(a) COLLECTION OF AMOUNT IN SAME MANNER AS PART B PREMIUM.—The amount of the annual beneficiary obligation determined under section 2227 shall be paid to the Medicare Trust Fund in the same manner as monthly premiums under part B of title XVIII were payable to the credit of the Federal Supplementary Medical Insurance Trust Fund under section 1840 (relating to payment of premiums) as in effect as of the date of enactment of this title.

''(b) INFORMATION NECESSARY FOR COLLECTION.—In order to carry out paragraph (1), the Medicare Board shall transmit to the Commissioner of Social Security—

''(1) at the beginning of each year, the name, social security account number, and annual bene-

ficiary obligation owed by each individual enrolled in a Medicare plan for each month during the year; and

''(2) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.

''SEC. 2229. RELATION TO CERTAIN PROVISIONS.

''(a) RELATION TO CERTAIN PROVISIONS.—Beginning on January 1, 2004, the following provisions of law are modified as follows, in order to reflect the policies specified in this part:

''(1) CHANGE IN PAYMENT RULES.—Subject to subsection (b), in applying section 1853 (relating to payments to Medicare+Choice organizations), payment rates established under section 2226 shall supersede the annual Medicare+Choice capitation rate calculated under section 1853(c) (relating to calculation of annual Medicare+Choice capitation rates).

''(2) PART B PREMIUM.—No separate premium is payable under section 1839 (relating to amount of premiums).

''(b) RELATION TO OTHER PROVISIONS.—The fact that a provision is not cited in this subsection does not indicate that the provision is not modified under this title in some manner consistent with section 2200(a).

''PART C—MEDICARE BOARD CHARTER

''SEC. 2241. MEDICARE BOARD.

''(a) ESTABLISHMENT.—There is established, as an independent agency in the executive branch of the Government, a Medicare Board (in this part referred to as the 'Board').

''(b) MEMBERSHIP.—

''(1) NUMBER AND APPOINTMENT.—The Board shall be composed of 7 members appointed by the President, by and with the advice and consent of the Senate.

''(2) DEADLINE FOR INITIAL APPOINTMENT.—The initial members of the Board shall be nominated for appointment by not later than 6 months after the date of enactment of this title.

''(3) TERMS.—

''(A) IN GENERAL.—The terms of members of the Board shall be for 7 years, except that of the members first appointed—

''(i) 3 shall be appointed for terms of 3 years;

''(ii) 2 shall be appointed for terms of 5 years; and

''(iii) 2 shall be appointed for terms of 7 years.

''(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office.

''(C) LIMITATION ON NUMBER OF TERMS.—Any person appointed as a member of the Board shall not be eligible for reappointment to the Board after having served 2 terms.

''(4) CHAIRPERSON AND OTHER OFFICERS.—The Board shall elect a chairperson and such officers as the Board determines appropriate.

''(c) OPERATION OF THE BOARD.—

''(1) MEETINGS.—The Board shall meet at the call of its chairperson or a majority of its members.

''(2) QUORUM.—A quorum shall consist of 4 members of the Board, except that the Board may establish a lesser quorum to conduct a hearing under section 2243(a).

''SEC. 2242. DUTIES OF THE BOARD.

''(a) ADMINISTRATION OF COMPETITIVE PREMIUM SYSTEM.—Except as otherwise provided in this title and

effective with respect to benefits furnished on or after January 1, 2004, the Board shall—

''(1) coordinate determinations of beneficiary eligibility and enrollment under title XVIII with the Commissioner of Social Security;

''(2) enter into, and enforce, contracts with entities for the offering of Medicare plans under part A of this title, including contracting with the Division of HCFA-Sponsored Plans of HCFA (as established under section 2281(a)(1)) for the offering of the HCFA-sponsored plans;

''(3) disseminate to Medicare beneficiaries information with respect to benefits, limitations on payment, under Medicare plans, including a comparative analysis of Medicare plans and the quality of such plans in the area in which the Medicare beneficiary resides; and

''(4) establish a Medicare beneficiary education program to provide timely, readable, accurate, and understandable information to Medicare beneficiaries regarding Medicare plan options.

''(b) RELATION TO HCFA-SPONSORED PLANS.—The Board shall not be responsible for the establishment and operation of HCFA-sponsored plans (provided for under section 2282), but shall have oversight authority over such

plans in a similar manner to that provided with respect to other Medicare plans.

''(c) TRANSITION PROVISIONS.—The Secretary and the Board shall cooperate to establish an appropriate transition of responsibility for the administration of title XVIII and other related laws, from the Secretary to the Board as is appropriate to carry out the purposes of this title and as is consistent with the responsibilities of the Division of Health Programs of HCFA (established under section 2281(a)(2)). Insofar as a responsibility is transferred to the Board under this subsection, any reference to the Secretary in title XVIII or other provision of law with respect to such responsibility is deemed to be a reference to the Board.

''SEC. 2243. POWERS OF THE BOARD.

''(a) IN GENERAL.—The Board may, for the purpose of carrying out its duties, promulgate regulations, hold hearings, sit and act at times and places, take testimony, and receive evidence as the Board considers appropriate.

''(b) CONTRACT AUTHORITY.—The Board may contract with, and compensate, government and private agencies or persons for items and services, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

''(c) BOARD AUTHORITY TO PERMIT FLEXIBILITY IN REQUIREMENTS.—In promulgating regulations under

subsection (a) to carry out the requirements of part C of title XVIII, the Board may modify the regulations previously promulgated by the Secretary to carry out such requirements (other than those relating to benefits or beneficiary protections) as may be appropriate to better meet the needs of Medicare beneficiaries and promote fair and open competition among Medicare plans.

''(d) OVERSEEING SOLVENCY OF HCFA-SPONSORED PLANS.—The Board shall monitor and oversee the financial solvency of the HCFA-sponsored plans in a manner similar to the manner in which State insurance commissioners monitor and oversee the solvency of health insurance issuers in the States. The Board shall include in its periodic reports to Congress an analysis of the solvency of such plans.

''SEC. 2244. BOARD PERSONNEL MATTERS.

''(a) MEMBERS.—

''(1) COMPENSATION.—Members of the Board shall be compensated at the rate provided for level II of the Executive Schedule under section 5315 of title 5, United States Code.

''(2) REMOVAL.—The President may remove a member of the Board only for neglect of duty or malfeasance in office.

