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107TH CONGRESS
2^D SESSION

H. R. 4985

[Report No. 107-550, Part 1]

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.

IN THE HOUSE OF REPRESENTATIVES

JUNE 21, 2002

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

JUNE 26, 2002

Reported from the Committee on Energy and Commerce

JUNE 26, 2002

Referral to the Committee on Ways and Means extended for a period ending not later than June 28, 2002

JUNE 28, 2002

Committee on Ways and Means discharged; committed to the Committee of the Whole House on the State of the Union and ordered to be printed

A BILL

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.

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

3 **TITLE II—MEDICARE+CHOICE**
 4 **REVITALIZATION AND**
 5 **MEDICARE+CHOICE COM-**
 6 **PETITION PROGRAM**
 7 **Subtitle A—Medicare+Choice**
 8 **Revitalization**

9 **SEC. 201. MEDICARE+CHOICE IMPROVEMENTS.**

10 (a) EQUALIZING PAYMENTS BETWEEN FEE-FOR-
 11 SERVICE AND MEDICARE+CHOICE.—

12 (1) IN GENERAL.—Section 1853(c)(1) (42
 13 U.S.C. 1395w–23(c)(1)) is amended by adding at
 14 the end the following:

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

17 “(i) IN GENERAL.—For 2003 and
 18 2004, the adjusted average per capita cost
 19 for the year involved, determined under
 20 section 1876(a)(4) for the
 21 Medicare+Choice payment area for serv-
 22 ices covered under parts A and B for indi-

1 individuals entitled to benefits under part A
2 and enrolled under part B who are not en-
3 rolled in a Medicare+Choice plan under
4 this part for the year, but adjusted to ex-
5 clude costs attributable to payments under
6 section 1886(h).

7 “(ii) INCLUSION OF COSTS OF VA AND
8 DOD MILITARY FACILITY SERVICES TO
9 MEDICARE-ELIGIBLE BENEFICIARIES.—In
10 determining the adjusted average per cap-
11 ita cost under clause (i) for a year, such
12 cost shall be adjusted to include the Sec-
13 retary’s estimate, on a per capita basis, of
14 the amount of additional payments that
15 would have been made in the area involved
16 under this title if individuals entitled to
17 benefits under this title had not received
18 services from facilities of the Department
19 of Veterans Affairs or the Department of
20 Defense.”.

21 (2) CONFORMING AMENDMENT.—Such section
22 is further amended, in the matter before subpara-
23 graph (A), by striking “or (C)” and inserting “(C),
24 or (D)”.

25 (b) REVISION OF BLEND.—

1 (1) REVISION OF NATIONAL AVERAGE USED IN
2 CALCULATION OF BLEND.—Section
3 1853(c)(4)(B)(i)(II) (42 U.S.C. 1395w–
4 23(c)(4)(B)(i)(II)) is amended by inserting “who
5 (with respect to determinations for 2003 and for
6 2004) are enrolled in a Medicare+Choice plan”
7 after “the average number of medicare bene-
8 ficiaries”.

9 (2) CHANGE IN BUDGET NEUTRALITY.—Section
10 1853(c) (42 U.S.C. 1395w–23(c)) is amended—

11 (A) in paragraph (1)(A), by inserting “(for
12 a year before 2003)” after “multiplied”; and

13 (B) in paragraph (5), by inserting “(before
14 2003)” after “for each year”.

15 (c) REVISION IN MINIMUM PERCENTAGE INCREASE
16 FOR 2003 AND 2004.—Section 1853(c)(1)(C) (42 U.S.C.
17 1395w–23(c)(1)(C)) is amended by striking clause (iv)
18 and inserting the following:

19 “(iv) For 2002, 102 percent of the
20 annual Medicare+Choice capitation rate
21 under this paragraph for the area for
22 2001.

23 “(v) For 2003 and 2004, 103 percent
24 of the annual Medicare+Choice capitation

1 rate under this paragraph for the area for
2 the previous year.

3 “(iv) For 2005 and each succeeding
4 year, 102 percent of the annual
5 Medicare+Choice capitation rate under
6 this paragraph for the area for the pre-
7 vious year.”.

8 (d) INCLUSION OF COSTS OF DOD AND VA MILI-
9 TARY FACILITY SERVICES TO MEDICARE-ELIGIBLE
10 BENEFICIARIES IN CALCULATION OF MEDICARE+CHOICE
11 PAYMENT RATES.—Section 1853(c)(3) (42 U.S.C.
12 1395w-23(c)(3)) is amended—

13 (1) in subparagraph (A), by striking “subpara-
14 graph (B)” and inserting “subparagraphs (B) and
15 (E)”, and

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

18 “(E) INCLUSION OF COSTS OF DOD AND
19 VA MILITARY FACILITY SERVICES TO MEDICARE-
20 ELIGIBLE BENEFICIARIES.—In determining the
21 area-specific Medicare+Choice capitation rate
22 under subparagraph (A) for a year (beginning
23 with 2003), the annual per capita rate of pay-
24 ment for 1997 determined under section
25 1876(a)(1)(C) shall be adjusted to include in

1 the rate the Secretary's estimate, on a per cap-
2 ita basis, of the amount of additional payments
3 that would have been made in the area involved
4 under this title if individuals entitled to benefits
5 under this title had not received services from
6 facilities of the Department of Defense or the
7 Department of Veterans Affairs.”.

8 (e) ANNOUNCEMENT OF REVISED
9 MEDICARE+CHOICE PAYMENT RATES.—Within 2 weeks
10 after the date of the enactment of this Act, the Secretary
11 shall determine, and shall announce (in a manner intended
12 to provide notice to interested parties) Medicare+Choice
13 capitation rates under section 1853 of the Social Security
14 Act (42 U.S.C. 1395w-23) for 2003, revised in accordance
15 with the provisions of this section.

16 (f) MEDPAC STUDY OF AAPCC.—

17 (1) STUDY.—The Medicare Payment Advisory
18 Commission shall conduct a study that assesses the
19 method used for determining the adjusted average
20 per capita cost (AAPCC) under section 1876(a)(4)
21 of the Social Security Act (42 U.S.C.
22 1395mm(a)(4)). Such study shall examine—

23 (A) the bases for variation in such costs
24 between different areas, including differences in
25 input prices, utilization, and practice patterns;

1 (B) the appropriate geographic area for
2 payment under the Medicare+Choice program
3 under part C of title XVIII of such Act; and

4 (C) the accuracy of risk adjustment meth-
5 ods in reflecting differences in costs of pro-
6 viding care to different groups of beneficiaries
7 served under such program.

