107TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPT. 107–550
Part 1

MEDICARE MODERNIZATION AND PRESCRIPTION DRUG ACT OF 2002 (TITLE II & IV: MEDICARE+CHOICE REVITALIZATION AND COMPETITION PROGRAM; PROVISIONS RELATING TO PART A)

JUNE 26, 2002.—Ordered to be printed

Mr. TAUZIN, from the Committee on Energy and Commerce, submitted the following

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 4985]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 4985) to amend title XVIII of the Social Security Act to revitalize the Medicare+Choice program, establish a Medicare+Choice competition program, and to improve payments to hospitals and other providers under part A of the medicare program, having considered the same report favorably thereon without amendment and recommend that the bill do pass.

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99–006

PURPOSE AND SUMMARY

The purpose of H.R. 4985 is to stabilize and revitalize the Medicare+Choice program. The bill also begins the first stage of modernizing the Medicare program by instituting a bidding system for health plans that participate in Medicare. It also creates demonstration programs that place private plans on a level playing field with the traditional Medicare fee-for-service program. H.R. 4985 also makes needed updates to Medicare inpatient hospital reimbursements.

BACKGROUND AND NEED FOR LEGISLATION

In 1997, Congress passed the Balanced Budget Act (BBA) of 1997, which included the creation of the Medicare+Choice program. This legislation redesigned the system for setting Medicare payment rates for managed health care plans that contract with Medicare. The goals in creating Medicare+Choice were to expand health plans to markets where access to managed care plans was limited or nonexistent, and to offer new types of health plans in all areas.

Medicare+Choice is an important program for many seniors in the Medicare program. Currently, about 5.8 million, or about 15.6 percent of beneficiaries, are enrolled in a Medicare+Choice plan. This amount is less than were enrolled last year when about 17% of Medicare beneficiaries were enrolled in Medicare+Choice. The precipitous decline in Medicare+Choice enrollment is largely due to the significant number of health plans, about 316, that have left the program or significantly reduced benefits in the last three years.

Medicare+Choice plans have left the program for a variety of reasons. One of the reasons plans have left is related to inadequate payment from Medicare, in combination with rising provider cost increases and difficulties in maintaining adequate provider networks. In 2001, the vast majority of plans received their reimbursement through the minimum update payment methodology. Unfortunately, these minimum increases in reimbursement lag considerably behind the medical inflation rate, and more importantly, the payment increases received by fee-for service providers in the same counties. Another complicating factor in keeping Medicare+Choice plans in the program has been the complicated and burdensome regulatory environment. Therefore, it is critical to infuse the program with additional resources to ensure that beneficiaries will continue to have a choice in their health plans.

Today, Medicare covers just over half of the average senior's annual medical expenses and the benefits package is lacking. For instance, the benefit is administered in two separate parts (Parts A and B), has split deductibles based on the location of service and lacks many important health benefits. It takes months and sometimes years for the program to cover new medical treatments, and often covering new treatments requires an act of Congress.

In order to sustain Medicare and modernize the program a new structure for the program is needed. The Committee has held several hearings on methods to modernize the program. In particular, some people have expressed interest in moving to a system that would be similar to the Federal Employees Health Benefits Plan (FEHBP). Under this structure beneficiaries would pick from a

number of competing plans that offer comprehensive benefits. Health plans would be paid based on bids in comparison to the fee-for-service benchmark payment amounts.

HEARINGS

The Committee on Energy and Commerce has not held hearings on this legislation.

COMMITTEE CONSIDERATION

On Friday, June 21, 2002, the Full Committee met in open mark-up session and favorably ordered reported a Committee Print on Medicare+Choice Revitalization and Medicare+Choice Competition Program, by a roll call vote of 26 yeas and 15 nays, without amendment, a quorum being present. Chairman Tauzin then introduced H.R. 4985 to reflect the Committee's action.

COMMITTEE VOTES

Clause 3(b) of Rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. The following are the recorded votes taken on the motion by Mr. Tauzin to order H.R. 4985 reported to the House, and on the amendments offered to the measure, including the names of those members voting for and against.

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 56

BILL: H.R. 4985, Medicare+Choice Revitalization and Medicare+Choice Competition Program.

AMENDMENT: An amendment offered by Mr. Pallone, No. 1, to eliminate the Medicare+Choice premium support.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 17 yeas to 26 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Markey	X		
Mr. Upton		X		Mr. Hall			
Mr. Stearns				Mr. Boucher			
Mr. Gillmor				Mr. Towns	X		
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox				Mr. Brown	X		
Mr. Deal		X		Mr. Gordon			
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Ganske		X		Ms. Eshoo			
Mr. Norwood		X		Mr. Stupak	X		
Mrs. Cubin		X		Mr. Engel			
Mr. Shimkus		X		Mr. Sawyer	X		
Mrs. Wilson		X		Mr. Wynn			
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy			
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt				Ms. DeGette	X		
Mr. Davis		X		Mr. Barrett	X		
Mr. Bryant		X		Mr. Luther	X		
Mr. Ehrlich		X		Ms. Capps	X		
Mr. Buyer		X		Mr. Doyle	X		
Mr. Radanovich				Mr. John			
Mr. Bass		X		Ms. Harman			
Mr. Pitts		X					
Ms. Bono		X					
Mr. Walden		X					
Mr. Terry		X					
Mr. Fletcher		X					

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 57

BILL: H.R. 4985, Medicare+Choice Revitalization and Medicare+Choice Competition Program.

AMENDMENT: An amendment offered by Mr. Luther, No. 2, to increase the floor payment.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 18 yeas to 24 nays, and 1 present.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell			
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Markey	X		
Mr. Upton		X		Mr. Hall			
Mr. Stearns				Mr. Boucher			
Mr. Gillmor				Mr. Towns	X		
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon			
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Ganske	X			Ms. Eshoo			
Mr. Norwood		X		Mr. Stupak			X
Mrs. Cubin		X		Mr. Engel			
Mr. Shimkus		X		Mr. Sawyer	X		
Mrs. Wilson	X			Mr. Wynn			
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering	X			Ms. McCarthy			
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt				Ms. DeGette	X		
Mr. Davis				Mr. Barrett	X		
Mr. Bryant		X		Mr. Luther	X		
Mr. Ehrlich		X		Ms. Capps	X		
Mr. Buyer		X		Mr. Doyle	X		
Mr. Radanovich		X		Mr. John			
Mr. Bass		X		Ms. Harman			
Mr. Pitts		X					
Ms. Bono		X					
Mr. Walden		X					
Mr. Terry		X					
Mr. Fletcher		X					

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 58

BILL: H.R. 4985, Medicare+Choice Revitalization and Medicare+Choice Competition Program.

AMENDMENT: An amendment offered by Mr. Pallone, No. 5, to eliminate Medicare+Choice changes in part B premium.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 17 yeas to 27 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Markey	X		
Mr. Upton		X		Mr. Hall			
Mr. Stearns		X		Mr. Boucher			
Mr. Gillmor				Mr. Towns	X		
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon			
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Ganske		X		Ms. Eshoo			
Mr. Norwood				Mr. Stupak	X		
Mrs. Cubin		X		Mr. Engel			
Mr. Shimkus		X		Mr. Sawyer	X		
Mrs. Wilson		X		Mr. Wynn			
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy			
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt				Ms. DeGette	X		
Mr. Davis				Mr. Barrett	X		
Mr. Bryant		X		Mr. Luther	X		
Mr. Ehrlich		X		Ms. Capps	X		
Mr. Buyer		X		Mr. Doyle	X		
Mr. Radanovich		X		Mr. John			
Mr. Bass		X		Ms. Harman			
Mr. Pitts		X					
Ms. Bono		X					
Mr. Walden		X					
Mr. Terry		X					
Mr. Fletcher		X					

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 59

BILL: H.R. 4985, Medicare+Choice Revitalization and Medicare+Choice Competition Program.

MOTION: Motion offered by Mr. Tauzin to order H.R. 4985 reported to the House.

DISPOSITION: **AGREED TO**, by a roll call vote of 26 yeas to 15 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin	X			Mr. Dingell		X	
Mr. Bilirakis	X			Mr. Waxman		X	
Mr. Barton	X			Mr. Markey		X	
Mr. Upton	X			Mr. Hall			
Mr. Stearns				Mr. Boucher			
Mr. Gillmor				Mr. Towns		X	
Mr. Greenwood	X			Mr. Pallone		X	
Mr. Cox	X			Mr. Brown		X	
Mr. Deal	X			Mr. Gordon			
Mr. Burr	X			Mr. Deutsch			
Mr. Whitfield	X			Mr. Rush		X	
Mr. Ganske	X			Ms. Eshoo			
Mr. Norwood	X			Mr. Stupak		X	
Mrs. Cubin	X			Mr. Engel			
Mr. Shimkus	X			Mr. Sawyer		X	
Mrs. Wilson	X			Mr. Wynn			
Mr. Shadegg	X			Mr. Green			
Mr. Pickering	X			Ms. McCarthy			
Mr. Fossella	X			Mr. Strickland		X	
Mr. Blunt				Ms. DeGette		X	
Mr. Davis				Mr. Barrett		X	
Mr. Bryant				Mr. Luther		X	
Mr. Ehrlich	X			Ms. Capps		X	
Mr. Buyer	X			Mr. Doyle		X	
Mr. Radanovich	X			Mr. John			
Mr. Bass	X			Ms. Harman			
Mr. Pitts	X						
Ms. Bono	X						
Mr. Walden	X						
Mr. Terry	X						
Mr. Fletcher	X						

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of Rule XIII of the Rules of the House of Representatives, the Committee has not held oversight or legislative hearings on this legislation.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

H.R. 4985 will revitalize the Medicare+Choice program by making a new payment option available to Medicare+Choice plans. The legislation also makes permanent changes to underlying burdensome Medicare regulations. The legislation further institutes a competitive bidding structure for plans beginning in 2005, and creates a small demonstration program for areas with significant Medicare+Choice penetration. Finally, H.R. 4985 updates payments for inpatient hospital services to ensure adequate reimbursement levels for these services.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of Rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 4985, to amend title XVIII of the Social Security Act to revitalize the Medicare+Choice Program, establish a Medicare+Choice competition program, and to improve payments to hospitals and other providers under part A of the Medicare Program, would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974, which is included in the report to accompany H.R. 4984.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of Rule XIII of the Rules of the House of Representatives, the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974 is included in the report to accompany H.R. 4984.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act. The estimate is included in the report to accompany H.R. 4984.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 3(d)(1) of Rule XIII of the Rules of the House of Representatives, the Committee finds that the Constitutional au-

thority for this legislation is provided in Article I, section 8, clause 3, which grants Congress the power to regulate commerce with foreign nations, among the several States, and with the Indian tribes.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

TITLE II—MEDICARE+CHOICE REVITALIZATION AND MEDICARE COMPETITION PROGRAM

Subtitle A—Medicare+Choice Revitalization

Section 201. Medicare+Choice Improvements

This section adds the option for Medicare+Choice plans to be paid at 100% fee-for-service rates for 2003 and 2004, excluding direct graduate medical education costs. Payments for 2003 and 2004 also factor in indirect medical education costs and costs associated with delivering benefits to covered individuals that use Veterans Affairs or the Department of Defense medical services. This section allows for the blend payment rate to be calculated from the number of beneficiaries that are enrolled in a M+C plan in a particular area, for 2003 and 2004. It also eliminates the application of budget neutrality for M+C payments for 2003 and 2004. This section also increases the minimum update payment amount from 2% to 3% for 2003 and 2004. It adjusts the area-specific M+C rate for DOD and VA military facility services to Medicare-eligible beneficiaries.