''(b) STAFF AND SUPPORT SERVICES.—

''(1) EXECUTIVE DIRECTOR.—The chairperson shall appoint an executive director of the Board who shall be paid at a rate specified by the Board.

''(2) STAFF.—With the approval of the Board, the executive director may appoint such personnel as the executive director considers appropriate.

''(3) INAPPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Board shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

''(4) EXPERTS AND CONSULTANTS.—With the approval of the Board, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

''(c) TRANSFER OF PERSONNEL, ASSETS, ETC.—For purposes of the Board carrying out its duties, the Secretary and the Board may provide for the transfer to the Board of such civil service personnel employed by the Department of Health and Human Services, and such resources and assets of the Department used in carrying out title XVIII, as the Board requires.

"SEC. 2245. REPORTS; COMMUNICATIONS WITH CONGRESS.

"(a) REPORT ON MEDICARE PROGRAM.—Not less frequently than annually, the Board shall submit to Congress such reports describing the medicare program under title XVIII as the Board determines appropriate.

"(b) MAINTAINING INDEPENDENCE OF BOARD IN COMMUNICATIONS WITH CONGRESS.—The Board may directly submit to Congress reports, legislative recommendations, testimony, or comments on legislation. No officer or agency of the United States may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to the submission to Congress of such reports, recommendations, testimony, or comments.

"SEC. 2246. FUNDING OF THE BOARD.

"(a) INITIAL YEARS.—There is authorized to be appropriated to the Board for each of fiscal years 2002 and 2003, in appropriate part from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, such sums as are necessary for the Board to carry out its duties.

"(b) FEES.—For purposes of the Board carrying out its duties for fiscal years beginning after fiscal year 2003, the Board may levy on Medicare plans an assessment sufficient to pay its estimated expenses and the salaries of its members and employees for a fiscal year. Such assess-

ments shall be deposited into the Medicare Trust Fund (established under section 2221) and shall be available for such purpose without regard to amounts provided for in advance by appropriations Acts.

''PART D—UNIFIED MEDICARE TRUST FUND

''SEC. 2261. UNIFIED MEDICARE TRUST FUND.

''(a) ESTABLISHMENT.—Beginning on January 1, 2004, there is created on the books of the Treasury of the United States a trust fund to be known as the Medicare Trust Fund.

''(b) AMOUNTS IN MEDICARE TRUST FUND.—

''(1) IN GENERAL.—The Medicare Trust Fund shall consist of the following amounts:

''(A) Amounts deposited in, or appropriated to, the Medicare Trust Fund as provided in this title.

''(B) Any gifts and bequests made to the Medicare Trust Fund as provided in section 201(i)(1).

''(2) APPROPRIATION OF HOSPITAL INSURANCE TAXES.—

''(A) IN GENERAL.—Beginning January 1, 2004, and for each subsequent year, there is appropriated to the Medicare Trust Fund, out of moneys in the Treasury not otherwise appro-

priated, an amount equal to 100 percent of the taxes described in paragraphs (1) and (2) of section 1817(a).

''(B) TRANSFER.—The amounts appropriated pursuant to subparagraph (A) shall be transferred from time to time from the general fund in the Treasury to the Medicare Trust Fund. The amount to be transferred under this paragraph shall be determined on the basis of estimates by the Secretary of the Treasury of the taxes, described in such paragraph, paid to or deposited into the Treasury. The Secretary of the Treasury shall make adjustments in amounts subsequently transferred to the extent that prior estimates were in excess of, or were less than, such taxes.

''(3) GENERAL REVENUE CONTRIBUTION.—Beginning January 1, 2004, and for each subsequent year, there is appropriated to the Medicare Trust Fund, out of moneys in the Treasury not otherwise appropriated, from time to time, subject to the limitation described in section 2262(c), an amount equal to the amount by which the aggregate expenditures under this title (including payments made to Medicare plans under section 2226) exceed the sum of—

''(A) the amount appropriated under paragraph (2) for the period involved;

''(B) the beneficiary obligations collected under section 2227 for such period; and

''(C) the fees collected under section 2246 for such period.

''(4) TRANSFER OF BALANCES IN HI AND SMI TRUST FUNDS.—On January 1, 2004, the Secretary of the Treasury shall transfer to the Medicare Trust Fund any balances in the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Trust Fund.

''(5) APPLICATION TO OBLIGATIONS OF, AND AMOUNTS OWED TO, THE PART A AND B TRUST FUNDS.—

''(A) CERTIFICATION.—Beginning January 1, 2004, the Director of the Division of HCFA-Sponsored Plans of HCFA shall periodically certify to the Board of Trustees of the Medicare Trust Fund any amounts that would otherwise be—

''(i) payable from the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Trust

Fund for items and services provided prior to such date; or

''(ii) due to such Trust Funds for items and services provided prior to such date.

''(B) TRANSFERS AND DEPOSITS.—

''(i) TRANSFERS.—If the Director of the Division of HCFA-Sponsored Plans of HCFA certifies an amount pursuant to subparagraph (A)(i), the Board of Trustees of the Medicare Trust Fund shall transfer to the Director of the Division of HCFA-Sponsored Plans of HCFA from such Trust Fund an amount equal to the amount certified.

''(ii) DEPOSITS.—If the Director of the Division of HCFA-Sponsored Plans of HCFA certifies an amount pursuant to subparagraph (A)(ii), the Director of the Division of HCFA-Sponsored Plans shall deposit in the Medicare Trust Fund an amount equal to the amount certified.

''(c) APPLICATION OF HI TRUST FUND PROVISIONS.—Subject to other provisions of this title, the provisions of subsections (b) through (k) of section 1817 shall

apply to title XVIII and the Medicare Trust Fund in the same manner as they apply to part A of title XVIII and the Federal Hospital Insurance Trust Fund, respectively.

''(d) CONFORMING PROVISIONS.—Beginning on January 1, 2004—

''(1) no additional amounts are authorized to be appropriated under section 1844(a); and

''(2) no amounts shall be deposited in, or appropriated to, the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Trust Fund.

''(e) CONFORMING REFERENCES.—Beginning on January 1, 2004, any reference in law or regulation (in effect before such date) to the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Trust Fund is deemed a reference to the Medicare Trust Fund.

''SEC. 2262. PROGRAMMATIC INSOLVENCY AND LIMITATION ON GENERAL REVENUE FINANCING.