8 (2) REPORT.—Not later than 9 months after
9 the date of the enactment of this Act, the Commis-
10 sion shall submit to Congress a report on the study
11 conducted under paragraph (1). Such report shall
12 include recommendations regarding changes in the
13 methods for computing the adjusted average per
14 capita cost among different areas.

15 **SEC. 202. MAKING PERMANENT CHANGE IN**
16 **MEDICARE+CHOICE REPORTING DEADLINES**
17 **AND ANNUAL, COORDINATED ELECTION PE-**
18 **RIOD.**

19 (a) CHANGE IN REPORTING DEADLINE.—Section
20 1854(a)(1) (42 U.S.C. 1395w-24(a)(1)), as amended by
21 section 532(b)(1) of the Public Health Security and Bio-
22 terrorism Preparedness and Response Act of 2002, is
23 amended by striking “2002, 2003, and 2004 (or July 1
24 of each other year)” and inserting “2002 and each subse-
25 quent year (or July 1 of each year before 2002)”.

1 (b) DELAY IN ANNUAL, COORDINATED ELECTION
2 PERIOD.—Section 1851(e)(3)(B) (42 U.S.C. 1395w–
3 21(e)(3)(B)), as amended by section 532(c)(1)(A) of the
4 Public Health Security and Bioterrorism Preparedness
5 and Response Act of 2002, is amended by striking “and
6 after 2005, the month of November before such year and
7 with respect to 2003, 2004, and 2005” and inserting “,
8 the month of November before such year and with respect
9 to 2003 and any subsequent year”.

10 (c) ANNUAL ANNOUNCEMENT OF PAYMENT
11 RATES.—Section 1853(b)(1) (42 U.S.C. 1395w–
12 23(b)(1)), as amended by section 532(d)(1) of the Public
13 Health Security and Bioterrorism Preparedness and Re-
14 sponse Act of 2002, is amended by striking “and after
15 2005 not later than March 1 before the calendar year con-
16 cerned and for 2004 and 2005” and inserting “not later
17 than March 1 before the calendar year concerned and for
18 2004 and each subsequent year”.

19 (d) REQUIRING PROVISION OF AVAILABLE INFORMA-
20 TION COMPARING PLAN OPTIONS.—The first sentence of
21 section 1851(d)(2)(A)(ii) (42 U.S.C. 1395w–
22 21(d)(2)(A)(ii)) is amended by inserting before the period
23 the following: “to the extent such information is available
24 at the time of preparation of materials for the mailing”.

1 **SEC. 203. AVOIDING DUPLICATIVE STATE REGULATION.**

2 (a) IN GENERAL.—Section 1856(b)(3) (42 U.S.C.
3 1395w–26(b)(3)) is amended to read as follows:

4 “(3) RELATION TO STATE LAWS.—The stand-
5 ards established under this subsection shall super-
6 sede any State law or regulation (other than State
7 licensing laws or State laws relating to plan sol-
8 vency) with respect to Medicare+Choice plans which
9 are offered by Medicare+Choice organizations under
10 this part.”.

11 (b) EFFECTIVE DATE.—The amendment made by
12 subsection (a) shall take effect on the date of the enact-
13 ment of this Act.

14 **SEC. 204. SPECIALIZED MEDICARE+CHOICE PLANS FOR**
15 **SPECIAL NEEDS BENEFICIARIES.**

16 (a) TREATMENT AS COORDINATED CARE PLAN.—
17 Section 1851(a)(2)(A) (42 U.S.C. 1395w–21(a)(2)(A)) is
18 amended by adding at the end the following new sentence:
19 “Specialized Medicare+Choice plans for special needs
20 beneficiaries (as defined in section 1859(b)(4)) may be
21 any type of coordinated care plan.”.

22 (b) SPECIALIZED MEDICARE+CHOICE PLAN FOR
23 SPECIAL NEEDS BENEFICIARIES DEFINED.—Section
24 1859(b) (42 U.S.C. 1395w–29(b)) is amended by adding
25 at the end the following new paragraph:

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

3 “(A) IN GENERAL.—The term ‘specialized
4 Medicare+Choice plan for special needs bene-
5 ficiaries’ means a Medicare+Choice plan that
6 exclusively serves special needs beneficiaries (as
7 defined in subparagraph (B)).

8 “(B) SPECIAL NEEDS BENEFICIARY.—The
9 term ‘special needs beneficiary’ means a
10 Medicare+Choice eligible individual who—

11 “(i) is institutionalized (as defined by
12 the Secretary);

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

15 “(iii) meets such requirements as the
16 Secretary may determine would benefit
17 from enrollment in such a specialized
18 Medicare+Choice plan described in sub-
19 paragraph (A) for individuals with severe
20 or disabling chronic conditions.”.

21 (c) RESTRICTION ON ENROLLMENT PERMITTED.—
22 Section 1859 (42 U.S.C. 1395w-29) is amended by add-
23 ing at the end the following new subsection:

24 “(f) RESTRICTION ON ENROLLMENT FOR SPECIAL-
25 IZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS

1 BENEFICIARIES.—In the case of a specialized
2 Medicare+Choice plan (as defined in subsection (b)(4)),
3 notwithstanding any other provision of this part and in
4 accordance with regulations of the Secretary and for peri-
5 ods before January 1, 2007, the plan may restrict the en-
6 rollment of individuals under the plan to individuals who
7 are within one or more classes of special needs bene-
8 ficiaries.”.

9 (d) REPORT TO CONGRESS.—Not later than Decem-
10 ber 31, 2005, the Medicare Benefits Administrator shall
11 submit to Congress a report that assesses the impact of
12 specialized Medicare+Choice plans for special needs bene-
13 ficiaries on the cost and quality of services provided to
14 enrollees. Such report shall include an assessment of the
15 costs and savings to the medicare program as a result of
16 amendments made by subsections (a), (b), and (c).

17 (e) EFFECTIVE DATES.—

18 (1) IN GENERAL.—The amendments made by
19 subsections (a), (b), and (c) shall take effect upon
20 the date of the enactment of this Act.

21 (2) DEADLINE FOR ISSUANCE OF REQUIRE-
22 MENTS FOR SPECIAL NEEDS BENEFICIARIES; TRAN-
23 SITION.—No later than 6 months after the date of
24 the enactment of this Act, the Secretary of Health
25 and Human Services shall issue final regulations to

1 establish requirements for special needs beneficiaries
2 under section 1859(b)(4)(B)(iii) of the Social Secu-
3 rity Act, as added by subsection (b).