This section also requires MedPAC to conduct a study on the variation in costs that occur in different areas due to the particulars of the AAPCC payment formula and also to assess the risk adjustment mechanisms used in calculating AAPCC payment amounts.

This section is effective upon enactment.

Section 202. Making Permanent Change in Medicare+Choice Reporting Deadlines and Annual, Coordinated Election Period

Section 202 permanently extends some of the deadline changes that were temporarily changed by P.L. 107–188. CMS would make its annual announcement of payment rates no later than the 2nd Monday in May of each year. The deadline for plans to submit their information would be no later than the 2nd Monday in September. The annual coordinated election period would take place from November 15 through December 31 of each year.

This section is effective upon enactment.

Section 203. Avoiding Duplicative State Regulation

Section 203 ensures that M+C plans will not be subject to duplicate State laws. Federal standards will supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency).

This section is effective upon enactment.

Section 204. Specialized Medicare+Choice Plans for Special Needs Beneficiaries

Section 204 establishes a new M+C option—specialized M+C plans for special needs beneficiaries (such as the EverCare demonstration). Special needs beneficiaries are defined as those M+C eligible individuals who are institutionalized, entitled to Medicaid, or meet requirements determined by the Secretary. Enrollment in specialized M+C plans could be limited to special needs beneficiaries until January 1, 2007. The Medicare Benefits Administrator would be required to report to Congress by December 31, 2005 providing an assessment of the impact of these plans. The Secretary would be required to issue final regulations establishing requirements for special needs beneficiaries within 6 months after enactment of this legislation.

This section is effective upon enactment.

Section 205. Medicare MSAs

Section 205 exempts MSA plans from reporting encounter data to the Trustees. It also permanently extends Medicare MSAs and removes the enrollment cap. This provision ensures that MSA plans operate with the same balance billing requirement limitations as apply to M+C plans.

This section is effective upon enactment.

Section 206. Extension of Reasonable Cost and SHMO Contracts

Section 206 allows a reasonable cost contract to be extended or renewed beyond December 31, 2004 if there were no coordinated care M+C plans in its service area. A cost contract could re-enter a previously served area if all other coordinated care M+C plans in the area terminated their contracts. The Medicare Benefits Administrator will submit a report to Congress no later than February 1, 2004 on an appropriate transition for cost contract plans.

Section 206 also extends the waivers permitting operation of SHMOs through December 31, 2004. Nothing would prevent a SHMO from offering an M+C plan.

This section is effective upon enactment.

Subtitle B—Medicare+Choice Competition Program

Section 211. Medicare+Choice Competition Program

Beginning in 2005, a new M+C payment system would be established based on competitive bidding amounts for the provision of all items and services. The provision would establish a benchmark amount for each payment area and a procedure for plans to develop a bid amount. Additionally, enrollees would be eligible for rebates, under certain circumstances.

The bid amount would indicate the proportion of the bid attributable to the provision of: (1) statutory non-drug benefits; (2) statutory prescription drug benefits; and (3) non-statutory benefits. Plans would be required to submit this information and the actuarial basis for determining these amounts, as well as other information as the Administrator may require to verify the actuarial basis. The bid amount could not vary by enrollees within a plan.

The Administrator would have authority to negotiate monthly bid amounts (including portions of the bid), and may reject a bid

amount, or a portion of it, that is not supported by the actuarial bases provided by the plan.

The fee-for-service area-specific non-drug benchmark (benchmark) amount would be set at the largest of 1 of 3 amounts; (1) the minimum update; (2) the minimum percentage increase; or (3) a percentage of FFS costs (100% of FFS in 2005–2007 and 95% FFS thereafter). The percentage of FFS costs would be set at the AAPCC for that year, for a payment area (including costs for only the fee-for-service beneficiaries and not the costs for those enrolled in an M+C plan) adjusted for the exclusion of both direct and indirect medical education costs as well as inclusion of the costs for VA and DOD. While the FFS payment mechanism established in Section 201 would exclude only the direct costs of graduate medical education, the FFS payment in this section would exclude both direct and indirect graduate medical education costs.

Both the benchmark and the bids would be risk adjusted based on statewide assumptions or based on a determination by the Administrator.

If the risk adjusted benchmark exceeded the risk adjusted bid (for statutory non-drug benefits), beneficiaries would qualify for rebates of 75% of the difference in the form of: (1) a credit towards their M+C monthly supplementary beneficiary premium, or the premium imposed for prescription drug coverage; (2) a direct monthly payment; (3) other means approved by the Secretary; or (4) some combination. The government would retain the remaining 25% of the difference. If instead the monthly bid exceeded the benchmark, then enrollees would pay a M+C monthly basic beneficiary premium, which covered the amount by which the monthly bid exceeds the benchmark.

Plans would be paid based on their bid amounts. For plans with bids below the benchmark, their payment would be the bid amount, risk adjusted for demographic and health status factors, plus the rebate amount. The rebate amount would be distributed to the plan's enrollees by one of the approved methods, as discussed above. For plans with bids at or above the benchmark, their payments would equal the benchmark amount, risk adjusted for demographic and health status factors.

This section applies to payments and premiums beginning on or after January 2005.

Section 212. Demonstration Program for Competitive Areas

Section 212 establishes a demonstration program for "competitive-demonstration areas," defined as an area with a substantial number of M+C enrollees that during open season offers at least 2 M+C plans by different organizations, and that during March of the previous year had at least 50% of M+C eligibles enrolled in an M+C plan. The demonstration program would be limited to a maximum of 4 sites and no area could be designated as a competitive-demonstration area for more than 2 years.

For each competitive-demonstration area, the Administrator shall annually determine the choice non-drug benchmark amount defined as the sum of the weighted FFS and M+C components. The weighted FFS component would be calculated by multiplying the national fee-for-service market share for the year (defined as the nationwide proportion of M+C eligibles during March of the pre-

vious year who were not enrolled in an M+C plan) by the FFS area-specific non-drug benchmark amount (calculated in the same manner as the benchmark under Section 211). The M+C component would be calculated by multiplying 1 minus the FFS market share for the year by the weighted average of plan bids for the area and year. The weighted average of plan bids would equal the sum of the proportion of each plan's enrollees in the area times the unadjusted monthly non-drug bid amount, as calculated for each plan.

Similar to the Medicare competition program (defined in Section 211), if the choice risk adjusted benchmark exceeded the risk adjusted bid (for statutory non-drug benefits), then beneficiaries would qualify for rebates for 75% of the difference in the form of: (1) a credit towards their M+C monthly supplementary beneficiary premium, or the premium imposed for prescription drug coverage; (2) a direct monthly payment; (3) other means approved by the Secretary; or (4) some combination. If instead the monthly bid exceeded the benchmark, then enrollees would pay a M+C monthly basic beneficiary premium, which covered the amount by which the monthly bid exceeded the benchmark.

Similar to the Medicare competition program (defined in section 211), plans would be paid based on their bid amounts. For plans with bids below the choice benchmark, their payment would be the bid amount, risk adjusted for demographic and health status factors, plus the rebate amount for beneficiaries. For plans with bids at or above the choice benchmark, their payments would equal the benchmark amount, risk adjusted for demographic and health status factors.

All enrollees in competitive areas, including both FFS enrollees and M+C enrollees, could have an adjustment made to their Medicare Part B premium. If the FFS area specific non-drug benchmark was less than or equal to the choice non-drug benchmark, the Medicare Part B premium would be reduced by 75% of the difference. However, if the FFS area specific non-drug benchmark was greater than the choice non-drug benchmark, then the Medicare Part B premium would be increased by the full amount of the difference. Thus reductions or increases in premiums amounts would be paid by all beneficiaries in the area, regardless of whether or not they were enrolled in a M+C plan.

No later than 6 months after the designation of the 4th competitive-demonstration area, the Medicare Benefits Administrator would be required to submit a report to Congress on the impact of this demonstration program on Medicare beneficiaries, savings to the Medicare program, and adverse selection issues.

This section applies to payments and premiums beginning on or after January 1, 2005.

Section 213. Conforming Amendments

This section makes several conforming amendments to M+C laws and delineates the specific information that must be announced on an annual basis. It also allows prospective implementation of national coverage determinations that will result in a significant change in the costs to a M+C plan and permits geographic adjustment to allow the Administrator to consolidate multiple M+C payment areas into a single statewide M+C payment area.

This section is effective upon enactment.

TITLE IV—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

Section 401. Revision of Acute Care Hospital Payment Updates

For FY 2003, hospitals in rural, small urban, and large urban areas (a metropolitan statistical area with a population of a million or more) would receive an update of MBI minus 0.25 percentage points. Sole community hospitals would receive an update of the full MBI.

This section is effective upon enactment.

Section 402. 2-Year Increase in Level of Adjustment for Indirect Costs of Medical Education (IME)

Section 402 sets the IME adjustment to 6.0% in FY 2003, 5.9% in FY 2004, and current law thereafter (5.5%).

This section is effective upon enactment.

Section 403. Recognition of New Medical Technologies Under Inpatient Hospital PPS

The Secretary is required to add new diagnosis codes in April 1 of each year that would not affect Medicare's payment or DRG classification until the following fiscal year. The Secretary will not be able to deny a service or technology treatment as a new technology if the service (or technology) has been in use for a period of time shorter than the 2- to 3-year period after the implementation of a billing code that permits identification of a sample of specific discharges where the service had been used. When establishing whether DRG payments are inadequate, the Secretary would be required to apply a threshold that is 50% of the national standardized amount for all hospitals or one standard deviation for the DRG involved. The Secretary is required to provide additional clarification in regulation on the criteria used to determine whether a new service represents a substantial improvement on existing treatment and is required to deem that a technology provides substantial improvement on an existing treatment if the technology meets certain requirements. The Secretary is also required to obtain public input regarding whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries. Further, before establishing an add-on payment for new technology, the Secretary is directed to demonstrate a preference for assigning an eligible technology into a DRG, taking into account similar clinical or anatomical characteristics and the relative cost of the technology. The Secretary would assign an eligible technology into a DRG where the average cost of care most closely approximates the cost of the new technology. Add-on payments for new technology must be calculated based on the marginal rate associated with outlier cases.