''(a) ANNUAL DETERMINATIONS.—In addition to any other duties, the Board of Trustees of the Medicare Trust Fund (in this section referred to as the 'Board of Trustees') shall determine and report to Congress as part of its annual report each year the following:

''(1) The percentage of total expenditures from the Medicare Trust Fund that is financed by the general revenue contributions described in section 2261(b)(3).

''(2) The first fiscal year (if any) that the Medicare Trust Fund is projected to become programmatically insolvent (as defined in subsection (b)).

''(3) After taking into account the limitation described in subsection (c), the first fiscal year (if any) in which the amounts in the Medicare Trust Fund will be insufficient to pay for the total expenses incurred under title XVIII (as revised by this title).

''(b) PROGRAMMATIC INSOLVENCY DEFINED.—

''(1) IN GENERAL.—For purposes of this part, the Medicare Trust Fund shall be deemed to be 'programmatically insolvent' for a fiscal year if the amount appropriated to the Medicare Trust Fund under section 2261(b)(3) would, but for subsection (c), exceed 40 percent of the amount described in paragraph (2).

''(2) NET EXPENDITURES ON BASIC BENEFITS.—The amount described in this paragraph is, as estimated by the Board of Trustees in consultation with the Medicare Board and the Secretary of

the Treasury, the total expenditures from the Medicare Trust Fund in the fiscal year involved, reduced by an amount equal to the administrative expenses of the Medicare Board for that fiscal year.

''(c) LIMITATION ON GENERAL REVENUE FINANCING.—The amount of the appropriation provided in section 2261(b)(3) in a fiscal year may not exceed 40 percent of the amount described in subsection (b)(2).

''PART E—HCFA DUTIES AND RESPONSIBILITIES

''SEC. 2281. REORGANIZATION OF HCFA.

''(a) ESTABLISHMENT OF DIVISIONS.—

''(1) DIVISION OF HCFA-SPONSORED PLANS.—There is established within HCFA the Division of HCFA-Sponsored Plans.

''(2) DIVISION OF HEALTH PROGRAMS.—There is established within HCFA the Division of Health Programs.

''(b) ADMINISTRATION.—

''(1) IN GENERAL.—Each Division established under subsection (a) shall be administered by a Director appointed by the President with the advice and consent of the Senate. Level V of the Executive Schedule Pay Rates shall apply to each Director.

''(2) APPOINTMENT.—The President shall nominate a Director for each Division established

under subsection (a) by not later than 6 months after the date of enactment of this Act.

''(c) TRANSFER OF FUNCTIONS.—

''(1) DIVISION OF HCFA-SPONSORED PLANS.—There are transferred to the Division of HCFA-Sponsored Plans all functions relating to health care benefits that are made available under title XVIII through the original fee-for-service program (referred to in section 1851(a)(1)(A)) which HCFA exercised on the day before the date of enactment of this title (including all related functions of any officer or employee of HCFA).

''(2) DIVISION OF HEALTH PROGRAMS.—There are transferred to the Division of Health Programs all functions which HCFA exercised on the day before the date of enactment of this title which are not transferred under paragraph (1) to the Division of HCFA-Sponsored Plans, including functions relating to the following:

''(A) The administration of the Medicaid Program under title XIX.

''(B) The administration of the State children's health insurance program under title XXI.

"(C) Federal support of graduate medical education.

"(D) Federal support of hospitals that serve a significantly disproportionate number of patients who have low income.

"(3) DETERMINATION OF CERTAIN FUNCTIONS.—If necessary, the Office of Management and Budget shall make any determination of the functions that are transferred under paragraphs (1) and (2).

"(4) DEFINITION OF FUNCTION.—In this section, the term 'function' means any duty, obligation, power, authority, responsibility, right, privilege, activity, or program.

"(5) OFFICE.—The term 'office' includes any office, administration, agency, institute, unit, organizational entity, or component thereof.

"(d) PERSONNEL.—

"(1) APPOINTMENTS.—Each Director appointed in accordance with subsection (b) may appoint and fix the compensation of such officers and employees, including investigators, attorneys, and administrative law judges, as may be necessary to carry out the respective functions transferred under subsection (c). Except as otherwise provided by law,

such officers and employees shall be appointed in accordance with the civil service laws and their compensation fixed in accordance with title 5, United States Code.

''(2) EXPERTS AND CONSULTANTS.—Each such Director may—

''(A) obtain the services of experts and consultants in accordance with section 3109 of title 5, United States Code, and compensate such experts and consultants for each day (including travel time) at rates not in excess of the rate of pay for level IV of the Executive Schedule under section 5315 of such title; and

''(B) pay experts and consultants who are serving away from their homes or regular place of business travel expenses and per diem in lieu of subsistence at rates authorized by sections 5702 and 5703 of such title for persons in Government service employed intermittently.

''(e) DELEGATION AND ASSIGNMENT.—Except where otherwise expressly prohibited by law or otherwise provided by this section, each Director appointed in accordance with subsection (b) may delegate any of the functions transferred to the Director under subsection (c) and any function transferred or granted to such Director after the

effective date of this title to such officers and employees of the Division headed by such Director as the Director may designate, and may authorize successive redelegations of such functions as may be necessary or appropriate. No delegation of functions by the Director of the Division of HCFA-Sponsored Plans or the Division of Health Programs under this paragraph or under any other provision of law shall relieve such Director of responsibility for the administration of such functions.

''(f) REORGANIZATION.—Each Director appointed in accordance with subsection (b) may allocate or reallocate any function transferred under subsection (c) among the officers of the Division headed by the Director, and to establish, consolidate, alter, or discontinue such organizational entities in the Division as may be necessary or appropriate.

''(g) RULES.—Each Director appointed in accordance with subsection (b) may prescribe, in accordance with the provisions of chapters 5 and 6 of title 5, United States Code, such rules and regulations as such Director determines are necessary or appropriate to administer and manage the functions of the Division headed by the Director.

''(h) TRANSFER AND ALLOCATIONS OF APPROPRIATIONS AND PERSONNEL.—Except as otherwise provided

in this section, the personnel employed in connection with, and the assets, liabilities, contracts, property, records, and unexpended balances of appropriations, authorizations, allocations, and other funds employed, used, held, arising from, available to, or to be made available in connection with the functions transferred under subsection (c), subject to section 1531 of title 31, United States Code, shall be transferred to the Division of HCFA-Sponsored Plans or the Division of Health Programs, as appropriate. Unexpended funds transferred pursuant to this subsection shall be used only for the purposes for which the funds were originally authorized and appropriated.