4 **SEC. 205. MEDICARE MSAS.**

5 (a) EXEMPTION FROM QUALITY ASSURANCE PRO-
6 GRAM REQUIREMENT.—

7 (1) IN GENERAL.—Section 1852(e)(1) (42
8 U.S.C. 1395w–22(e)(1)) is amended by inserting
9 “(other than MSA plans)” after “Medicare+Choice
10 plans”.

11 (2) CONFORMING AMENDMENTS.—Section 1852
12 (42 U.S.C. 1395w–22) is amended—

13 (A) in subsection (c)(1)(I), by inserting be-
14 fore the period at the end the following: “if re-
15 quired under such section”; and

16 (B) in subparagraphs (A) and (B) of sub-
17 section (e)(2), by striking “, a non-network
18 MSA plan,” and “, NON-NETWORK MSA
19 PLANS,” each place it appears.

20 (b) MAKING PROGRAM PERMANENT AND ELIMI-
21 NATING CAP.—Section 1851(b)(4) (42 U.S.C. 1395w–
22 21(b)(4)) is amended—

23 (1) in the heading of subparagraph (A), by
24 striking “ON A DEMONSTRATION BASIS”;

1 (2) by striking the first sentence of subpara-
2 graph (A); and

3 (3) by striking the second sentence of subpara-
4 graph (C).

5 (c) APPLYING LIMITATIONS ON BALANCE BILL-
6 ING.—Section 1852(k)(1) (42 U.S.C. 1395w–22(k)(1)) is
7 amended by inserting “or with an organization offering
8 a MSA plan” after “section 1851(a)(2)(A)”.

9 (d) ADDITIONAL AMENDMENT.—Section
10 1851(e)(5)(A) (42 U.S.C. 1395w–21(e)(5)(A)) is
11 amended—

12 (1) by adding “or” at the end of clause (i);

13 (2) by striking “, or” at the end of clause (ii)
14 and inserting a semicolon; and

15 (3) by striking clause (iii).

16 **SEC. 206. EXTENSION OF REASONABLE COST AND SHMO**
17 **CONTRACTS.**

18 (a) REASONABLE COST CONTRACTS.—

19 (1) IN GENERAL.—Section 1876(h)(5)(C) (42
20 U.S.C. 1395mm(h)(5)(C)) is amended—

21 (A) by inserting “(i)” after “(C)”;

22 (B) by inserting before the period the fol-
23 lowing: “, except (subject to clause (ii)) in the
24 case of a contract for an area which is not cov-
25 ered in the service area of 1 or more coordi-

1 nated care Medicare+Choice plans under part
2 C”; and

3 (C) by adding at the end the following new
4 clause:

5 “(ii) In the case in which—

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

9 “(II) such area is no longer included in such
10 service area after such date by reason of the oper-
11 ation of clause (i) because of the inclusion of such
12 area within the service area of a Medicare+Choice
13 plan; and

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

16 such reasonable cost reimbursement contract may be ex-
17 tended and renewed to cover such area (so long as it is
18 not included in the service area of any Medicare+Choice
19 plan).”.

20 (2) STUDY.—The Medicare Benefits Adminis-
21 trator shall conduct a study of an appropriate tran-
22 sition for plans offered under reasonable cost con-
23 tracts under section 1876 of the Social Security Act
24 on and after January 1, 2005. Such a transition
25 may take into account whether there are one or

1 more coordinated care Medicare+Choice plans being
2 offered in the areas involved. Not later than Feb-
3 ruary 1, 2004, the Administrator shall submit to
4 Congress a report on such study and shall include
5 recommendations regarding any changes in the
6 amendment made by paragraph (1) as the Adminis-
7 trator determines to be appropriate.

8 (b) EXTENSION OF SOCIAL HEALTH MAINTENANCE
9 ORGANIZATION (SHMO) DEMONSTRATION PROJECT.—

10 (1) IN GENERAL.—Section 4018(b)(1) of the
11 Omnibus Budget Reconciliation Act of 1987 is
12 amended by striking “the date that is 30 months
13 after the date that the Secretary submits to Con-
14 gress the report described in section 4014(e) of the
15 Balanced Budget Act of 1997” and inserting “De-
16 cember 31, 2004”.

17 (2) SHMOs OFFERING MEDICARE+CHOICE
18 PLANS.—Nothing in such section 4018 shall be con-
19 strued as preventing a social health maintenance or-
20 ganization from offering a Medicare+Choice plan
21 under part C of title XVIII of the Social Security
22 Act.

1 **Subtitle B—Medicare+Choice**
2 **Competition Program**

3 **SEC. 211. MEDICARE+CHOICE COMPETITION PROGRAM.**

4 (a) SUBMISSION OF BID AMOUNTS.—Section 1854
5 (42 U.S.C. 1395w–24) is amended—

6 (1) by amending the heading to read as follows:

7 “SUBMISSION OF BID AMOUNTS”;

8 (2) in subsection (a)(1)(A)—

9 (A) by striking “(A)” and inserting “(A)(i)
10 if the following year is before 2005,”; and

11 (B) by inserting before the semicolon at
12 the end the following: “ or (ii) if the following
13 year is 2005 or later, the information described
14 in paragraph (6)(A)”;

15 (3) by adding at the end of subsection (a) the
16 following:

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

19 “(A) INFORMATION TO BE SUBMITTED.—

20 The information described in this subparagraph
21 is as follows:

22 “(i) The monthly aggregate bid
23 amount for provision of all items and serv-
24 ices under this part and the actuarial basis
25 for determining such amount.

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

3 “(I) the provision of statutory
4 non-drug benefits (such portion re-
5 ferred to in this part as the
6 ‘unadjusted non-drug monthly bid
7 amount’);

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

10 “(III) the provision of non-statu-
11 tory benefits;

12 and the actuarial basis for determining
13 such proportions.

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

18 “(B) STATUTORY BENEFITS DEFINED.—

19 For purposes of this part:

20 “(i) The term ‘statutory non-drug
21 benefits’ means benefits under parts A and
22 B.

23 “(ii) The term ‘statutory prescription
24 drug benefits’ means benefits under part
25 D.

1 “(iii) The term ‘statutory benefits’
2 means statutory prescription drug benefits
3 and statutory non-drug benefits.