This section is effective October 1, 2003. The Secretary is also directed to automatically reconsider a new technology application that was denied in FY 2003 as a FY 2004 application under these new provisions. If the application is granted, the maximum time period permitted for the new technology classification will be extended by 12 months.

Section 404. Phase-In of Federal Rate for Hospitals in Puerto Rico

Hospitals in Puerto Rico will receive Medicare payments based on a 50/50 split between federal and local amounts before October 1, 2003. From FY 2004 through FY 2007, an increasing amount of the payment rate would be based on the federal rate-55% federal and 45% local in FY 2004, 60% federal and 40% local in FY 2005, 65% federal and 35% local in FY 2006, 70% federal and 30% local in FY 2007, and 75% federal and 25% local for FY 2007 and subsequent fiscal years.

This section is effective upon enactment.

Section 405. Reference to Provision Relating to Enhanced Disproportionate Share Hospital (DSH) Payments for Rural Hospitals and Urban Hospitals with Fewer than 100 Beds

Section 405 increases the adjustment for rural hospitals and small urban hospitals that serve a disproportionate share of low-income Medicare and Medicaid patients. (see section 302).

This section is effective upon enactment.

Section 406. Reference to Provision Relating to 2-Year Phased-In Increase in the Standardized Amount in Rural and Small Urban Areas to Achieve a Single, Uniform Standardized Amount

The provision increases the standardized amount for other areas to the standardized amount paid to hospitals in large urban areas over a 2-year period. (see section 303).

This section is effective upon enactment.

Section 407. Reference to Provision for More Frequent Updates in the Weights Used in Hospital Market Basket

The provision requires more frequent updates in the hospital market basket. (see section 304).

This section is effective upon enactment.

Section 408. Reference to Provision Making Improvements to Critical Access Hospital Program

Starting with payments made on or after January 1, 2003, eligible critical access hospitals (CAHs) will be able to receive payments made on a PIP basis for inpatient services. This section precludes the Secretary from requiring that all physicians providing services in a CAH assign their billing right to the CAH in order for it to be able to be paid at 115% of the fee schedule for the professional services provided by the physicians. A CAH cannot receive payment based on 115% of the fee schedule for any individual physician who did not assign billing rights to the CAH. The Secretary is required to specify standards for determining whether a CAH has seasonal variations in patient admissions that would justify a 5-bed increase in the number of beds it can maintain (and still retain its classification as a CAH). This provision extends the grant program that permits annual appropriations from Medicare's Federal Hospital Insurance Trust Fund of $25 million through FY 2007.

PIP payments are effective starting with payments made on or after January 1, 2003. The condition for application of the special physician payment provision is effective as if included in BBRA.

The CAH bed limit applies to designations made on or after January 1, 2003.

Subtitle B—Skilled Nursing Facility Services

Section 411. Payment for Covered Skilled Nursing Facility Services

The nursing component of the case-mix adjusted Federal payment rate will be increased 8% over the rates for SNF care specified in the PPS final rule. This increase applies to SNF services furnished on or after October 1, 2002 through September 30, 2005. Starting October 1, 2003, the per diem payment amount for a SNF resident with AIDS will be increased by 128%. The 128% increase will not apply on or after such date as the Secretary certifies that there is an appropriate change to the SNF case mix adjustment to cover the increased costs associated with caring for residents with AIDS.

This section applies to services furnished on or after October 1, 2003.

Subtitle C—Hospice

Section 421. Coverage of Hospice Consultation Services

Beginning January 1, 2004, consultation services for individuals who are terminally ill, including (1) an evaluation of the individual's need for pain and symptom management, (2) counseling the individual with respect to end-of-life issues and care options, and (3) advising the individual regarding advanced care planning, will be covered by the Medicare program when provided by a physician who is the medical director or an employee of a hospice program. Persons entitled to these services are individuals who had not elected the hospice benefit or had not previously received consultation services. The hospice program will be paid an amount equivalent to the amount established for an office or other outpatient visit for evaluation and management associated with presenting problems of moderate severity under the physician fee schedule (excluding practice expense).

This section applies to consultation services provided by a hospice program on or after January 1, 2004.

Section 422. 10 Percent Increase in Payment for Hospice Care Furnished in a Frontier Area

The Medicare daily payment rate for hospice care furnished in a frontier area, i.e., a county in which the population density is less than 7 persons per square mile, is increased by 10% for 5 years (January 1, 2003 through December 31, 2007). Not later than January 1, 2007, the Comptroller General will report to Congress on the costs of furnishing hospice care in frontier areas and recommend whether it is appropriate to extend, or modify, the 10% payment rate increase.

This section is effective upon enactment.

Section 423. Rural Hospice Demonstration Project

Section 423 requires the Secretary to conduct a demonstration project for the delivery of hospice care for beneficiaries in rural areas. Under the project, beneficiaries who are unable to receive

hospice care at home because they lack an appropriate caregiver will be provided such care in a facility of 20 or fewer beds, which offers within its walls the full range of covered hospice benefits. The project is limited to three hospice programs over a period of 3 years for each. The hospice programs participating in the project will comply with requirements otherwise applicable to hospice care, except that they will not be required to offer services outside the home nor be subject to the limitation on inpatient days. Payments will be at the same rates. The Secretary may require the participating programs to comply with additional quality assurance standards for provisions of services in their facilities. The Secretary is required to submit a report to Congress, including recommendations regarding extension of such project to all programs serving rural areas upon completion of the project.

This section is effective upon enactment.

Subtitle D—Other Provisions

Section 431. Demonstration Project for Use of Recovery Audit Contractors

Section 431 requires the Secretary to conduct a demonstration project in at least 2 states with at least 3 contractors for at least 3 years to demonstrate the use of recovery audit contractors under the Medicare Integrity Program in identifying and recouping overpayments for services under Part A of the Medicare program. Such contractors can receive payment on a contingent basis. Further, the Secretary can retain a percentage of the amount recovered by the recovery audit contractors for the CMS program management account. The Secretary is also required to examine the efficacy of using recovery audit contractors for medical necessity determinations, accuracy of coding, and other payment policies in which overpayments arise. The Secretary can waive Medicare statutory provisions to pay for the contractors' services. The Secretary is required only to enter into a recovery audit contract with an entity that has knowledge of the payment rules and regulations under Medicare or will contract with another entity that has such knowledge. Existing claims processing contractors (fiscal intermediaries and carriers) and any other entity that carries out similar activities with respect to providers of Part A services that would constitute a conflict of interest are ineligible. Those who have demonstrated proficiency in carrying out recovery audits with private insurers or under the Medicaid program are given preference. The Secretary must submit a report to Congress within 6 months of completion of the project on the impact of the project on savings to the Medicare program and recommendations on the cost-effectiveness of extending or expanding the project.

This section is effective upon enactment.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

SCOPE OF BENEFITS

SEC. 1812. (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1814(d)(2) to him (subject to the provisions of this part) for—

(1) * * *

* * * * * * *

(3) for individuals not enrolled in part B, home health services, and for individuals so enrolled, post-institutional home health services furnished during a home health spell of illness for up to 100 visits during such spell of illness; **[**and**]**

(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each and an unlimited number of subsequent periods of 60 days each with respect to which the individual makes an election under subsection (d)(1)**[**.**]***; and*

(5) for individuals who are terminally ill, have not made an election under subsection (d)(1), and have not have previously received services under this paragraph, services that are furnished by a physician who is the medical director or an employee of a hospice program and that consist of—

(A) an evaluation of the individual's need for pain and symptom management;

(B) counseling the individual with respect to end-of-life issues and care options; and

(C) advising the individual regarding advanced care planning.

* * * * * * *

CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

Requirement of Requests and Certifications

SEC. 1814. (a) * * *

* * * * * * *

Payment for Hospice Care

(i)(1)(A) * * *

* * * * * * *

(D) With respect to hospice care furnished in a frontier area on or after January 1, 2003, and before January 1, 2008, the payment rates otherwise established for such care shall be increased by 10

percent. For purposes of this subparagraph, the term "frontier area" means a county in which the population density is less than 7 persons per square mile.

* * * * * * *

(4) The amount paid to a hospice program with respect to the services under section 1812(a)(5) for which payment may be made under this part shall be equal to an amount equivalent to the amount established for an office or other outpatient visit for evaluation and management associated with presenting problems of moderate severity under the fee schedule established under section 1848(b), other than the portion of such amount attributable to the practice expense component.

* * * * * * *

AMOUNTS OF PREMIUMS

SEC. 1839. (a)(1) * * *

(2) The monthly premium of each individual enrolled under this part for each month after December 1983 shall be the amount determined under paragraph (3), adjusted as required in accordance with subsections (b), (c), and (f)**[**, and to reflect 80 percent of any reduction elected under section 1854(f)(1)(E).**]**.

* * * * * * *

(h)(1) In the case of an individual who resides in a competitive-demonstration area designated under section 1851(k)(1) and who is not enrolled in a Medicare+Choice plan under part C, the monthly premium otherwise applied under this part (determined without regard to subsections (b) and (f) or any adjustment under this subsection) shall be adjusted as follows: If the fee-for-service area-specific non-drug bid (as defined in section 1853(k)(6)) for the Medicare+Choice area in which the individual resides for a month—

(A) does not exceed the choice non-drug benchmark (as determined under section 1853(k)(2)) for such area, the amount of the premium for the individual for the month shall be reduced by an amount equal to 75 percent of the amount by which such benchmark exceeds such fee-for-service bid; or

(B) exceeds such choice non-drug benchmark, the amount of the premium for the individual for the month shall be adjusted to ensure that—

(i) the sum of the amount of the adjusted premium and the choice non-drug benchmark for the area, is equal to

(ii) the sum of the unadjusted premium plus amount of the fee-for-service area-specific non-drug bid for the area.

(2) Nothing in this subsection shall be construed as preventing a reduction under paragraph (1)(A) in the premium otherwise applicable under this part to zero or from requiring the provision of a rebate to the extent such premium would otherwise be required to be less than zero.

(3) The adjustment in the premium under this subsection shall be effected in such manner as the Medicare Benefits Administrator determines appropriate.