''(i) INCIDENTAL TRANSFERS.—The Director of the Office of Management and Budget, at such time or times as the Director shall provide, is authorized to make such determinations as may be necessary with regard to the functions transferred by subsection (c), and to make such additional incidental dispositions of personnel, assets, liabilities, grants, contracts, property, records, and unexpended balances of appropriations, authorizations, allocations, and other funds held, used, arising from, available to, or to be made available in connection with such functions, as may be necessary to carry out the provisions of this section. The Director of the Office of Management and Budget shall provide for the termination of the affairs

of all entities terminated by this section and for such further measures and dispositions as may be necessary to effectuate the purposes of this section.

''(j) EFFECT ON PERSONNEL.—

''(1) IN GENERAL.—Except as otherwise provided by this section, the transfer pursuant to this section of full-time personnel (except special Government employees) and part-time personnel holding permanent positions shall not cause any such personnel to be separated or reduced in grade or compensation for 1 year after the date of transfer of such personnel under this section.

''(2) EXECUTIVE SCHEDULE POSITIONS.—Except as otherwise provided in this section, any person who, on the day preceding the effective date of this title, held a position compensated in accordance with the Executive Schedule prescribed in chapter 53 of title 5, United States Code, and who, without a break in service, is appointed in the Division of HCFA-Sponsored Plans or the Division of Health Programs to a position having duties comparable to the duties performed immediately preceding such appointment shall continue to be compensated in such new position at not less than the rate provided for

such previous position, for the duration of the service of such person in such new position.

''(k) SAVINGS PROVISIONS.—

''(1) CONTINUING EFFECT OF LEGAL DOCUMENTS.—All orders, determinations, rules, regulations, permits, agreements, grants, contracts, certificates, licenses, registrations, privileges, and other administrative actions—

''(A) which have been issued, made, granted, or allowed to become effective by the President, any Federal agency or official thereof, or by a court of competent jurisdiction, in the performance of functions which are transferred under subsection (c); and

''(B) which are in effect at the time this title takes effect, or were final before the effective date of this title and are to become effective on or after the effective date of this title,

shall continue in effect according to their terms until modified, terminated, superseded, set aside, or revoked in accordance with law by the President, the Director of the Division of HCFA-Sponsored Plans or the Director of the Division of Health Programs (as appropriate) or other authorized official, a court of competent jurisdiction, or by operation of law.

''(2) PROCEEDINGS NOT AFFECTED.—The provisions of this section shall not affect any proceedings, including notices of proposed rulemaking, or any application for any license, permit, certificate, or financial assistance pending before HCFA at the time this title takes effect, with respect to functions transferred by subsection (c), and such proceedings and applications shall be continued. Orders shall be issued in such proceedings, appeals shall be taken therefrom, and payments shall be made pursuant to such orders, as if this section had not been enacted, and orders issued in any such proceedings shall continue in effect until modified, terminated, superseded, or revoked by a duly authorized official, by a court of competent jurisdiction, or by operation of law. Nothing in this paragraph shall be deemed to prohibit the discontinuance or modification of any such proceeding under the same terms and conditions and to the same extent that such proceeding could have been discontinued or modified if this section had not been enacted.

''(3) SUITS NOT AFFECTED.—The provisions of this section shall not affect suits commenced before the effective date of this title, and in all such suits, proceedings shall be had, appeals taken, and judg-

ments rendered in the same manner and with the same effect as if this section had not been enacted.

''(4) NONABATEMENT OF ACTIONS.—No suit, action, or other proceeding commenced by or against HCFA or by or against any individual in the official capacity of such individual as an officer of HCFA, shall abate by reason of enactment of this section.

''(5) ADMINISTRATIVE ACTIONS RELATING TO PROMULGATION OF REGULATIONS.—Any administrative action relating to the preparation or promulgation of a regulation by HCFA relating to a function transferred under this section may be continued by the Division of HCFA-Sponsored Plans or the Division of Health Programs (as appropriate) with the same effect as if this section had not been enacted.

''(l) SEPARABILITY.—If a provision of this section or its application to any person or circumstance is held invalid, neither the remainder of this section nor the application of the provision to other persons or circumstances shall be affected.

''(m) TRANSITION.—Each Director appointed in accordance with subsection (b) may utilize—

''(1) the services of such officers, employees, and other personnel of the Department of Health and Human Services with respect to functions trans-

ferred to the Division of HCFA-Sponsored Plans or the Division of Health Programs under subsection (c); and

''(2) funds appropriated to such functions for such period of time as may reasonably be needed to facilitate the orderly implementation of this section.

''(n) REFERENCES.—Reference in any other Federal law, Executive order, rule, regulation, or delegation of authority, or any document of or relating to HCFA with regard to functions transferred under subsection (c), shall be deemed to refer to the Division of HCFA-Sponsored Plans, the Director of the Division of HCFA-Sponsored Plans, the Division of Health Programs, or the Director of the Division of Health Programs, as appropriate.

''SEC. 2282. ESTABLISHMENT OF HCFA-SPONSORED PLANS.

''(a) ESTABLISHMENT.—

''(1) IN GENERAL.—Beginning on January 1, 2004, the Director of the Division of HCFA-Sponsored Plans of HCFA (in this section referred to as the ''Director'') shall offer the Medicare plans described in paragraph (2).

''(2) HCFA-SPONSORED PLANS.—

''(A) HCFA-SPONSORED STANDARD PLANS.—The Director shall offer 1 standard Medicare plan throughout the United States,

which shall include only the core benefits under section 2202(a).

''(B) HCFA-SPONSORED HIGH OPTION PLANS.—The Director shall offer at least 1 high option Medicare plan in each area within the United States, which shall include only—

''(i) the core benefits under section 2202(a);

''(ii) the outpatient prescription drug benefit under section 2202(b), which shall be provided in accordance with section 2283; and

''(iii) stop-loss coverage under section 2202(c).

''(3) APPROVAL OF HCFA-SPONSORED PLANS.—

''(A) IN GENERAL.—Except as otherwise provided in this title, the HCFA-sponsored plans shall be subject to the provisions of this title in the same manner as other Medicare plans, including the requirement that the Director submit information regarding each HCFA-sponsored plan to be offered pursuant to section 2222 and the required Board approval of such plans pursuant to section 2223.