4 “(C) ACCEPTANCE AND NEGOTIATION OF
5 BID AMOUNTS.—The Administrator has the au-
6 thority to negotiate regarding monthly bid
7 amounts submitted under subparagraph (A)
8 (and the proportion described in subparagraph
9 (A)(ii)). The Administrator may reject such a
10 bid amount or proportion if the Administrator
11 determines that such amount or proportion is
12 not supported by the actuarial bases provided
13 under subparagraph (A).”.

14 (b) PROVIDING FOR BENEFICIARY SAVINGS FOR
15 CERTAIN PLANS.—

16 (1) IN GENERAL.—Section 1854(b) (42 U.S.C.
17 1395w-24(b)) is amended—

18 (A) by adding at the end of paragraph (1)
19 the following new subparagraph:

20 “(C) BENEFICIARY REBATE RULE.—

21 “(i) REQUIREMENT.—The
22 Medicare+Choice plan shall provide to the
23 enrollee a monthly rebate equal to 75
24 percent of the average per capita savings

1 (if any) described in paragraph (3) appli-
2 cable to the plan and year involved.

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

6 “(I) through the crediting of the
7 amount of the rebate towards the
8 Medicare+Choice monthly supple-
9 mentary beneficiary premium or the
10 premium imposed for prescription
11 drug coverage under part D;

12 “(II) through a direct monthly
13 payment (through electronic funds
14 transfer or otherwise); or

15 “(III) through other means ap-
16 proved by the Medicare Benefits Ad-
17 ministrators,

18 or any combination thereof.”; and

19 (B) by adding at the end the following new
20 paragraph:

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

1 “(A) DETERMINATION OF STATE-WIDE AV-
2 ERAGE RISK ADJUSTMENT.—

3 “(i) IN GENERAL.—The Medicare
4 Benefits Administrator shall determine, at
5 the same time rates are promulgated under
6 section 1853(b)(1) (beginning with 2005),
7 for each State the average of the risk ad-
8 justment factors to be applied to enrollees
9 under section 1853(a)(1)(A) in that State.
10 In the case of a State in which a
11 Medicare+Choice plan was offered in the
12 previous year, the Administrator may com-
13 pute such average based upon risk adjust-
14 ment factors applied in that State in a pre-
15 vious year.

16 “(ii) TREATMENT OF NEW STATES.—
17 In the case of a State in which no
18 Medicare+Choice plan was offered in the
19 previous year, the Administrator shall esti-
20 mate such average. In making such esti-
21 mate, the Administrator may use average
22 risk adjustment factors applied to com-
23 parable States or applied on a national
24 basis.

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

5 “(i) adjust the fee-for-service area-
6 specific non-drug benchmark amount by
7 the applicable average risk adjustment fac-
8 tor computed under subparagraph (A); and

9 “(ii) adjust the unadjusted non-drug
10 monthly bid amount by such applicable av-
11 erage risk adjustment factor.

12 “(C) DETERMINATION OF AVERAGE PER
13 CAPITA MONTHLY SAVINGS.—The average per
14 capita monthly savings described in this sub-
15 paragraph is equal to the amount (if any) by
16 which—

17 “(i) the risk-adjusted benchmark
18 amount computed under subparagraph
19 (B)(i), exceeds

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

22 “(D) AUTHORITY TO DETERMINE RISK AD-
23 JUSTMENT FOR AREAS OTHER THAN STATES.—
24 The Administrator may provide for the deter-
25 mination and application of risk adjustment

1 factors under this paragraph on the basis of
2 areas other than States.”.

3 (2) COMPUTATION OF FEE-FOR-SERVICE AREA-
4 SPECIFIC NON-DRUG BENCHMARK.—Section 1853
5 (42 U.S.C. 1395w–23) is amended by adding at the
6 end the following new subsection:

7 “(j) COMPUTATION OF FEE-FOR-SERVICE AREA-SPE-
8 CIFIC NON-DRUG BENCHMARK AMOUNT.—For purposes
9 of this part, the term ‘fee-for-service area-specific non-
10 drug benchmark amount’ means, with respect to a
11 Medicare+Choice payment area for a month in a year,
12 an amount equal to the greater of the following (but in
13 no case less than $\frac{1}{12}$ of the rate computed under sub-
14 section (c)(1), without regard to subparagraph (A), for the
15 year):

16 “(1) BASED ON 100 PERCENT OF FEE-FOR-
17 SERVICE COSTS IN THE AREA.—An amount equal to
18 $\frac{1}{12}$ of 100 percent (for 2005 through 2007, or 95
19 percent for 2008 and years thereafter) of the ad-
20 justed average per capita cost for the year involved,
21 determined under section 1876(a)(4) for the
22 Medicare+Choice payment area, for the area and
23 the year involved, for services covered under parts A
24 and B for individuals entitled to benefits under part
25 A and enrolled under part B who are not enrolled

1 in a Medicare+Choice plan under this part for the
2 year, and adjusted to exclude from such cost the
3 amount the Medicare Benefits Administrator esti-
4 mates is payable for costs described in subclauses (I)
5 and (II) of subsection (c)(3)(C)(i) for the year in-
6 volved and also adjusted in the manner described in
7 subsection (c)(1)(D)(ii) (relating to inclusion of
8 costs of VA and DOD military facility services to
9 medicare-eligible beneficiaries).

10 “(2) MINIMUM MONTHLY AMOUNT.—The min-
11 imum amount specified in this paragraph is the
12 amount specified in subsection (c)(1)(B)(iv) for the
13 year involved.”.

14 (c) PAYMENT OF PLANS BASED ON BID AMOUNTS.—

15 (1) IN GENERAL.—Section 1853(a)(1)(A) (42
16 U.S.C. 1395w-23) is amended by striking “in an
17 amount” and all that follows and inserting the fol-
18 lowing: “in an amount determined as follows:

19 “(i) PAYMENT BEFORE 2005.—For
20 years before 2005, the payment amount
21 shall be equal to $\frac{1}{12}$ of the annual
22 Medicare+Choice capitation rate (as cal-
23 culated under subsection (c)) with respect
24 to that individual for that area, reduced by
25 the amount of any reduction elected under

1 section 1854(f)(1)(E) and adjusted under
2 clause (iii).

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

6 “(I) PLANS WITH BIDS BELOW
7 BENCHMARK.—In the case of a plan
8 for which there are average per capita
9 monthly savings described in section
10 1854(b)(3)(C), the payment under
11 this subsection is equal to the
12 unadjusted non-drug monthly bid
13 amount, adjusted under clause (iii),
14 plus the amount of the monthly rebate
15 computed under section
16 1854(b)(1)(C)(i) for that plan and
17 year.