(4) In order to carry out this subsection (insofar as it is effected through the manner of collection of premiums under 1840(a)), the

Medicare Benefits Administrator shall transmit to the Commissioner of Social Security—

(A) at the beginning of each year, the name, social security account number, and the amount of the adjustment (if any) under this subsection for each individual enrolled under this part for each month during the year; and

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

* * * * * * *

APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS AND CONTINGENCY RESERVE

SEC. 1844. (a) * * *

* * * * * * *

(c) The Secretary shall determine the Government contribution under subparagraphs (A) and (B) of subsection (a)(1) without regard to any premium reduction resulting from an election under section 1854(f)(1)(E) *and without regard to any premium adjustment effected under section 1839(h).*

* * * * * * *

PART C—MEDICARE+CHOICE PROGRAM

ELIGIBILITY, ELECTION, AND ENROLLMENT

SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS THROUGH MEDICARE+CHOICE PLANS.—

(1) * * *

(2) TYPES OF MEDICARE+CHOICE PLANS THAT MAY BE AVAILABLE.—A Medicare+Choice plan may be any of the following types of plans of health insurance:

(A) COORDINATED CARE PLANS.—Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without point of service options), plans offered by provider-sponsored organizations (as defined in section 1855(d)), and preferred provider organization plans. *Specialized Medicare+Choice plans for special needs beneficiaries (as defined in section 1859(b)(4)) may be any type of coordinated care plan.*

* * * * * * *

(b) SPECIAL RULES.—

(1) * * *

* * * * * * *

(4) COVERAGE UNDER MSA PLANS [ON A DEMONSTRATION BASIS].—

(A) IN GENERAL.—[An individual is not eligible to enroll in an MSA plan under this part—

[(i) on or after January 1, 2003, unless the enrollment is the continuation of such an enrollment in effect as of such date; or

[(ii) as of any date if the number of such individuals so enrolled as of such date has reached 390,000.]

Under rules established by the Secretary, an individual is not eligible to enroll (or continue enrollment) in an MSA plan for a year unless the individual provides assurances satisfactory to the Secretary that the individual will reside in the United States for at least 183 days during the year.

* * * * * * *

(C) REPORTS.—The Secretary shall submit to Congress periodic reports on the numbers of individuals enrolled in such plans and on the evaluation being conducted under subparagraph (B). [The Secretary shall submit such a report, by not later than March 1, 2002, on whether the time limitation under subparagraph (A)(i) should be extended or removed and whether to change the numerical limitation under subparagraph (A)(ii).]

* * * * * * *

(d) PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.—

(1) * * *

(2) PROVISION OF NOTICE.—

(A) OPEN SEASON NOTIFICATION.—At least 15 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B)), the Secretary shall mail to each Medicare+Choice eligible individual residing in an area the following:

(i) GENERAL INFORMATION.—The general information described in paragraph (3).

(ii) LIST OF PLANS AND COMPARISON OF PLAN OPTIONS.—A list identifying the Medicare+Choice plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans *to the extent such information is available at the time of preparation of materials for the mailing*. Such information shall be presented in a comparative form.

* * * * * * *

(e) COVERAGE ELECTION PERIODS.—

(1) * * *

* * * * * * *

(3) ANNUAL, COORDINATED ELECTION PERIOD.—

(A) * * *

(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term "annual, coordinated election period" means, with respect to a year before 2003 [and after 2005, the month of November before such year and with respect to 2003, 2004, and 2005], *the month of November before such year and with respect to 2003 and any subsequent year*, the period beginning on November 15 and ending on December 31 of the year before such year.

* * * * * * *

(5) SPECIAL RULES FOR MSA PLANS.—Notwithstanding the preceding provisions of this subsection, an individual—

(A) may elect an MSA plan only during—

(i) an initial open enrollment period described in paragraph (1), *or*

(ii) an annual, coordinated election period described in paragraph (3)(B)[, or]*;*

[(iii) the month of November 1998;]

* * * * * * *

(h) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—

(1) * * *

* * * * * * *

(4) PROHIBITION OF CERTAIN MARKETING PRACTICES.—Each Medicare+Choice organization shall conform to fair marketing standards, in relation to Medicare+Choice plans offered under this part, included in the standards established under section 1856. Such standards—

(A) shall not permit a Medicare+Choice organization to provide for cash or other monetary rebates as an inducement for enrollment or otherwise *except as provided under section 1854(b)(1)(C)*, and

* * * * * * *

BENEFITS AND BENEFICIARY PROTECTIONS

SEC. 1852. (a) BASIC BENEFITS.—

(1) * * *

* * * * * * *

[(5) NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If there is a national coverage determination or legislative change in benefits required to be provided under this part made in the period beginning on the date of an announcement under section 1853(b) and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to a Medicare+Choice organization of providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the determination of the annual Medicare+Choice capitation rate under section 1853 included in the announcement made at the beginning of such period, then, unless otherwise required by law—

[(A) such determination or legislative change in benefits shall not apply to contracts under this part until the first contract year that begins after the end of such period, and

[(B) if such coverage determination or legislative change provides for coverage of additional benefits or coverage under additional circumstances, section 1851(i)(1) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period.

The projection under the previous sentence shall be based on an analysis by the Chief Actuary of the Health Care Financing Administration of the actuarial costs associated with the coverage determination or legislative change in benefits.]

(5) PROSPECTIVE IMPLEMENTATION OF NATIONAL COVERAGE DETERMINATIONS.—The Secretary shall only implement a national coverage determination that will result in a significant change in the costs to a Medicare+Choice organization in a prospective manner that applies to announcements made under section 1853(b) after the date of the implementation of the determination.

(b) ANTIDISCRIMINATION.—

(1) BENEFICIARIES.—

(A) IN GENERAL.—A Medicare+Choice organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act. *The Administrator shall not approve a plan of an organization if the Administrator determines that the benefits are designed to substantially discourage enrollment by certain Medicare+Choice eligible individuals with the organization.*

* * * * * * *

(c) DISCLOSURE REQUIREMENTS.—

(1) DETAILED DESCRIPTION OF PLAN PROVISIONS.—A Medicare+Choice organization shall disclose, in clear, accurate, and standardized form to each enrollee with a Medicare+Choice plan offered by the organization under this part at the time of enrollment and at least annually thereafter, the following information regarding such plan:

(A) * * *

* * * * * * *

(I) QUALITY ASSURANCE PROGRAM.—A description of the organization's quality assurance program under subsection (e) *if required under such section*.

* * * * * * *

(e) QUALITY ASSURANCE PROGRAM.—

(1) IN GENERAL.—Each Medicare+Choice organization must have arrangements, consistent with any regulation, for an ongoing quality assurance program for health care services it provides to individuals enrolled with Medicare+Choice plans *(other than MSA plans)* of the organization.

* * * * * * *

(2) ELEMENTS OF PROGRAM.—

(A) IN GENERAL.—The quality assurance program of an organization with respect to a Medicare+Choice plan (other than a Medicare+Choice private fee-for-service plan**[**, a non-network MSA plan,**]** or a preferred provider organization plan) it offers shall—

(i) * * *

* * * * * * *

(B) ELEMENTS OF PROGRAM FOR ORGANIZATIONS OFFERING MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLANS**[**, NON-NETWORK MSA PLANS,**]** AND PREFERRED PROVIDER ORGANIZATION PLANS.—The quality assurance program of an

organization with respect to a Medicare+Choice private fee-for-service plan[, a non-network MSA plan,] or a preferred provider organization plan it offers shall—

(i) * * *

* * * * * * *

(k) TREATMENT OF SERVICES FURNISHED BY CERTAIN PROVIDERS.—

(1) IN GENERAL.—Except as provided in paragraph (2), a physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a Medicare+Choice organization described in section 1851(a)(2)(A) *or with an organization offering a MSA plan* shall accept as payment in full for covered services under this title that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this title (but not enrolled with a Medicare+Choice organization under this part) also applies with respect to an individual so enrolled.

* * * * * * *

PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS

SEC. 1853. (a) PAYMENTS TO ORGANIZATIONS.—

(1) MONTHLY PAYMENTS.—

(A) IN GENERAL.—Under a contract under section 1857 and subject to subsections (e), (g), and (i) and section 1859(e)(4), the Secretary shall make monthly payments under this section in advance to each Medicare+Choice organization, with respect to coverage of an individual under this part in a Medicare+Choice payment area for a month, [in an amount equal to 1/12 of the annual Medicare+Choice capitation rate (as calculated under subsection (c)) with respect to that individual for that area, reduced by the amount of any reduction elected under section 1854(f)(1)(E) and adjusted for such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such factors, if such changes will improve the determination of actuarial equivalence.] *in an amount determined as follows:*

(i) PAYMENT BEFORE 2005.—For years before 2005, the payment amount shall be equal to 1/12 of the annual Medicare+Choice capitation rate (as calculated under subsection (c)) with respect to that individual for that area, reduced by the amount of any reduction elected under section 1854(f)(1)(E) and adjusted under clause (iii).

(ii) PAYMENT FOR STATUTORY NON-DRUG BENEFITS BEGINNING WITH 2005.—For years beginning with 2005—

(I) PLANS WITH BIDS BELOW BENCHMARK.—In the case of a plan for which there are average per capita monthly savings described in section 1854(b)(3)(C), the payment under this subsection is equal to the unadjusted non-drug monthly bid amount, adjusted under clause (iii), plus the amount of the monthly rebate computed under section 1854(b)(1)(C)(i) for that plan and year.

(II) PLANS WITH BIDS AT OR ABOVE BENCHMARK.—In the case of a plan for which there are no average per capita monthly savings described in section 1854(b)(3)(C), the payment amount under this subsection is equal to the fee-for-service area-specific non-drug benchmark amount, adjusted under clause (iii).

(iii) DEMOGRAPHIC ADJUSTMENT, INCLUDING ADJUSTMENT FOR HEALTH STATUS.—The Administrator shall adjust the payment amount under clause (i), the unadjusted non-drug monthly bid amount under clause (ii)(I), and the fee-for-service area-specific non-drug benchmark amount under clause (ii)(II) for such risk factors as age, disability status, gender, institutional status, and such other factors as the Administrator determines to be appropriate, including adjustment for health status under paragraph (3), so as to ensure actuarial equivalence. The Administrator may add to, modify, or substitute for such adjustment factors if such changes will improve the determination of actuarial equivalence.

(iv) REFERENCE TO SUBSIDY PAYMENT FOR STATUTORY DRUG BENEFITS.—In the case in which an enrollee is enrolled under part D, the Medicare+Choice organization also is entitled to a subsidy payment amount under section 1860H.

* * * * * * *

(b) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—

(1) ANNUAL ANNOUNCEMENT.—The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) for years before 2004 **[**and after 2005 not later than March 1 before the calendar year concerned and for 2004 and 2005**]** *not later than March 1 before the calendar year concerned and for 2004 and each subsequent year* not later than the second Monday in May before **[**the respective calendar year—

[(A) the annual Medicare+Choice capitation rate for each Medicare+Choice payment area for the year, and

[(B) the risk and other factors to be used in adjusting such rates under subsection (a)(1)(A) for payments for months in that year.**]**

* * * * * * *

(3) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (1), the Secretary shall include an explanation of the assumptions and changes in methodology used in the announcement **[**in sufficient detail so that

Medicare+Choice organizations can compute monthly adjusted Medicare+Choice capitation rates for individuals in each Medicare+Choice payment area which is in whole or in part within the service area of such an organization**]**.