''(B) PREMIUM BID APPROVAL.—The premiums submitted under section 2222 for the HCFA-sponsored standard plan and each HCFA-sponsored high option plan shall be computed separately to ensure that the HCFA-sponsored standard plan and each HCFA-sponsored high option plan is separately self-sustaining, without cross subsidies between the plans.

''(b) FINANCIAL PROVISIONS.—

''(1) ASSUMPTION OF FINANCIAL RISK.—Except as provided in section 2283(c), the Division of HCFA-Sponsored Plans of HCFA shall bear full financial risk for the provision of services under the HCFA-sponsored plans in the same manner as a Medicare+Choice organization bears full financial risk for a Medicare+Choice plan that it offers under section 1855(b). In assuming such risk, the Division of HCFA-Sponsored Plans may ensure continued solvency of such plans through improvements in the efficiency and economy of the HCFA-sponsored plans.

''(2) FUNDING.—

''(A) IN GENERAL.—In order to provide for capital for the HCFA-sponsored plans prior

to January 1, 2004, the Board of Trustees of the Federal Hospital Insurance Trust Fund, at the direction of the Medicare Board, shall transfer from such Trust Fund to the Division of HCFA-Sponsored Plans of HCFA such amounts as may be necessary to provide for the following:

''(i) INITIAL CAPITALIZATION ACCOUNT.—Amounts that may be required for the initial organization of HCFA-sponsored plans.

''(ii) WORKING CAPITAL (CASH FLOW) ACCOUNT.—Amounts that may be required as working capital in order to assure timely payment of obligations by such plans.

''(iii) CONTINGENCY RESERVE.—Reasonable amounts that should be held in reserve to cover actuarial contingencies.

''(B) ESTABLISHMENT OF AMOUNTS.—The amounts described in subparagraph (A) shall be established by the Director and are subject to review and approval by the Medicare Board.

''(C) AMOUNT OF CONTINGENCY RESERVE.—In reviewing and approving the amount of the contingency reserve described in

subparagraph (A)(iii), the Medicare Board shall consider similar amounts required for health insurance coverage offered under State law, taking into account differences between the different actuarial risks and demographic characteristics of the populations being served.

''(3) SEPARATE ACCOUNT.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Division of HCFA-Sponsored Plans of HCFA shall maintain the amounts transferred under this paragraph in a separate account, which shall only be available for expenses associated with the establishment and operation of the HCFA-sponsored plans.

''(B) LIMITATION.—Except as provided in section 2281(h) (relating to transfer of appropriations in connection with functions transferred to the Division of HCFA-Sponsored Plans under such section), and section 2261(b)(4) (relating to obligations of the part A and part B trust funds), no funds from the Medicare Trust Fund may be appropriated to the Division of HCFA-Sponsored Plans of HCFA.

"SEC. 2283. PARTNERSHIPS WITH PRIVATE ENTITIES TO OFFER HCFA-SPONSORED HIGH OPTION PLANS.

''(a) PARTNERSHIPS.—

''(1) IN GENERAL.—The Director of the Division of HCFA-Sponsored Plans of HCFA (in this section referred to as the 'Director') shall contract with private entities for the provision of outpatient prescription drug benefits under a HCFA-sponsored high option plan.

''(2) PRIVATE ENTITIES.—The private entities described in paragraph (1) shall include insurers (including issuers of Medicare supplemental policies under section 1882), pharmaceutical benefit managers, chain pharmacies, groups of independent pharmacies, and other private entities that the Medicare Board determines are appropriate.

''(3) AREAS.—The Director may award a contract to a private entity under this section on a local, regional, or national basis.

''(4) DRUG BENEFITS ONLY THROUGH PRIVATE ENTITIES.—Drug benefits under a HCFA-sponsored high option plan shall only be offered through a contract with a private entity under this section.

''(b) DIRECTOR REQUIRED TO CONTRACT WITH ANY WILLING QUALIFIED PRIVATE ENTITY.—The Director

may not exclude a private entity from receiving a contract to provide outpatient prescription drug benefits under a HCFA-sponsored high option plan if—

''(1) the private entity meets all of the requirements established by the Medicare Board for providing such benefits; and

''(2) the Medicare Board approves the partnership.

''(c) PRIVATE ENTITY AT FINANCIAL RISK.—A private entity with a contract under this section shall bear full financial risk for the provision of outpatient prescription drug benefits under a HCFA-sponsored high option plan. The Division of HCFA-Sponsored Plans of HCFA shall bear no financial risk for the provision of such benefits.

''SEC. 2284. HCFA BUSINESS PLANNING AND ADMINISTRATIVE FLEXIBILITY.

''(a) SUBMISSION OF BUSINESS PLAN.—

''(1) IN GENERAL.—On January 1 of each year (but not later than January 1, 2003), the Director of the Division of HCFA-Sponsored Plans of HCFA (in this section referred to as the 'Director') shall submit a business plan on the operation of the HCFA-sponsored standard and high-option plans to—

''(A) both Houses of Congress;

''(B) the Director of the Congressional Budget Office;

''(C) the Comptroller General of the United States; and

''(D) the Chairman of the Medicare Payment Advisory Commission.

''(2) BUSINESS PLAN.—The business plan on the operation of the HCFA-sponsored standard and high-option plans described in paragraph (1) shall include—

''(A) a comprehensive payment and management plan for all aspects of offering the core benefits under such plans;

''(B) information regarding contracts with private entities under section 2283 for the provision of outpatient prescription drug benefits under HCFA-sponsored high option plans;

''(C) recommendations for the coordination of, and improvements to, benefits provided under the HCFA-sponsored standard and high-option plans; and

''(D) a legislative proposal that implements the business plan.

''(b) MAINTAINING INDEPENDENCE.—

''(1) EXEMPTION FROM OMB OVERSIGHT.—The Director may directly submit the business plan under subsection (a) to Congress and the individuals described in subparagraphs (B) through (D) of subsection (a)(1). No officer or agency of the United States may require the Director to submit such plan to any officer or agency of the United States for approval, comments, or review, prior to the submission of the plan to Congress and such individuals.

''(2) EXEMPTION FROM APA REQUIREMENTS.—Any action of the Director in preparing or submitting the business plan under subsection (a) to Congress and the individuals described in subparagraphs (B) through (D) of subsection (a)(1) shall be exempt from the requirements of subchapter 2 of chapter 5 of title 5, United States Code (commonly known as the 'Administrative Procedure Act').