18 “(II) PLANS WITH BIDS AT OR
19 ABOVE BENCHMARK.—In the case of a
20 plan for which there are no average
21 per capita monthly savings described
22 in section 1854(b)(3)(C), the payment
23 amount under this subsection is equal
24 to the fee-for-service area-specific non-

1 drug benchmark amount, adjusted
2 under clause (iii).

3 “(iii) DEMOGRAPHIC ADJUSTMENT,
4 INCLUDING ADJUSTMENT FOR HEALTH
5 STATUS.—The Administrator shall adjust
6 the payment amount under clause (i), the
7 unadjusted non-drug monthly bid amount
8 under clause (ii)(I), and the fee-for-service
9 area-specific non-drug benchmark amount
10 under clause (ii)(II) for such risk factors
11 as age, disability status, gender, institu-
12 tional status, and such other factors as the
13 Administrator determines to be appro-
14 priate, including adjustment for health sta-
15 tus under paragraph (3), so as to ensure
16 actuarial equivalence. The Administrator
17 may add to, modify, or substitute for such
18 adjustment factors if such changes will im-
19 prove the determination of actuarial
20 equivalence.

21 “(iv) REFERENCE TO SUBSIDY PAY-
22 MENT FOR STATUTORY DRUG BENEFITS.—
23 In the case in which an enrollee is enrolled
24 under part D, the Medicare+Choice orga-

1 nization also is entitled to a subsidy pay-
2 ment amount under section 1860H.”.

3 (d) CONFORMING AMENDMENTS.—

4 (1) PROTECTION AGAINST BENEFICIARY SELEC-
5 TION.—Section 1852(b)(1)(A) (42 U.S.C. 1395w-
6 22(b)(1)(A)) is amended by adding at the end the
7 following: “The Administrator shall not approve a
8 plan of an organization if the Administrator deter-
9 mines that the benefits are designed to substantially
10 discourage enrollment by certain Medicare+Choice
11 eligible individuals with the organization.”.

12 (2) CONFORMING AMENDMENT TO PREMIUM
13 TERMINOLOGY.—Subparagraphs (A) and (B) of sec-
14 tion 1854(b)(2) (42 U.S.C. 1395w-24(b)(2)) are
15 amended to read as follows:

16 “(A) MEDICARE+CHOICE MONTHLY BASIC
17 BENEFICIARY PREMIUM.—The term
18 ‘Medicare+Choice monthly basic beneficiary
19 premium’ means, with respect to a
20 Medicare+Choice plan—

21 “(i) described in section
22 1853(a)(1)(A)(ii)(I) (relating to plans pro-
23 viding rebates), zero; or

24 “(ii) described in section
25 1853(a)(1)(A)(ii)(II), the amount (if any)

1 by which the unadjusted non-drug monthly
2 bid amount exceeds the fee-for-service
3 area-specific non-drug benchmark amount.

4 “(B) MEDICARE+CHOICE MONTHLY SUP-
5 PLEMENTAL BENEFICIARY PREMIUM.—The
6 term ‘Medicare+Choice monthly supplemental
7 beneficiary premium’ means, with respect to a
8 Medicare+Choice plan, the portion of the ag-
9 gregate monthly bid amount submitted under
10 clause (i) of subsection (a)(6)(A) for the year
11 that is attributable under such section to the
12 provision of nonstatutory benefits.”.

13 (3) REQUIREMENT FOR UNIFORM BID
14 AMOUNTS.—Section 1854(e) (42 U.S.C. 1395w-
15 24(c)) is amended to read as follows:

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

21 (4) PERMITTING BENEFICIARY REBATES.—

22 (A) Section 1851(h)(4)(A) (42 U.S.C.
23 1395w-21(h)(4)(A)) is amended by inserting
24 “except as provided under section
25 1854(b)(1)(C)” after “or otherwise”.

1 (B) Section 1854(d) (42 U.S.C. 1395w-
2 24(d)) is amended by inserting “, except as pro-
3 vided under subsection (b)(1)(C),” after “and
4 may not provide”.

5 (e) EFFECTIVE DATE.—The amendments made by
6 this section shall apply to payments and premiums for
7 months beginning with January 2005.

8 **SEC. 212. DEMONSTRATION PROGRAM FOR COMPETITIVE-**
9 **DEMONSTRATION AREAS.**

10 (a) IDENTIFICATION OF COMPETITIVE-DEMONSTRA-
11 TION AREAS FOR DEMONSTRATION PROGRAM; COMPUTA-
12 TION OF CHOICE NON-DRUG BENCHMARKS.—Section
13 1853, as amended by section 211(b)(2), is amended by
14 adding at the end the following new subsection:

15 “(k) ESTABLISHMENT OF COMPETITIVE DEM-
16 ONSTRATION PROGRAM.—

17 “(1) DESIGNATION OF COMPETITIVE-DEM-
18 ONSTRATION AREAS AS PART OF PROGRAM.—

19 “(A) IN GENERAL.—For purposes of this
20 part, the Administrator shall establish a dem-
21 onstration program under which the Adminis-
22 trator designates Medicare+Choice areas as
23 competitive-demonstration areas consistent with
24 the following limitations:

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

6 “(ii) LIMITATION ON PERIOD OF DES-
7 IGNATION OF ANY AREA.—The Adminis-
8 trator may not designate any area as a
9 competitive-demonstration area for a pe-
10 riod of more than 2 years.

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

15 “(B) QUALIFICATIONS FOR DESIGNA-
16 TION.—For purposes of this title, a
17 Medicare+Choice area (which is a metropolitan
18 statistical area or other area with a substantial
19 number of Medicare+Choice enrollees) may not
20 be designated as a ‘competitive-demonstration
21 area’ for a 2-year period beginning with a year
22 unless the Administrator determines, by such
23 date before the beginning of the year as the Ad-
24 ministrator determines appropriate, that—

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

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

13 “(2) CHOICE NON-DRUG BENCHMARK
14 AMOUNT.—For purposes of this part, the term
15 ‘choice non-drug benchmark amount’ means, with
16 respect to a Medicare+Choice payment area for a
17 month in a year, the sum of the 2 components de-
18 scribed in paragraph (3) for the area and year. The
19 Administrator shall compute such benchmark
20 amount for each competitive-demonstration area be-
21 fore the beginning of each annual, coordinated elec-
22 tion period under section 1851(e)(3)(B) for each
23 year (beginning with 2005) in which it is designated
24 as such an area.