(c) CALCULATION OF ANNUAL MEDICARE+CHOICE CAPITATION RATES.—

(1) IN GENERAL.—For purposes of this part, subject to paragraphs (6)(C) and (7), each annual Medicare+Choice capitation rate, for a Medicare+Choice payment area for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraph (A), (B), **[**or (C)**]** *(C), or (D)*:

(A) BLENDED CAPITATION RATE.—The sum of—

(i) * * *

* * * * * * *

multiplied *(for a year before 2003)* by the budget neutrality adjustment factor determined under paragraph (5).

* * * * * * *

(C) MINIMUM PERCENTAGE INCREASE.—

(i) * * *

* * * * * * *

[(iv) For 2002 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.**]**

(iv) For 2002, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2001.

(v) For 2003 and 2004, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

(vi) For 2005 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

(D) BASED ON 100 PERCENT OF FEE-FOR-SERVICE COSTS.—

(i) IN GENERAL.—For 2003 and 2004, the adjusted average per capita cost for the year involved, determined under section 1876(a)(4) for the Medicare+Choice payment area for services covered under parts A and B for individuals entitled to benefits under part A and enrolled under part B who are not enrolled in a Medicare+Choice plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1886(h).

(ii) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the adjusted average per capita cost under clause (i) for a year, such cost shall be adjusted to include the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the De-

partment of Veterans Affairs or the Department of Defense.

* * * * * * *

(3) ANNUAL AREA-SPECIFIC MEDICARE+CHOICE CAPITATION RATE.—

(A) IN GENERAL.—For purposes of paragraph (1)(A), subject to [subparagraph (B)] *subparagraphs (B) and (E)*, the annual area-specific Medicare+Choice capitation rate for a Medicare+Choice payment area—

(i) * * *

* * * * * * *

(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 2003), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

(4) INPUT-PRICE-ADJUSTED ANNUAL NATIONAL MEDICARE+CHOICE CAPITATION RATE.—

(A) * * *

(B) NATIONAL STANDARDIZED ANNUAL MEDICARE+CHOICE CAPITATION RATE.—In subparagraph (A)(i), the "national standardized annual Medicare+Choice capitation rate" for a year is equal to—

(i) the sum (for all Medicare+Choice payment areas) of the product of—

(I) the annual area-specific Medicare+Choice capitation rate for that year for the area under paragraph (3), and

(II) the average number of medicare beneficiaries *who (with respect to determinations for 2003 and for 2004) are enrolled in a Medicare+Choice plan* residing in that area in the year, multiplied by the average of the risk factor weights used to adjust payments under subsection (a)(1)(A) for such beneficiaries in such area; divided by

* * * * * * *

(5) PAYMENT ADJUSTMENT BUDGET NEUTRALITY FACTOR.—For purposes of paragraph (1)(A), for each year *(before 2003)*, the Secretary shall determine a budget neutrality adjustment factor so that the aggregate of the payments under this part (other than those attributable to subsections (a)(3)(C)(iii) and (i)) shall equal the aggregate payments that would have been made under this part if payment were based entirely on area-specific capitation rates.

(d) MEDICARE+CHOICE PAYMENT AREA DEFINED.—

(1) * * *

* * * * * * *

(3) GEOGRAPHIC ADJUSTMENT.—

(A) IN GENERAL.—Upon written request of the chief executive officer of a State for a contract year (beginning after 1998) made by not later than February 1 of the previous year, the Secretary shall make a geographic adjustment to a Medicare+Choice payment area in the State otherwise determined under paragraph (1)—

[(i) to a single statewide Medicare+Choice payment area,]

(i) to a single statewide Medicare+Choice payment area,

* * * * * * *

[(B) BUDGET NEUTRALITY ADJUSTMENT.—In the case of a State requesting an adjustment under this paragraph, the Secretary shall initially (and annually thereafter) adjust the payment rates otherwise established under this section for Medicare+Choice payment areas in the State in a manner so that the aggregate of the payments under this section in the State shall not exceed the aggregate payments that would have been made under this section for Medicare+Choice payment areas in the State in the absence of the adjustment under this paragraph.]

(B) BUDGET NEUTRALITY ADJUSTMENT.—In the case of a State requesting an adjustment under this paragraph, the Medicare Benefits Administrator shall initially (and annually thereafter) adjust the payment rates otherwise established under this section for Medicare+Choice payment areas in the State in a manner so that the aggregate of the payments under this section in the State shall not exceed the aggregate payments that would have been made under this section for Medicare+Choice payment areas in the State in the absence of the adjustment under this paragraph.

* * * * * * *

(j) COMPUTATION OF FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG BENCHMARK AMOUNT.—For purposes of this part, the term "fee-for-service area-specific non-drug benchmark amount" means, with respect to a Medicare+Choice payment area for a month in a year, an amount equal to the greater of the following (but in no case less than 1/12 of the rate computed under subsection (c)(1), without regard to subparagraph (A), for the year):

(1) BASED ON 100 PERCENT OF FEE-FOR-SERVICE COSTS IN THE AREA.—An amount equal to 1/12 of 100 percent (for 2005 through 2007, or 95 percent for 2008 and years thereafter) of the adjusted average per capita cost for the year involved, determined under section 1876(a)(4) for the Medicare+Choice payment area, for the area and the year involved, for services covered under parts A and B for individuals entitled to benefits under part A and enrolled under part B who are not enrolled in a Medicare+Choice plan under this part for the year, and adjusted to exclude from such cost the amount the Medicare Bene-

fits Administrator estimates is payable for costs described in subclauses (I) and (II) of subsection (c)(3)(C)(i) for the year involved and also adjusted in the manner described in subsection (c)(1)(D)(ii) (relating to inclusion of costs of VA and DOD military facility services to medicare-eligible beneficiaries).

(2) MINIMUM MONTHLY AMOUNT.—The minimum amount specified in this paragraph is the amount specified in subsection (c)(1)(B)(iv) for the year involved.

(k) ESTABLISHMENT OF COMPETITIVE DEMONSTRATION PROGRAM.—

(1) DESIGNATION OF COMPETITIVE-DEMONSTRATION AREAS AS PART OF PROGRAM.—

(A) IN GENERAL.—For purposes of this part, the Administrator shall establish a demonstration program under which the Administrator designates Medicare+Choice areas as competitive-demonstration areas consistent with the following limitations:

(i) LIMITATION ON NUMBER OF AREAS THAT MAY BE DESIGNATED.—The Administrator may not designate more than 4 areas as competitive-demonstration areas.

(ii) LIMITATION ON PERIOD OF DESIGNATION OF ANY AREA.—The Administrator may not designate any area as a competitive-demonstration area for a period of more than 2 years.

The Administrator has the discretion to decide whether or not to designate as a competitive-demonstration area an area that qualifies for such designation.

(B) QUALIFICATIONS FOR DESIGNATION.—For purposes of this title, a Medicare+Choice area (which is a metropolitan statistical area or other area with a substantial number of Medicare+Choice enrollees) may not be designated as a "competitive-demonstration area" for a 2-year period beginning with a year unless the Administrator determines, by such date before the beginning of the year as the Administrator determines appropriate, that—

(i) there will be offered during the open enrollment period under this part before the beginning of the year at least 2 Medicare+Choice plans (in addition to the fee-for-service program under parts A and B), each offered by a different Medicare+Choice organization; and

(ii) during March of the previous year at least 50 percent of the number of Medicare+Choice eligible individuals who reside in the area were enrolled in a Medicare+Choice plan.

(2) CHOICE NON-DRUG BENCHMARK AMOUNT.—For purposes of this part, the term "choice non-drug benchmark amount" means, with respect to a Medicare+Choice payment area for a month in a year, the sum of the 2 components described in paragraph (3) for the area and year. The Administrator shall compute such benchmark amount for each competitive-demonstration area before the beginning of each annual, coordinated election period under section 1851(e)(3)(B) for each year (beginning with 2005) in which it is designated as such an area.

(3) 2 COMPONENTS.—For purposes of paragraph (2), the 2 components described in this paragraph for an area and a year are the following:

(A) FEE-FOR-SERVICE COMPONENT WEIGHTED BY NATIONAL FEE-FOR-SERVICE MARKET SHARE.—The product of the following:

(i) NATIONAL FEE-FOR-SERVICE MARKET SHARE.—The national fee-for-service market share percentage (determined under paragraph (5)) for the year.

(ii) FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG BID.—The fee-for-service area-specific non-drug bid (as defined in paragraph (6)) for the area and year.

(B) M+C COMPONENT WEIGHTED BY NATIONAL MEDICARE+CHOICE MARKET SHARE.—The product of the following:

(i) NATIONAL MEDICARE+CHOICE MARKET SHARE.—1 minus the national fee-for-service market share percentage for the year.

(ii) WEIGHTED AVERAGE OF PLAN BIDS IN AREA.—The weighted average of the plan bids for the area and year (as determined under paragraph (4)(A)).

(4) DETERMINATION OF WEIGHTED AVERAGE BIDS FOR AN AREA.—

(A) IN GENERAL.—For purposes of paragraph (3)(B)(ii), the weighted average of plan bids for an area and a year is the sum of the following products for Medicare+Choice plans described in subparagraph (C) in the area and year:

(i) PROPORTION OF EACH PLAN'S ENROLLEES IN THE AREA.—The number of individuals described in subparagraph (B), divided by the total number of such individuals for all Medicare+Choice plans described in subparagraph (C) for that area and year.

(ii) MONTHLY NON-DRUG BID AMOUNT.—The unadjusted non-drug monthly bid amount.

(B) COUNTING OF INDIVIDUALS.—The Administrator shall count, for each Medicare+Choice plan described in subparagraph (C) for an area and year, the number of individuals who reside in the area and who were enrolled under such plan under this part during March of the previous year.

(C) EXCLUSION OF PLANS NOT OFFERED IN PREVIOUS YEAR.—For an area and year, the Medicare+Choice plans described in this subparagraph are plans that are offered in the area and year and were offered in the area in March of the previous year.

(5) COMPUTATION OF NATIONAL FEE-FOR-SERVICE MARKET SHARE PERCENTAGE.—The Administrator shall determine, for a year, the proportion (in this subsection referred to as the "national fee-for-service market share percentage") of Medicare+Choice eligible individuals who during March of the previous year were not enrolled in a Medicare+Choice plan.

(6) FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG BID.—For purposes of this part, the term "fee-for-service area-specific non-drug bid" means, for an area and year, the amount described in section 1853(j)(1) for the area and year, except that any ref-

erence to a percent of less than 100 percent shall be deemed a reference to 100 percent.

PREMIUMS *AND BID AMOUNTS*.