''(c) COMMENTS.—

''(1) IN GENERAL.—Not later than 60 days after the date on which the Director submits the business plan under subsection (a) to the individuals described in subparagraphs (B) through (D) of subsection (a)(1), such individuals shall independently submit comments on such plan to Congress. Such comments should address the impact that the plan

would have on costs, providers, and beneficiary access to care under the medicare program.

''(2) OPPORTUNITY FOR PUBLIC COMMENT.—The Director shall establish a procedure that allows for public comment on the business plan and shall submit to Congress a summary of such comments not later than the date described in paragraph (1).

''(d) CONGRESSIONAL HEARINGS.—Each year that the business plan is submitted to Congress pursuant to subsection (a)(1), the appropriate committees of Congress shall hold hearings on such plan.

''(e) FAST-TRACK CONSIDERATION OF BUSINESS PLAN LEGISLATION.—

''(1) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This subsection is enacted by Congress—

''(A) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and is deemed a part of the rules of each House of Congress, but—

''(i) is applicable only with respect to the procedure to be followed in that House of Congress in the case of an implementing bill (as defined in paragraph (4)); and

''(ii) supersedes other rules only to the extent that such rules are inconsistent with this section; and

''(B) with full recognition of the constitutional right of either House of Congress to change the rules (so far as relating to the procedure of that House of Congress) at any time, in the same manner and to the same extent as in the case of any other rule of that House of Congress.

''(2) INTRODUCTION AND REFERRAL.—

''(A) INTRODUCTION.—

''(i) IN GENERAL.—Subject to subparagraph (B), on the day on which the Director submits the business plan required to be submitted on January 1, 2006, pursuant to subsection (a)(1) to the House of Representatives and the Senate, the legislative proposal contained in such plan shall be introduced as a bill (by request) in the following manner:

''(I) HOUSE OF REPRESENTATIVES.—In the House of Representatives, by the Majority Leader, for himself and the Minority Leader, or

by Members of the House of Representatives designated by the Majority Leader and Minority Leader.

''(II) SENATE.—In the Senate, by the Majority Leader, for himself and the Minority Leader, or by Members of the Senate designated by the Majority Leader and Minority Leader.

''(ii) SPECIAL RULE.—If either House of Congress is not in session on the day on which the business plan is submitted, the legislative proposal contained in such plan shall be introduced as a bill in that House of Congress, as provided in subparagraph (A), on the first day thereafter on which that House of Congress is in session.

''(B) REFERRAL.—Such bills shall be referred by the presiding officers of the respective Houses to the appropriate committee, or, in the case of a bill containing provisions within the jurisdiction of 2 or more committees, jointly to such committees for consideration of those provisions within their respective jurisdictions.

''(3) CONSIDERATION.—After the legislative proposal has been introduced as a bill and referred

under paragraph (2), such implementing bill shall be considered in the same manner as an implementing bill is considered under subsections (d), (e), (f), and (g) of section 151 of the Trade Act of 1974 (19 U.S.C. 2191).

''(4) IMPLEMENTING BILL DEFINED.—In this section, the term 'implementing bill' means only the legislative proposal contained in the business plan required to be submitted on January 1, 2006, by the Director to the House of Representatives and the Senate under subsection (a)(1), and introduced and referred as provided in paragraph (2) as a bill of either House of Congress.

''(5) COUNTING OF DAYS.—For purposes of this section, any period of days referred to in section 151 of the Trade Act of 1974 shall be computed by excluding—

''(A) the days on which either House of Congress is not in session because of an adjournment of more than 3 days to a day certain or an adjournment of Congress sine die; and

''(B) any Saturday and Sunday, not excluded under subparagraph (A), when either House is not in session.

''(f) IMPLEMENTATION OF BUSINESS PLANS SUBMITTED AFTER 2008.—Beginning with the business plan required to be submitted on January 1, 2009, under subsection (a)(1), the Director may implement the provisions of such plan without further legislative action.''.

TITLE II—SPECIAL PROTECTIONS

Subtitle A—Protection Package for Certain Areas

SEC. 201. LIMITATION ON BENEFICIARY OBLIGATIONS IN CERTAIN AREAS.

Section 2227(a) of the Social Security Act, as added by section 101, is amended—

(1) in paragraph (3), by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively;

(2) by redesignating paragraphs (1) through (3) as subparagraphs (A) through (C), respectively;

(3) by striking ''(a) COMPUTATION OF BENEFICIARY OBLIGATION.—Subject to subsection (b),'' and inserting the following:

''(a) COMPUTATION OF BENEFICIARY OBLIGATION.—

''(1) IN GENERAL.—Subject to subsection (b),''; and

(4) by adding at the end the following:

''(2) LIMITATION ON BENEFICIARY OBLIGATIONS IN CERTAIN AREAS.—Notwithstanding paragraph (1), if the only Medicare plans offered in a service area are the HCFA-sponsored plans—

''(A) the beneficiary obligation for the HCFA-sponsored standard plan shall not exceed the applicable percent for the year (as determined under paragraph (1)(C)) of the national average premium; and

''(B) the beneficiary obligation for any HCFA-sponsored high option plan shall not exceed the sum of—

''(i) the applicable percent for the year (as so determined) of the national average premium; and

''(ii) the amount by which the beneficiary obligation for the HCFA-sponsored high option plan exceeds the beneficiary obligation for the HCFA-sponsored standard plan.''.

SEC. 202. GUARANTEE OF OUTPATIENT PRESCRIPTION DRUGS UNDER HCFA-SPONSORED HIGH OPTION PLANS.

Section 2283 of the Social Security Act, as added by section 101, is amended—

(1) in subsection (a)(4), by striking ''Drug benefits'' and inserting ''Except as provided in subsection (d), drug benefits''; and

(2) by adding at the end the following:

''(d) PROTECTION FOR AREAS WITH NO CONTRACT WITH A PRIVATE ENTITY IN EFFECT.—In the case of an area where no private entity has entered into a contract with the Director for the provision of outpatient prescription drug benefits under a HCFA-sponsored high option plan, the Medicare Board shall establish an arrangement through which the Board guarantees to Medicare beneficiaries enrolled in such plan the coverage for outpatient prescription drugs required under section 2282.''.

Subtitle B—Low-Income Medicare Beneficiary Protection Package

SEC. 251. MEDICARE PLANS FOR LOW-INCOME MEDICARE BENEFICIARIES.