1 “(3) 2 COMPONENTS.—For purposes of para-
2 graph (2), the 2 components described in this para-
3 graph for an area and a year are the following:

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

7 “(i) NATIONAL FEE-FOR-SERVICE
8 MARKET SHARE.—The national fee-for-
9 service market share percentage (deter-
10 mined under paragraph (5)) for the year.

11 “(ii) FEE-FOR-SERVICE AREA-SPE-
12 CIFIC NON-DRUG BID.—The fee-for-service
13 area-specific non-drug bid (as defined in
14 paragraph (6)) for the area and year.

15 “(B) M+C COMPONENT WEIGHTED BY NA-
16 TIONAL MEDICARE+CHOICE MARKET SHARE.—
17 The product of the following:

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

22 “(ii) WEIGHTED AVERAGE OF PLAN
23 BIDS IN AREA.—The weighted average of
24 the plan bids for the area and year (as de-
25 termined under paragraph (4)(A)).

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

3 “(A) IN GENERAL.—For purposes of para-
4 graph (3)(B)(ii), the weighted average of plan
5 bids for an area and a year is the sum of the
6 following products for Medicare+Choice plans
7 described in subparagraph (C) in the area and
8 year:

9 “(i) PROPORTION OF EACH PLAN’S
10 ENROLLEES IN THE AREA.—The number
11 of individuals described in subparagraph
12 (B), divided by the total number of such
13 individuals for all Medicare+Choice plans
14 described in subparagraph (C) for that
15 area and year.

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

19 “(B) COUNTING OF INDIVIDUALS.—The
20 Administrator shall count, for each
21 Medicare+Choice plan described in subpara-
22 graph (C) for an area and year, the number of
23 individuals who reside in the area and who were
24 enrolled under such plan under this part during
25 March of the previous year.

1 “(C) EXCLUSION OF PLANS NOT OFFERED
2 IN PREVIOUS YEAR.—For an area and year, the
3 Medicare+Choice plans described in this sub-
4 paragraph are plans that are offered in the area
5 and year and were offered in the area in March
6 of the previous year.

7 “(5) COMPUTATION OF NATIONAL FEE-FOR-
8 SERVICE MARKET SHARE PERCENTAGE.—The Ad-
9 ministrators shall determine, for a year, the propor-
10 tion (in this subsection referred to as the ‘national
11 fee-for-service market share percentage’) of
12 Medicare+Choice eligible individuals who during
13 March of the previous year were not enrolled in a
14 Medicare+Choice plan.

15 “(6) FEE-FOR-SERVICE AREA-SPECIFIC NON-
16 DRUG BID.—For purposes of this part, the term
17 ‘fee-for-service area-specific non-drug bid’ means, for
18 an area and year, the amount described in section
19 1853(j)(1) for the area and year, except that any
20 reference to a percent of less than 100 percent shall
21 be deemed a reference to 100 percent.”.

22 (b) APPLICATION OF CHOICE NON-DRUG BENCH-
23 MARK IN COMPETITIVE-DEMONSTRATION AREAS.—

24 (1) IN GENERAL.—Section 1854 is amended—

1 (A) in subsection (b)(1)(C)(i), as added by
2 section 211(b)(1)(A), by striking “(i) REQUIRE-
3 MENT.—If” and inserting “(i) REQUIREMENT
4 FOR NON-COMPETITIVE-DEMONSTRATION
5 AREAS.—In the case of a Medicare+Choice
6 payment area that is not a competitive-dem-
7 onstration area designated under section
8 1853(k)(1), if”;

9 (B) in subsection (b)(1)(C), as so added,
10 by inserting after clause (i) the following new
11 clause:

12 “(ii) REQUIREMENT FOR COMPETI-
13 TIVE-DEMONSTRATION AREAS.—In the
14 case of a Medicare+Choice payment area
15 that is designated as a competitive-dem-
16 onstration area under section 1853(k)(1),
17 if there are average per capita monthly
18 savings described in paragraph (4) for a
19 Medicare+Choice plan and year, the
20 Medicare+Choice plan shall provide to the
21 enrollee a monthly rebate equal to 75 per-
22 cent of such savings.”;

23 (C) by adding at the end of subsection (b),
24 as amended by section 211(b)(1), the following
25 new paragraph:

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

15 (D) in subsection (d), as amended by sec-
16 tion 211(d)(4), by inserting “and subsection
17 (b)(1)(D)” after “subsection (b)(1)(C),”.

18 (2) CONFORMING AMENDMENTS.—

19 (A) PAYMENT OF PLANS.—Section
20 1853(a)(1)(A)(ii), as amended by section
21 211(c)(1), is amended—

22 (i) in subclause (I), by inserting “(or,
23 in the case of a competitive-demonstration
24 area, the choice non-drug benchmark
25 amount)” after “benchmark amount”; and

1 (ii) in subclauses (I) and (II), by in-
2 serting “(or, in the case of a competitive-
3 demonstration area, described in section
4 1854(b)(4))” after “section
5 1854(b)(1)(C)”.

6 (B) DEFINITION OF MONTHLY BASIC PRE-
7 MIUM.—Section 1854(b)(2)(A)(ii), as amended
8 by section 211(d)(2), is amended by inserting
9 “(or, in the case of a competitive-demonstration
10 area, the choice non-drug benchmark amount)”
11 after “benchmark amount”.

12 (c) PREMIUM ADJUSTMENT.—Section 1839 (42
13 U.S.C. 1395r) is amended by adding at the end the fol-
14 lowing new subsection:

15 “(h)(1) In the case of an individual who resides in
16 a competitive-demonstration area designated under section
17 1851(k)(1) and who is not enrolled in a Medicare+Choice
18 plan under part C, the monthly premium otherwise applied
19 under this part (determined without regard to subsections
20 (b) and (f) or any adjustment under this subsection) shall
21 be adjusted as follows: If the fee-for-service area-specific
22 non-drug bid (as defined in section 1853(k)(6)) for the
23 Medicare+Choice area in which the individual resides for
24 a month—

1 “(A) does not exceed the choice non-drug
2 benchmark (as determined under section
3 1853(k)(2)) for such area, the amount of the pre-
4 mium for the individual for the month shall be re-
5 duced by an amount equal to 75 percent of the
6 amount by which such benchmark exceeds such fee-
7 for-service bid; or

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

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

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

17 “(2) Nothing in this subsection shall be construed as
18 preventing a reduction under paragraph (1)(A) in the pre-
19 mium otherwise applicable under this part to zero or from
20 requiring the provision of a rebate to the extent such pre-
21 mium would otherwise be required to be less than zero.