SEC. 1854. (a) SUBMISSION OF PROPOSED PREMIUMS *AND BID AMOUNTS* AND RELATED INFORMATION.—

(1) IN GENERAL.—Not later than the second Monday in September of [2002, 2003, and 2004 (or July 1 of each other year)] *2002 and each subsequent year (or July 1 of each year before 2002)*, each Medicare+Choice organization shall submit to the Secretary, in a form and manner specified by the Secretary and for each Medicare+Choice plan for the service area (or segment of such an area if permitted under subsection (h)) in which it intends to be offered in the following year—

[(A)] *(A)(i) if the following year is before 2005,* the information described in paragraph (2), (3), or (4) for the type of plan involved *or (ii) if the following year is 2005 or later, the information described in paragraph (6)(A)*; and

* * * * * * *

(5) REVIEW.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall review the adjusted community rates, the amounts of the basic and supplemental premiums, and values filed under *paragraphs (2), (3), and (4) of* this subsection and shall approve or disapprove such rates, amounts, and values so submitted. The Chief Actuary of the Health Care Financing Administration shall review the actuarial assumptions and data used by the Medicare+Choice organization with respect to such rates, amounts, and values so submitted to determine the appropriateness of such assumptions and data.

* * * * * * *

(6) SUBMISSION OF BID AMOUNTS BY MEDICARE+CHOICE ORGANIZATIONS.—

(A) INFORMATION TO BE SUBMITTED.—The information described in this subparagraph is as follows:

(i) The monthly aggregate bid amount for provision of all items and services under this part and the actuarial basis for determining such amount.

(ii) The proportions of such bid amount that are attributable to—

(I) the provision of statutory non-drug benefits (such portion referred to in this part as the "unadjusted non-drug monthly bid amount");

(II) the provision of statutory prescription drug benefits; and

(III) the provision of non-statutory benefits;

and the actuarial basis for determining such proportions.

(iii) Such additional information as the Administrator may require to verify the actuarial bases described in clauses (i) and (ii).

(B) STATUTORY BENEFITS DEFINED.—For purposes of this part:

(i) The term "statutory non-drug benefits" means benefits under parts A and B.

(ii) The term "statutory prescription drug benefits" means benefits under part D.

(iii) The term "statutory benefits" means statutory prescription drug benefits and statutory non-drug benefits.

(C) ACCEPTANCE AND NEGOTIATION OF BID AMOUNTS.—The Administrator has the authority to negotiate regarding monthly bid amounts submitted under subparagraph (A) (and the proportion described in subparagraph (A)(ii)). The Administrator may reject such a bid amount or proportion if the Administrator determines that such amount or proportion is not supported by the actuarial bases provided under subparagraph (A).

(b) MONTHLY PREMIUM CHARGED.—

(1) IN GENERAL.—

(A) * * *

* * * * * * *

(C) BENEFICIARY REBATE RULE.—

(i) REQUIREMENT.—The Medicare+Choice plan shall provide to the enrollee a monthly rebate equal to 75 percent of the average per capita savings (if any) described in paragraph (3) applicable to the plan and year involved.

(ii) REQUIREMENT FOR COMPETITIVE-DEMONSTRATION AREAS.—In the case of a Medicare+Choice payment area that is designated as a competitive-demonstration area under section 1853(k)(1), if there are average per capita monthly savings described in paragraph (4) for a Medicare+Choice plan and year, the Medicare+Choice plan shall provide to the enrollee a monthly rebate equal to 75 percent of such savings.

(iii) FORM OF REBATE.—A rebate required under this subparagraph shall be provided—

(I) through the crediting of the amount of the rebate towards the Medicare+Choice monthly supplementary beneficiary premium or the premium imposed for prescription drug coverage under part D;

(II) through a direct monthly payment (through electronic funds transfer or otherwise); or

(III) through other means approved by the Medicare Benefits Administrator,

or any combination thereof.

(2) PREMIUM TERMINOLOGY DEFINED.—For purposes of this part:

[(A) THE MEDICARE+CHOICE MONTHLY BASIC BENEFICIARY PREMIUM.—The term "Medicare+Choice monthly basic beneficiary premium" means, with respect to a Medicare+Choice plan, the amount authorized to be charged under subsection (e)(1) for the plan, or, in the case of a Medicare+Choice private fee-for-service plan, the amount filed under subsection (a)(4)(A)(ii).

[(B) MEDICARE+CHOICE MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The term "Medicare+Choice monthly

supplemental beneficiary premium" means, with respect to a Medicare+Choice plan, the amount authorized to be charged under subsection (e)(2) for the plan or, in the case of a MSA plan or Medicare+Choice private fee-for-service plan, the amount filed under paragraph (3)(B) or (4)(B) of subsection (a).]

(A) MEDICARE+CHOICE MONTHLY BASIC BENEFICIARY PREMIUM.—The term "Medicare+Choice monthly basic beneficiary premium" means, with respect to a Medicare+Choice plan—

(i) described in section 1853(a)(1)(A)(ii)(I) (relating to plans providing rebates), zero; or

(ii) described in section 1853(a)(1)(A)(ii)(II), the amount (if any) by which the unadjusted non-drug monthly bid amount exceeds the fee-for-service area-specific non-drug benchmark amount (or, in the case of a competitive-demonstration area, the choice non-drug benchmark amount).

(B) MEDICARE+CHOICE MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The term "Medicare+Choice monthly supplemental beneficiary premium" means, with respect to a Medicare+Choice plan, the portion of the aggregate monthly bid amount submitted under clause (i) of subsection (a)(6)(A) for the year that is attributable under such section to the provision of nonstatutory benefits.

(3) COMPUTATION OF AVERAGE PER CAPITA MONTHLY SAVINGS.—For purposes of paragraph (1)(C)(i), the average per capita monthly savings referred to in such paragraph for a Medicare+Choice plan and year is computed as follows:

(A) DETERMINATION OF STATE-WIDE AVERAGE RISK ADJUSTMENT.—

(i) IN GENERAL.—The Medicare Benefits Administrator shall determine, at the same time rates are promulgated under section 1853(b)(1) (beginning with 2005), for each State the average of the risk adjustment factors to be applied to enrollees under section 1853(a)(1)(A) in that State. In the case of a State in which a Medicare+Choice plan was offered in the previous year, the Administrator may compute such average based upon risk adjustment factors applied in that State in a previous year.

(ii) TREATMENT OF NEW STATES.—In the case of a State in which no Medicare+Choice plan was offered in the previous year, the Administrator shall estimate such average. In making such estimate, the Administrator may use average risk adjustment factors applied to comparable States or applied on a national basis.

(B) DETERMINATION OF RISK ADJUSTED BENCHMARK AND RISK-ADJUSTED BID.—For each Medicare+Choice plan offered in a State, the Administrator shall—

(i) adjust the fee-for-service area-specific non-drug benchmark amount by the applicable average risk adjustment factor computed under subparagraph (A); and

(ii) adjust the unadjusted non-drug monthly bid amount by such applicable average risk adjustment factor.

(C) DETERMINATION OF AVERAGE PER CAPITA MONTHLY SAVINGS.—The average per capita monthly savings described in this subparagraph is equal to the amount (if any) by which—

(i) the risk-adjusted benchmark amount computed under subparagraph (B)(i), exceeds

(ii) the risk-adjusted bid computed under subparagraph (B)(ii).

(D) AUTHORITY TO DETERMINE RISK ADJUSTMENT FOR AREAS OTHER THAN STATES.—The Administrator may provide for the determination and application of risk adjustment factors under this paragraph on the basis of areas other than States.

(4) COMPUTATION OF AVERAGE PER CAPITA MONTHLY SAVINGS FOR COMPETITIVE-DEMONSTRATION AREAS.—For purposes of paragraph (1)(C)(ii), the average per capita monthly savings referred to in such paragraph for a Medicare+Choice plan and year shall be computed in the same manner as the average per capita monthly savings is computed under paragraph (3) except that the reference to the fee-for-service area-specific non-drug benchmark in paragraph (3)(B)(i) (or to the benchmark amount as adjusted under paragraph (3)(C)(i)) is deemed to be a reference to the choice non-drug benchmark amount (or such amount as adjusted in the manner described in paragraph (3)(B)(i)).

[(c) UNIFORM PREMIUM.—The Medicare+Choice monthly basic and supplemental beneficiary premium, the Medicare+Choice monthly MSA premium charged under subsection (b) of a Medicare+Choice organization under this part may not vary among individuals enrolled in the plan.]

(c) UNIFORM BID AMOUNTS.—The Medicare+Choice monthly bid amount submitted under subsection (a)(6) of a Medicare+Choice organization under this part may not vary among individuals enrolled in the plan.

(d) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each Medicare+Choice organization shall permit the payment of Medicare+Choice monthly basic and supplemental beneficiary premiums on a monthly basis, may terminate election of individuals for a Medicare+Choice plan for failure to make premium payments only in accordance with section 1851(g)(3)(B)(i), and may not provide*, except as provided under subsection (b)(1)(C), and subsection (b)(1)(D)* for cash or other monetary rebates as an inducement for enrollment or otherwise.

[(e) LIMITATION ON ENROLLEE LIABILITY.—

[(1) FOR BASIC AND ADDITIONAL BENEFITS.—In no event may—

[(A) the Medicare+Choice monthly basic beneficiary premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with a Medicare+Choice plan described in section 1851(a)(2)(A) of an organization with respect to required benefits described

in section 1852(a)(1)(A) and additional benefits (if any) required under subsection (f)(1)(A) for a year, exceed

[(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to benefits under part A and enrolled under part B if they were not members of a Medicare+Choice organization for the year.

[(2) FOR SUPPLEMENTAL BENEFITS.—If the Medicare+Choice organization provides to its members enrolled under this part in a Medicare+Choice plan described in section 1851(a)(2)(A) with respect to supplemental benefits described in section 1852(a)(3), the sum of the Medicare+Choice monthly supplemental beneficiary premium (multiplied by 12) charged and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such benefits may not exceed the adjusted community rate for such benefits (as defined in subsection (f)(3)).

[(3) DETERMINATION ON OTHER BASIS.—If the Secretary determines that adequate data are not available to determine the actuarial value under paragraph (1)(A) or (2), the Secretary may determine such amount with respect to all individuals in same geographic area, the State, or in the United States, eligible to enroll in the Medicare+Choice plan involved under this part or on the basis of other appropriate data.

[(4) SPECIAL RULE FOR PRIVATE FEE-FOR-SERVICE PLANS.—With respect to a Medicare+Choice private fee-for-service plan (other than a plan that is an MSA plan), in no event may—

[(A) the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with such a plan of an organization with respect to required benefits described in section 1852(a)(1), exceed

[(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to benefits under part A and enrolled under part B if they were not members of a Medicare+Choice organization for the year.