(a) IN GENERAL.—Title XXII of the Social Security Act, as added by section 101, is amended—

(1) by redesignating section 2229 as 2230; and

(2) by inserting after section 2228 the following:

"SEC. 2229. MEDICARE PLANS FOR LOW-INCOME MEDICARE BENEFICIARIES.

"(a) ENROLLMENT IN A MEDICARE PLAN.—

"(1) LOW-INCOME MEDICARE BENEFICIARY DEFINED.—For purposes of this part, the term 'low-income Medicare beneficiary' means a Medicare beneficiary whose income (as determined for purposes of section 1905(p)) does not exceed 135 percent of the official poverty line (referred to in paragraph (2)(A) of such section) applicable to a family of the size involved.

"(2) ZERO BENEFICIARY PREMIUM OBLIGATION FOR THE LOWEST COST HIGH OPTION MEDICARE PLAN.—A low-income Medicare beneficiary shall have no obligation to pay any amount for enrollment in the lowest cost (for such year) high option Medicare plan that is available (including on the basis of capacity to deliver services to enrollees) for the service area in which such beneficiary resides.

"(3) BENEFICIARY OBLIGATION IN CASE OF ENROLLMENT IN A MEDICARE PLAN THAT IS NOT THE LOWEST COST HIGH OPTION MEDICARE PLAN.—If a low-income Medicare beneficiary enrolls in a Medi-

care plan other than the lowest cost high option Medicare plan available to the beneficiary (including a standard Medicare plan), the amount of the beneficiary obligation shall be the lesser of—

''(A) the amount of the beneficiary obligation computed under section 2227; or

''(B) the amount by which—

''(i) the amount of the premium approved by the Board under section 2223 for the Medicare plan in which the beneficiary is enrolled; exceeds

''(ii) the amount of the premium approved by the Board under such section for the lowest cost high option Medicare plan available to the beneficiary.

''(4) BOARD PAYMENTS TO PLANS.—Payments to Medicare plans in which low-income Medicare beneficiaries are enrolled shall be made in the same manner as payments are made to Medicare plans under section 2226.

''(5) COLLECTION OF BENEFICIARY OBLIGATION.—The Medicare Board shall collect any beneficiary obligation determined under paragraph (3) in the same manner as the Board collects such obligations under section 2228.

''(b) ANNUAL ELIGIBILITY AND ENROLLMENT DETERMINATION BY STATES.—

''(1) IN GENERAL.—The Medicare Board shall establish an arrangement with each State (as defined for purposes of title XIX) under which the State shall—

''(A) determine whether a Medicare beneficiary in the State is a low-income Medicare beneficiary; and

''(B) notify the Board of such determination and of the Medicare plan in which the beneficiary chooses to enroll for such year.

''(2) DURATION.—A determination that a Medicare beneficiary is a low-income Medicare beneficiary shall remain valid for a period of 12 months so long as the beneficiary remains enrolled in a Medicare plan.

''(3) FEDERAL FINANCIAL ASSISTANCE FOR ADMINISTRATIVE COSTS.—For provisions relating to Federal financial assistance for the administrative costs incurred by a State in conducting the activities described in paragraph (1) of this section, see section 1903(a)(7)(B).

''(c) CONTINUATION OF STATE CONTRIBUTION REQUIREMENTS.—With respect to each low-income Medicare

beneficiary enrolled in a Medicare plan for a year, each State shall pay (to the Medicare Board, Medicare plan, or a provider, as appropriate) the following:

''(1) DUAL ELIGIBLES.—In the case of such a beneficiary who is eligible for medical assistance under title XIX—

''(A) the lesser of—

''(i) the applicable percent for the year (as determined under section 2227(a)(1)(C)) of the national average premium determined under section 2225(a) for such year; or

''(ii) the amount of the beneficiary obligation computed under section 2227 for the HCFA-sponsored standard plan for the service area in which the beneficiary resides for such year;

''(B) all coinsurance, deductibles, and cost-sharing imposed under the Medicare plan in which the beneficiary is enrolled;

''(C) any additional costs incurred by the beneficiary in excess of the stop-loss coverage for the core benefits provided under the Medicare plan in which the beneficiary is enrolled; and

''(D) to the extent consistent with the State plan under title XIX, any additional costs incurred by the beneficiary for outpatient prescription drugs in excess of the limit (if any) imposed for coverage of such drugs under the Medicare plan in which the beneficiary is enrolled.

''(2) QMBS, SLMBS, QI–IS.—

''(A) QMBS.—In the case of such a beneficiary who is described in section 1905(p)(1)—

''(i) the amount determined under paragraph (1)(A) of this section for such beneficiary; and

''(ii) all coinsurance, deductibles, and cost-sharing imposed under the Medicare plan in which the beneficiary is enrolled other than with respect to coverage of outpatient prescription drugs.

''(B) SLMBS, QI–IS.—In the case of such a beneficiary who is described in clause (iii) or clause (iv)(I) of section 1902(a)(10)(E), the amount determined under paragraph (1)(A) of this section for such beneficiary.

''(3) FEDERAL FINANCIAL ASSISTANCE FOR STATE CONTRIBUTIONS.—For payment of the Fed-

eral medical assistance percentage (as defined in section 1905(b)) of the payments made by a State under this subsection, see section 1903(a)(1)(B).

''(4) NONAPPLICATION OF OTHER STATE CONTRIBUTION REQUIREMENTS UNDER MEDICAID.—Insofar as this subsection applies to a low-income Medicare beneficiary, notwithstanding any other provision of law—

''(A) a State is not required to provide such beneficiary under a State plan under title XIX medical assistance with respect to Medicare cost-sharing described in section 1905(p)(3) that would otherwise be required to be provided under such plan to the beneficiary; and

''(B) except as provided in paragraphs (1)(B) and (7)(B) of section 1903(a), Federal financial assistance shall not be available under section 1903 with respect to any Medicare cost-sharing provided for such beneficiary.

''(5) NO EFFECT ON OTHER FMAP.—Nothing in this section shall be construed as limiting the ability of a State to receive Federal financial assistance under section 1903 for medical assistance (other than Medicare cost-sharing, insofar as the State's

requirement to provide Medicare cost-sharing to a low-income Medicare beneficiary is modified by this section) provided to a low-income Medicare beneficiary who is eligible for medical assistance under the State plan under title XIX.''.