22 “(3) The adjustment in the premium under this sub-
23 section shall be effected in such manner as the Medicare
24 Benefits Administrator determines appropriate.

1 “(4) In order to carry out this subsection (insofar as
2 it is effected through the manner of collection of premiums
3 under 1840(a)), the Medicare Benefits Administrator shall
4 transmit to the Commissioner of Social Security—

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

10 “(B) periodically throughout the year, informa-
11 tion to update the information previously trans-
12 mitted under this paragraph for the year.”.

13 (d) CONFORMING AMENDMENT.—Section 1844(c)
14 (42 U.S.C. 1395w(e)) is amended by inserting “and with-
15 out regard to any premium adjustment effected under sec-
16 tion 1839(h)” before the period at the end.

17 (e) REPORT ON DEMONSTRATION PROGRAM.—Not
18 later than 6 months after the date on which the designa-
19 tion of the 4th competitive-demonstration area under sec-
20 tion 1851(k)(1) of the Social Security Act ends, the Medi-
21 care Payment Advisory Commission shall submit to Con-
22 gress a report on the impact of the demonstration pro-
23 gram under the amendments made by this section, includ-
24 ing such impact on premiums of medicare beneficiaries,
25 savings to the medicare program, and on adverse selection.

1 (f) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to payments and premiums for pe-
3 riods beginning on or after January 1, 2005.

4 **SEC. 213. CONFORMING AMENDMENTS.**

5 (a) CONFORMING AMENDMENTS RELATING TO
6 BIDS.—

7 (1) Section 1854 (42 U.S.C. 1395w–24) is
8 amended—

9 (A) in the heading by inserting “AND BID
10 AMOUNTS” after “PREMIUMS”;

11 (B) in the heading of subsection (a), by in-
12 serting “AND BID AMOUNTS” after “PRE-
13 MIUMS”; and

14 (C) in subsection (a)(5)(A), by inserting
15 “paragraphs (2), (3), and (4) of” after “filed
16 under”.

17 (b) ADDITIONAL CONFORMING AMENDMENTS.—

18 (1) ANNUAL DETERMINATION AND ANNOUNCE-
19 MENT OF CERTAIN FACTORS.—Section 1853(b) (42
20 U.S.C. 1395w–23(b)) is amended—

21 (A) in paragraph (1), by striking “the cal-
22 endar year concerned” and all that follows and
23 inserting the following: “the calendar year con-
24 cerned with respect to each Medicare+Choice
25 payment area, the following:

1 “(A) PRE-COMPETITION INFORMATION.—

2 For years before 2005, the following:

3 “(i) MEDICARE+CHOICE CAPITATION
4 RATES.—The annual Medicare+Choice
5 capitation rate for each Medicare+Choice
6 payment area for the year.

7 “(ii) ADJUSTMENT FACTORS.—The
8 risk and other factors to be used in adjust-
9 ing such rates under subsection (a)(1)(A)
10 for payments for months in that year.

11 “(B) COMPETITION INFORMATION.—For
12 years beginning with 2005, the following:

13 “(i) BENCHMARKS.—The fee-for-serv-
14 ice area-specific non-drug benchmark
15 under section 1853(j) and, if applicable,
16 the choice non-drug benchmark under sec-
17 tion 1853(k)(2), for the year involved and,
18 if applicable, the national fee-for-service
19 market share percentage.

20 “(ii) ADJUSTMENT FACTORS.—The
21 adjustment factors applied under section
22 1853(a)(1)(A)(iii) (relating to demographic
23 adjustment), section 1853(a)(1)(B) (relat-
24 ing to adjustment for end-stage renal dis-

1 ease), and section 1853(a)(3) (relating to
2 health status adjustment).

3 “(iii) PROJECTED FEE-FOR-SERVICE
4 BID.—In the case of a competitive area,
5 the projected fee-for-service area-specific
6 non-drug bid (as determined under sub-
7 section (k)(6)) for the area.

8 “(iv) INDIVIDUALS.—The number of
9 individuals counted under subsection
10 (k)(4)(B) and enrolled in each
11 Medicare+Choice plan in the area.”; and

12 (B) in paragraph (3), by striking “in suffi-
13 cient detail” and all that follows up to the pe-
14 riod at the end.

15 (2) REPEAL OF PROVISIONS RELATING TO AD-
16 JUSTED COMMUNITY RATE (ACR).—

17 (A) IN GENERAL.—Subsections (e) and (f)
18 of section 1854 (42 U.S.C. 1395w–24) are re-
19 pealed.

20 (B) CONFORMING AMENDMENT.—Section
21 1839(a)(2) (42 U.S.C. 1395r(a)(2)) is amended
22 by striking “, and to reflect” and all that fol-
23 lows and inserting a period.

24 (3) PROSPECTIVE IMPLEMENTATION OF NA-
25 TIONAL COVERAGE DETERMINATIONS.—Section

1 1852(a)(5) (42 U.S.C. 1395w-22(a)(5)) is amended
2 to read as follows:

3 “(5) PROSPECTIVE IMPLEMENTATION OF NA-
4 TIONAL COVERAGE DETERMINATIONS.—The Sec-
5 retary shall only implement a national coverage de-
6 termination that will result in a significant change
7 in the costs to a Medicare+Choice organization in a
8 prospective manner that applies to announcements
9 made under section 1853(b) after the date of the
10 implementation of the determination.”.

11 (4) PERMITTING GEOGRAPHIC ADJUSTMENT TO
12 CONSOLIDATE MULTIPLE MEDICARE+CHOICE PAY-
13 MENT AREAS IN A STATE INTO A SINGLE STATEWIDE
14 MEDICARE+CHOICE PAYMENT AREA.—Section
15 1853(d)(3) (42 U.S.C. 1395w-23(e)(3)) is
16 amended—

17 (A) by amending clause (i) of subpara-
18 graph (A) to read as follows:

19 “(i) to a single statewide
20 Medicare+Choice payment area,”; and

21 (B) by amending subparagraph (B) to read
22 as follows:

23 “(B) BUDGET NEUTRALITY ADJUST-
24 MENT.—In the case of a State requesting an
25 adjustment under this paragraph, the Medicare

1 Benefits Administrator shall initially (and an-
2 nually thereafter) adjust the payment rates oth-
3 erwise established under this section for
4 Medicare+Choice payment areas in the State in
5 a manner so that the aggregate of the pay-
6 ments under this section in the State shall not
7 exceed the aggregate payments that would have
8 been made under this section for
9 Medicare+Choice payment areas in the State in
10 the absence of the adjustment under this para-
11 graph.”.