[(f) REQUIREMENT FOR ADDITIONAL BENEFITS.—

[(1) REQUIREMENT.—

[(A) IN GENERAL.—Each Medicare+Choice organization (in relation to a Medicare+Choice plan, other than an MSA plan, it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the plan for a contract year, subject to the succeeding provisions of this subsection, the organization shall provide to individuals such additional benefits (as the organization may specify) in a value which the Secretary determines is at least equal to the adjusted excess amount (as defined in subparagraph (C)).

[(B) EXCESS AMOUNT.—For purposes of this paragraph, the "excess amount", for an organization for a plan, is the amount (if any) by which—

[(i) the average of the capitation payments made to the organization under section 1853 for the plan at the beginning of contract year, exceeds

[(ii) the actuarial value of the required benefits described in section 1852(a)(1)(A) under the plan for individuals under this part, as determined based upon an adjusted community rate described in paragraph (3) (as reduced for the actuarial value of the coinsurance, copayments, and deductibles under parts A and B).

[(C) ADJUSTED EXCESS AMOUNT.—For purposes of this paragraph, the "adjusted excess amount", for an organization for a plan, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (2).

[(D) UNIFORM APPLICATION.—This paragraph shall be applied uniformly for all enrollees for a plan.

[(E) PREMIUM REDUCTIONS.—

[(i) IN GENERAL.—Subject to clause (ii), as part of providing any additional benefits required under subparagraph (A), a Medicare+Choice organization may elect a reduction in its payments under section 1853(a)(1)(A) with respect to a Medicare+Choice plan and the Secretary shall apply such reduction to reduce the premium under section 1839 of each enrollee in such plan as provided in section 1840(i).

[(ii) AMOUNT OF REDUCTION.—The amount of the reduction under clause (i) with respect to any enrollee in a Medicare+Choice plan—

[(I) may not exceed 125 percent of the premium described under section 1839(a)(3); and

[(II) shall apply uniformly to each enrollee of the Medicare+Choice plan to which such reduction applies.

[(F) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a Medicare+Choice organization from providing supplemental benefits (described in section 1852(a)(3)) that are in addition to the health care benefits otherwise required to be provided under this paragraph and from imposing a premium for such supplemental benefits.

[(2) STABILIZATION FUND.—A Medicare+Choice organization may provide that a part of the value of an excess amount described in paragraph (1) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of the amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the Medicare+Choice plan of the organization in accordance with such paragraph prior to the end of such periods, shall revert for the use of such trust funds.

[(3) ADJUSTED COMMUNITY RATE.—For purposes of this subsection, subject to paragraph (4), the term "adjusted commu-

nity rate" for a service or services means, at the election of a Medicare+Choice organization, either—

[(A) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a Medicare+Choice plan under this part if the rate of payment were determined under a "community rating system" (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)), or

[(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to such an individual, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the individuals electing coverage under this part and the utilization characteristics of the other enrollees with the plan (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of individuals selecting other Medicare+Choice coverage, or Medicare+Choice eligible individuals in the area, in the State, or in the United States, eligible to elect Medicare+Choice coverage under this part and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

[(4) DETERMINATION BASED ON INSUFFICIENT DATA.—For purposes of this subsection, if the Secretary finds that there is insufficient enrollment experience to determine an average of the capitation payments to be made under this part at the beginning of a contract period or to determine (in the case of a newly operated provider-sponsored organization or other new organization) the adjusted community rate for the organization, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this part and may determine such a rate using data in the general commercial marketplace.]

* * * * * * *

ESTABLISHMENT OF STANDARDS

SEC. 1856. (a) * * *

(b) ESTABLISHMENT OF OTHER STANDARDS.—

(1) * * *

* * * * * * *

[(3) RELATION TO STATE LAWS.—

[(A) IN GENERAL.—The standards established under this subsection shall supersede any State law or regulation (including standards described in subparagraph (B)) with respect to Medicare+Choice plans which are offered by Medicare+Choice organizations under this part to the extent such law or regulation is inconsistent with such standards.

[(B) STANDARDS SPECIFICALLY SUPERSEDED.—State standards relating to the following are superseded under this paragraph:

[(i) Benefit requirements (including cost-sharing requirements).

[(ii) Requirements relating to inclusion or treatment of providers.

[(iii) Coverage determinations (including related appeals and grievance processes).

[(iv) Requirements relating to marketing materials and summaries and schedules of benefits regarding a Medicare+Choice plan.]

(3) RELATION TO STATE LAWS.—The standards established under this subsection shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to Medicare+Choice plans which are offered by Medicare+Choice organizations under this part.

* * * * * * *

DEFINITIONS; MISCELLANEOUS PROVISIONS

SEC. 1859. (a) * * *

(b) DEFINITIONS RELATING TO MEDICARE+CHOICE PLANS.—

(1) * * *

* * * * * * *

(4) SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—

(A) IN GENERAL.—The term "specialized Medicare+Choice plan for special needs beneficiaries" means a Medicare+Choice plan that exclusively serves special needs beneficiaries (as defined in subparagraph (B)).

(B) SPECIAL NEEDS BENEFICIARY.—The term "special needs beneficiary" means a Medicare+Choice eligible individual who—

(i) is institutionalized (as defined by the Secretary);

(ii) is entitled to medical assistance under a State plan under title XIX; or

(iii) meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized Medicare+Choice plan described in subparagraph (A) for individuals with severe or disabling chronic conditions.

* * * * * * *

(f) RESTRICTION ON ENROLLMENT FOR SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—In the case of a specialized Medicare+Choice plan (as defined in subsection (b)(4)), notwithstanding any other provision of this part and in accordance with regulations of the Secretary and for periods before January 1, 2007, the plan may restrict the enrollment of individuals under the plan to individuals who are within one or more classes of special needs beneficiaries.

PART D—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) * * *

* * * * * * *

Hospice Care; Hospice Program

(dd)(1) * * *

(2) The term "hospice program" means a public agency or private organization (or a subdivision thereof) which—

(A)(i) is primarily engaged in providing the care and services described in paragraph (1) and makes such services available (as needed) on a 24-hour basis and which also provides bereavement counseling for the immediate family of terminally ill individuals *and services described in section 1812(a)(5)*,

* * * * * * *

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SEC. 1876. (a) * * *

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(h)(1) * * *

* * * * * * *

(5)(A) * * *

* * * * * * *

(C)*(i)* The Secretary may not extend or renew a reasonable cost reimbursement contract under this subsection for any period beyond December 31, 2004*, except (subject to clause (ii)) in the case of a contract for an area which is not covered in the service area of 1 or more coordinated care Medicare+Choice plans under part C*.

(ii) In the case in which—

(I) a reasonable cost reimbursement contract includes an area in its service area as of a date that is after December 31, 2003;

(II) such area is no longer included in such service area after such date by reason of the operation of clause (i) because of the inclusion of such area within the service area of a Medicare+Choice plan; and

(III) all Medicare+Choice plans subsequently terminate coverage in such area;

such reasonable cost reimbursement contract may be extended and renewed to cover such area (so long as it is not included in the service area of any Medicare+Choice plan).

* * * * * * *

PAYMENT TO HOSPITALS FOR INPATIENT HOSPITAL SERVICES

SEC. 1886. (a) * * *

(b)(1) * * *

* * * * * * *

(3)(A) * * *

(B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—

(I) * * *

* * * * * * *

[(XVIII) for fiscal year 2003, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas, and]

(XVIII) for fiscal year 2003, the market basket percentage increase for sole community hospitals and such increase minus 0.25 percentage points for other hospitals, and

(d)(1) * * *

* * * * * * *

(5)(A) * * *

(B) The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) under subsection (a)(2), except as follows:

(i) * * *

(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to c × (((1+r) to the nth power) − 1), where "r" is the ratio of the hospital's full-time equivalent interns and residents to beds and "n" equals .405. For discharges occurring—

(I) * * *

* * * * * * *

(VI) during fiscal year 2002, "c" is equal to 1.6; [and]

(VII) during fiscal year 2003, "c" is equal to 1.47;

(VIII) during fiscal year 2004, "c" is equal to 1.45; and

[(VII)] *(IX)* on or after October 1, [2002] *2004*, "c" is equal to 1.35.

* * * * * * *

(K)(i) Effective for discharges beginning on or after October 1, 2001, the Secretary shall establish a mechanism to recognize the costs of new medical services and technologies under the payment system established under this subsection. Such mechanism shall be established after notice and opportunity for public comment (in the publications required by subsection (e)(5) for a fiscal year or otherwise). *Such mechanism shall be modified to meet the requirements of clause (viii).*

(ii) The mechanism established pursuant to clause (i) shall—

(I) apply to a new medical service or technology if, based on the estimated costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate *(applying a threshold specified by the Secretary that is the lesser of 50 percent of the national average standardized amount for operating costs of inpatient hospital services for all hospitals and all diagnosis-related groups or one standard deviation for the diagnosis-related group involved)*;

* * * * * * *

(III) subject to paragraph (4)(C)(iii), provide for additional payment to be made under this subsection with respect to discharges involving a new medical service or technology de-

scribed in subclause (I) that occur during the period described in subclause (II) in an amount that adequately reflects the estimated average cost of such service or technology *(based on the marginal rate applied to costs under subparagraph (A))*; and

* * * * * * *

(vi)*(I)* For purposes of this subparagraph and subparagraph (L), a medical service or technology will be considered a "new medical service or technology" if the service or technology meets criteria established by the Secretary after notice and an opportunity for public comment.

(II) Under such criteria, a service or technology shall not be denied treatment as a new service or technology on the basis of the period of time in which the service or technology has been in use if such period ends before the end of the 2-to-3-year period that begins on the effective date of implementation of a code under ICD–9–CM (or a successor coding methodology) that enables the identification of a significant sample of specific discharges in which the service or technology has been used.

(III) The Secretary shall by regulation provide for further clarification of the criteria applied to determine whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries. Under such criteria, in determining whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries, the Secretary shall deem a service or technology as meeting such requirement if the service or technology is a drug or biological that is designated under section 506 or 526 of the Federal Food, Drug, and Cosmetic Act, approved under section 314.510 or 601.41 of title 21, Code of Federal Regulations, or designated for priority review when the marketing application for such drug or biological was filed or is a medical device for which an exemption has been granted under section 520(m) of such Act, for which priority review has been provided under section 515(d)(5) of such Act, or is a substantially equivalent device for which an expedited review is provided under section 513(f) of such Act.

(vii) Under the mechanism under this subparagraph, the Secretary shall provide for the addition of new diagnosis and procedure codes in April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) under this subsection until the fiscal year that begins after such date.

(viii) The mechanism established pursuant to clause (i) shall be adjusted to provide, before publication of a proposed rule, for public input regarding whether a new service or technology not described in the second sentence of clause (vi)(III) represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries as follows:

(I) The Secretary shall make public and periodically update a list of all the services and technologies for which an application for additional payment under this subparagraph is pending.

(II) The Secretary shall accept comments, recommendations, and data from the public regarding whether the service or technology represents a substantial improvement.