(b) CONFORMING AMENDMENTS.—

(1) FEDERAL FINANCIAL ASSISTANCE.—Section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) is amended—

(A) in paragraph (1), by striking ''quarter as medical assistance under the State plan; plus'' and inserting ''quarter—

''(A) as medical assistance under the State plan; and

''(B) under section 2229(c); plus''; and

(B) in paragraph (7)—

(i) by striking ''of the remainder'' and inserting ''of—

''(A) the remainder'';

(ii) by striking the period and inserting ''; and''

(iii) by adding at the end the following:

''(B) the amounts expended during such quarter to conduct the activities described in section 2229(b)(1).''.

(2) STUDY AND REPORT TO CONGRESS REGARDING TRANSITION PERIOD.—Section 2201(c)(3)(A)(ii) of the Social Security Act, as added by section 101, is amended by inserting ''(and, if applicable, under section 2229)'' after ''under section 2227''.

(3) AMOUNTS IN MEDICARE TRUST FUND.—Section 2261(b)(3)(B) of such Act, as so added, is amended by striking ''section 2227'' and inserting ''sections 2227 and 2229''.

TITLE III—MEDICARE BENEFICIARY OUTREACH AND EDUCATION

SEC. 301. MEDICARE CONSUMER COALITIONS.

(a) ESTABLISHMENT OF MEDICARE CONSUMER COALITIONS.—The Medicare Board (as defined in section 2200(d)(4) of the Social Security Act) shall establish Medicare Consumer Coalitions (as defined in subsection (b)) to conduct information programs in accordance with subsection (e) that—

(1) prepare comprehensive, accurate, and understandable information for Medicare beneficiaries

(as defined in section 2200(d)(3) of such Act) on enrollment in Medicare plans (as defined in section 2200(c)(1) of such Act); and

(2) disseminate such information to Medicare beneficiaries in a timely fashion.

(b) MEDICARE CONSUMER COALITION DEFINED.—In this section, the term ''Medicare Consumer Coalition'' means an entity that is a nonprofit organization operated under the direction of a board of directors that is primarily composed of Medicare beneficiaries.

(c) ESTABLISHMENT OF MEDICARE CONSUMER COALITIONS.—The Board shall—

(1) develop and disseminate a request for proposals to establish Medicare Consumer Coalitions in such areas as the Board determines appropriate to conduct the information programs described in subsection (a); and

(2) select a proposal to establish a Medicare Consumer Coalition to conduct the information programs in each such area, with a preference for broad participation by organizations with experience in providing information to Medicare beneficiaries.

(d) PAYMENT TO MEDICARE CONSUMER COALITIONS.—The Board shall pay to each Medicare Consumer

Coalition established under subsection (c) an amount equal to the sum of any costs incurred—

(1) in conducting the information programs under subsection (a); and

(2) in the hiring of staff to conduct the information programs under such subsection.

(e) INFORMATION PROGRAMS.—

(1) CONTENTS.—The information programs under subsection (a) shall include a comparison among available Medicare plans as follows:

(A) BENEFITS.—A comparison of the benefits provided under each Medicare plan.

(B) QUALITY AND PERFORMANCE.—The quality and performance of each Medicare plan.

(C) BENEFICIARY COSTS.—The costs to Medicare beneficiaries enrolled under each Medicare plan.

(D) CONSUMER SATISFACTION SURVEYS.—The results of consumer satisfaction surveys regarding each Medicare plan.

(E) ADDITIONAL INFORMATION.—Such additional information as the Board may prescribe.

(2) INFORMATION STANDARDS.—The Board shall develop standards to ensure that the informa-

tion provided to Medicare beneficiaries under the information programs is complete, accurate, and uniform.

(3) REVIEW OF INFORMATION.—

(A) IN GENERAL.—Subject to subparagraph (B), the Board may prescribe the procedures and conditions under which a Medicare Consumer Coalition may disseminate information to Medicare beneficiaries to ensure the coordination of Federal, State, and local outreach efforts to Medicare beneficiaries.

(B) DEADLINE.—Any information proposed to be furnished to Medicare beneficiaries under this section shall be submitted to the Board not later than 45 days before the date on which the information is to be disseminated to such beneficiaries.

(4) CONSULTATION.—In order to conduct the information programs under subsection (a), Medicare Consumer Coalitions shall consult with entities that offer Medicare plans, and public and private purchasers of health care benefits.

(f) MONITORING AND REPORT.—

(1) MONITORING.—The Board shall closely monitor and measure the impact of Medicare Consumer Coalitions on—

(A) the premiums of Medicare plans in such area;

(B) the quality of items and services covered under any such Medicare plan;

(C) the access of Medicare beneficiaries to items and services covered under the Medicare plan in such area;

(D) the choice of Medicare plans in such area;

(E) changes in enrollment in Medicare plans in such area; and

(F) such other factors as the Board determines appropriate.

(2) REPORT.—Not later than December 31, 2004, the Board shall submit to the appropriate committees of Congress a report on the aspects of Medicare Consumer Coalitions monitored under paragraph (1), together with an assessment of the outreach efforts conducted under this section.

(g) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated to carry out this section such sums as may be necessary.

(2) DEPOSIT INTO MEDICARE TRUST FUND.—Sums appropriated under paragraph (1) shall be transferred to the Medicare Trust Fund.

(h) EFFECTIVE DATE.—The Board shall establish the Medicare Consumer Coalitions under this section in a timely manner that ensures the information programs conducted by Medicare Consumer Coalitions begin not later than January 1, 2004.

TITLE IV—MISCELLANEOUS

SEC. 401. CONFORMING AMENDMENTS.

(a) EXECUTIVE SCHEDULE PAY RATES.—Section 5316 of title 5, United States Code, is amended by adding at the end the following:

''Director, Division of HCFA-Sponsored Plans, Health Care Financing Administration.

''Director, Division of Health Programs, Health Care Financing Administration.''.

(b) SUBMISSION OF ADDITIONAL CONFORMING AMENDMENTS.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall submit a legislative proposal to Con-

gress containing technical and conforming amendments to reflect the changes made by this Act.

SEC. 402. MEDICARE SUPPLEMENTAL POLICIES.

Notwithstanding section 1882 of the Social Security Act (42 U.S.C. 1395ss), beginning on January 1, 2004, only Medicare beneficiaries enrolled in the HCFA-sponsored standard plan established under section 2282(a)(2)(A) may purchase or renew Medicare supplemental insurance policies.

SEC. 403. EFFECTIVE DATE.

Unless otherwise specified in this Act, this Act and the amendments made by this Act shall take effect on the date of enactment of this Act.

○