(III) The Secretary shall provide for a meeting at which organizations representing hospitals, physicians, medicare beneficiaries, manufacturers, and any other interested party may present comments, recommendations, and data to the clinical staff of the Centers for Medicare & Medicaid Services before publication of a notice of proposed rulemaking regarding whether service or technology represents a substantial improvement.

(ix) Before establishing any add-on payment under this subparagraph with respect to a new technology, the Secretary shall seek to identify one or more diagnosis-related groups associated with such technology, based on similar clinical or anatomical characteristics and the cost of the technology. Within such groups the Secretary shall assign an eligible new technology into a diagnosis-related group where the average costs of care most closely approximate the costs of care of using the new technology. In such case, no add-on payment under this subparagraph shall be made with respect to such new technology and this clause shall not affect the application of paragraph (4)(C)(iii).

* * * * * * *

(9)(A) Notwithstanding section 1814(b) but subject to the provisions of section 1813, the amount of the payment with respect to the operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for inpatient hospital discharges is equal to the sum of—

(i) **[**for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)**]** *the applicable Puerto Rico percentage (specified in subparagraph (E))* of the Puerto Rico adjusted DRG prospective payment rate (determined under subparagraph (B) or (C)) for such discharges, and

(ii) **[**for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 25 percent)**]** *the applicable Federal percentage (specified in subparagraph (E))* of the discharge-weighted average of—

(I) * * *

* * * * * * *

(E) For purposes of subparagraph (A), for discharges occurring—

(i) between October 1, 1987, and September 30, 1997, the applicable Puerto Rico percentage is 75 percent and the applicable Federal percentage is 25 percent;

(ii) on or after October 1, 1997, and before October 1, 2003, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent;

(iii) during fiscal year 2004, the applicable Puerto Rico percentage is 45 percent and the applicable Federal percentage is 55 percent;

(iv) during fiscal year 2005, the applicable Puerto Rico percentage is 40 percent and the applicable Federal percentage is 60 percent;

(v) during fiscal year 2006, the applicable Puerto Rico percentage is 35 percent and the applicable Federal percentage is 65 percent;

(vi) during fiscal year 2007, the applicable Puerto Rico percentage is 30 percent and the applicable Federal percentage is 70 percent; and

(vii) on or after October 1, 2007, the applicable Puerto Rico percentage is 25 percent and the applicable Federal percentage is 75 percent.

* * * * * * *

PAYMENT TO SKILLED NURSING FACILITIES FOR ROUTINE SERVICE COSTS

SEC. 1888. (a) * * *

* * * * * * *

(e) PROSPECTIVE PAYMENT.—

(1) * * *

* * * * * * *

[(12) PAYMENT RULE FOR CERTAIN FACILITIES.—

[(A) IN GENERAL.—In the case of a qualified acute skilled nursing facility described in subparagraph (B), the per diem amount of payment shall be determined by applying the non-Federal percentage and Federal percentage specified in paragraph (2)(C)(ii).

[(B) FACILITY DESCRIBED.—For purposes of subparagraph (A), a qualified acute skilled nursing facility is a facility that—

[(i) was certified by the Secretary as a skilled nursing facility eligible to furnish services under this title before July 1, 1992;

[(ii) is a hospital-based facility; and

[(iii) for the cost reporting period beginning in fiscal year 1998, the facility had more than 60 percent of total patient days comprised of patients who are described in subparagraph (C).

[(C) DESCRIPTION OF PATIENTS.—For purposes of subparagraph (B), a patient described in this subparagraph is an individual who—

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

[(ii) is immuno-compromised secondary to an infectious disease, with specific diagnoses as specified by the Secretary.]

(12) ADJUSTMENT FOR RESIDENTS WITH AIDS.—

(A) IN GENERAL.—Subject to subparagraph (B), in the case of a resident of a skilled nursing facility who is afflicted with acquired immune deficiency syndrome (AIDS), the per diem amount of payment otherwise applicable shall be increased by 128 percent to reflect increased costs associated with such residents.

(B) SUNSET.—Subparagraph (A) shall not apply on and after such date as the Secretary certifies that there is an appropriate adjustment in the case mix under paragraph (4)(G)(i) to compensate for the increased costs associated with residents described in such subparagraph.

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SECTION 4018 OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987

SEC. 4018. SPECIAL RULES.

(a) * * *

(b) EXTENSION OF WAIVERS FOR SOCIAL HEALTH MAINTENANCE ORGANIZATIONS.—

(1) The Secretary of Health and Human Services shall extend without interruption, through [the date that is 30 months after the date that the Secretary submits to Congress the report described in section 4014(c) of the Balanced Budget Act of 1997] *December 31, 2004*, the approval of waivers granted under subsection (a) of section 2355 of the Deficit Reduction Act of 1984 for the demonstration project described in subsection (b) of that section, subject to the terms and conditions (other than duration of the project) established under that section (as amended by paragraph (2) of this subsection).

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SECTION 312 OF THE MEDICARE, MEDICAID, AND SCHIP BENEFITS IMPROVEMENT AND PROTECTION ACT OF 2000 (BIPA)

SEC. 312. INCREASE IN NURSING COMPONENT OF PPS FEDERAL RATE.

(a) IN GENERAL.—The Secretary of Health and Human Services shall increase by 16.66 percent the nursing component of the case-mix adjusted Federal prospective payment rate specified in Tables 3 and 4 of the final rule published in the Federal Register by the Health Care Financing Administration on July 31, 2000 (65 Fed. Reg. 46770) and as subsequently updated, effective for services furnished on or after April 1, 2001, and before October 1, 2002. *The Secretary of Health and Human Services shall increase by 8 percent the nursing component of the case-mix adjusted Federal prospective payment rate specified in Tables 3 and 4 of the final rule published in the Federal Register by the Health Care Financing Administration on July 31, 2000 (65 Fed. Reg. 46770) and as subsequently updated under section 1888(e)(4)(E)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(E)(ii)), effective for services furnished on or after October 1, 2002, and before October 1, 2005.*

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DISSENTING VIEWS

Today, seniors who enroll in Medicare fee-for-service are guaranteed the same set of defined benefits at the same predictable and affordable premium, regardless of where they live or what other private Medicare+Choice plans are participating in their area. H.R. 4985 contains several provisions that if enacted, would mark the beginning of the end of that guarantee.

In particular, this bill includes a demonstration program that sets the stage for the privatization of Medicare. Under this demonstration, the Federal Government's subsidy for each senior would be based on something other than the full cost of the fee-for-service program. By definition, this is premium support system. Instead of entitling seniors to a package of defined benefits, a premium support system would entitle Medicare beneficiaries to a monetary contribution—a voucher—that could be used toward the purchase of health insurance coverage.

In this demonstration, the amount of the voucher would be determined by the value of the "reference premium" for the county in which a senior lived. Seniors would enroll in either fee-for-service or an Medicare+Choice plan, and make up the difference between the fee-for-service or Medicare+Choice premium and the reference premium.

The coverage seniors could buy with this voucher would depend on the type of benefits Medicare+Choice plans decided to offer, which plans decided to offer coverage in these demonstration areas, and how much plans in these areas decided to charge. Different plans participating in the demonstration could charge different premiums, and the same plan could charge different premiums in different demonstration sites. In addition, the reference premium would vary among demonstration sites, so seniors in higher-cost demonstration sites would receive larger vouchers than seniors in lower-cost demonstration sites. As a result of this variation, the free-for-service premium would be different in each demonstration site. Also, seniors living in demonstration areas would pay different fee-for-service premiums than seniors in the rest of the country. This geographic disparity in premiums would be a first for the Medicare fee-for-service program, which has always charged seniors the same premium regardless of where they lived.

Another effect of the demonstrations is that seniors in these areas would pay more for the same coverage they have today. Fee-for-service premiums in the demonstration sites would almost certainly increase due to the difference in the populations enrolled in the fee-for-service program versus Medicare+Choice plans. Several studies from the General Accounting Office have demonstrated that seniors who enroll in Medicare+Choice plans tend to be younger

and healthier than seniors in the fee-for-service program.[1] Consequently, the initial reference premium would be lower than the fee-for-service premium. Seniors in these demonstration sites who wanted or needed to stay in fee-for-service would have to pay more out of their own pockets than the seniors who joined Medicare+Choice plans.

The seniors who would be particularly hurt by this premium support, or voucher experiment, would be the poorest seniors, who would no longer have the "choice" of staying in fee-for-service Medicare because it was too expensive. Their "choice" would be limited to the lowest-cost Medicare+Choice plan in their community. Seniors with chronic health care conditions would also be hurt, because they would have to pay more to preserve their "choice" of doctors and hospitals.

H.R. 4985 would unfairly penalize seniors who had the misfortune of living in one of these demonstration sites, who would not have chosen to participate in such an experiment. Instead, they would find themselves paying more for Medicare fee-for-service simply because the Secretary of Health and Human Services had designated their communities as testing grounds. We believe it is wrong to experiment with the Medicare program by shifting costs to seniors and the disabled.

The Committee bill includes another section that lays the groundwork for a privatized Medicare program. Beginning in 2005, H.R. 4985 establishes a Medicare+Choice "competition" program. This program also includes the concept of a "reference premium," which is the foundation for a premium support system.

Apart from the demonstration and competition sections, H.R. 4985 increases payments to Medicare+Choice plans. While we support this increase in funds, we disagree with several other pieces of the bill that make changes to the current Medicare+Choice program. First, the bill exempts Medicare+Choice plans from all state regulations, including laws that protect people enrolled in managed care plans. We oppose this provision because it takes away protections that seniors currently enjoy.

Second, H.R. 4985 permanently delays from July to September the adjusted community rate (ACR) filing deadline for Medicare+Choice plans. The bill, however, does not permanently delay the "lock-in provision," which limits seniors' ability to move in and out of managed care plans. The Bioterrorism Preparedness and Response Act of 2002 included equal delays in these two provisions, but the Committee bill only addresses the provision that is most favorable to Medicare+Choice plans.

Finally, H.R. 4985 re-institutes payments to Medicare+Choice plans for Indirect Medical Education (IME) payments, which have been carved out of plan payments since 1997. Again, we are not opposed to an increase in Medicare+Choice plan payments. We do object to the fact that Medicare+Choice plans are not required to pass along these IME payments to teaching hospitals. This provision is especially ill-conceived because a later section of H.R. 4985 allows IME adjustments to teaching hospitals to decrease from 6.5% to

[1] GAO, Medicare+Choice: Reforms Have Reduced, but Likely Not Eliminated, Excess Plan Payments, June 1999, GAO/HEHS–99–144.

6.0% in 2003, to 5.9% in 2004, then to 5.5% in 2005 and beyond. We would much rather have used additional IME payments to maintain the adjustment for teaching hospitals at the current level of 6.5%.

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