12 (d) EFFECTIVE DATE.—The amendments made by
13 this section shall apply to payments and premiums for pe-
14 riods beginning on or after January 1, 2005.

15 **TITLE IV—PROVISIONS**
16 **RELATING TO PART A**
17 **Subtitle A—Inpatient Hospital**
18 **Services**

19 **SEC. 401. REVISION OF ACUTE CARE HOSPITAL PAYMENT**
20 **UPDATES.**

21 Subclause (XVIII) of section 1886(b)(3)(B)(i) (42
22 U.S.C. 1395ww(b)(3)(B)(i)) is amended to read as fol-
23 lows:

24 “(XVIII) for fiscal year 2003, the market bas-
25 ket percentage increase for sole community hospitals

1 and such increase minus 0.25 percentage points for
 2 other hospitals, and”.

3 **SEC. 402. 2-YEAR INCREASE IN LEVEL OF ADJUSTMENT FOR**
 4 **INDIRECT COSTS OF MEDICAL EDUCATION**
 5 **(IME).**

6 Section 1886(d)(5)(B)(ii) (42 U.S.C.
 7 1395ww(d)(5)(B)(ii)) is amended—

8 (1) in subclause (VI) by striking “and” at the
 9 end;

10 (2) by redesignating subclause (VII) as sub-
 11 clause (IX);

12 (3) in subclause (VIII) as so redesignated, by
 13 striking “2002” and inserting “2004”; and

14 (4) by inserting after subclause (VI) the fol-
 15 lowing new subclause:

16 “(VII) during fiscal year 2003, ‘c’ is equal
 17 to 1.47;

18 “(VIII) during fiscal year 2004, ‘c’ is
 19 equal to 1.45; and”.

20 **SEC. 403. RECOGNITION OF NEW MEDICAL TECHNOLOGIES**
 21 **UNDER INPATIENT HOSPITAL PPS.**

22 (a) IMPROVING TIMELINESS OF DATA COLLEC-
 23 TION.—Section 1886(d)(5)(K) (42 U.S.C.
 24 1395ww(d)(5)(K)) is amended by adding at the end the
 25 following new clause:

1 “(vii) Under the mechanism under this subpara-
2 graph, the Secretary shall provide for the addition of new
3 diagnosis and procedure codes in April 1 of each year, but
4 the addition of such codes shall not require the Secretary
5 to adjust the payment (or diagnosis-related group classi-
6 fication) under this subsection until the fiscal year that
7 begins after such date.”.

8 (b) ELIGIBILITY STANDARD.—

9 (1) MINIMUM PERIOD FOR RECOGNITION OF
10 NEW TECHNOLOGIES.—Section 1886(d)(5)(K)(vi)
11 (42 U.S.C. 1395ww(d)(5)(K)(vi)) is amended—

12 (A) by inserting “(I)” after “(vi)”; and

13 (B) by adding at the end the following new
14 subclause:

15 “(II) Under such criteria, a service or technology
16 shall not be denied treatment as a new service or tech-
17 nology on the basis of the period of time in which the serv-
18 ice or technology has been in use if such period ends before
19 the end of the 2-to-3-year period that begins on the effec-
20 tive date of implementation of a code under ICD–9–CM
21 (or a successor coding methodology) that enables the iden-
22 tification of a significant sample of specific discharges in
23 which the service or technology has been used.”.

24 (2) ADJUSTMENT OF THRESHOLD.—Section
25 1886(d)(5)(K)(ii)(I) (42 U.S.C.

1 1395ww(d)(5)(K)(ii)(I) is amended by inserting
2 “(applying a threshold specified by the Secretary
3 that is the lesser of 50 percent of the national aver-
4 age standardized amount for operating costs of inpa-
5 tient hospital services for all hospitals and all diag-
6 nosis-related groups or one standard deviation for
7 the diagnosis-related group involved)” after “is inad-
8 equate”.

9 (3) CRITERION FOR SUBSTANTIAL IMPROVE-
10 MENT.—Section 1886(d)(5)(K)(vi) (42 U.S.C.
11 1395ww(d)(5)(K)(vi)), as amended by paragraph
12 (1), is further amended by adding at the end the fol-
13 lowing subclause:

14 “(III) The Secretary shall by regulation provide for
15 further clarification of the criteria applied to determine
16 whether a new service or technology represents an advance
17 in medical technology that substantially improves the diag-
18 nosis or treatment of beneficiaries. Under such criteria,
19 in determining whether a new service or technology rep-
20 resents an advance in medical technology that substan-
21 tially improves the diagnosis or treatment of beneficiaries,
22 the Secretary shall deem a service or technology as meet-
23 ing such requirement if the service or technology is a drug
24 or biological that is designated under section 506 or 526
25 of the Federal Food, Drug, and Cosmetic Act, approved

1 under section 314.510 or 601.41 of title 21, Code of Fed-
2 eral Regulations, or designated for priority review when
3 the marketing application for such drug or biological was
4 filed or is a medical device for which an exemption has
5 been granted under section 520(m) of such Act, for which
6 priority review has been provided under section 515(d)(5)
7 of such Act, or is a substantially equivalent device for
8 which an expedited review is provided under section 513(f)
9 of such Act.”.

10 (4) PROCESS FOR PUBLIC INPUT.—Section
11 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)), as
12 amended by paragraph (1), is amended—

13 (A) in clause (i), by adding at the end the
14 following: “Such mechanism shall be modified
15 to meet the requirements of clause (viii).”; and

16 (B) by adding at the end the following new
17 clause:

18 “(viii) The mechanism established pursuant to clause
19 (i) shall be adjusted to provide, before publication of a
20 proposed rule, for public input regarding whether a new
21 service or technology not described in the second sentence
22 of clause (vi)(III) represents an advance in medical tech-
23 nology that substantially improves the diagnosis or treat-
24 ment of beneficiaries as follows:

1 “(I) The Secretary shall make public and peri-
2 odically update a list of all the services and tech-
3 nologies for which an application for additional pay-
4 ment under this subparagraph is pending.

5 “(II) The Secretary shall accept comments, rec-
6 ommendations, and data from the public regarding
7 whether the service or technology represents a sub-
8 stantial improvement.

9 “(III) The Secretary shall provide for a meeting
10 at which organizations representing hospitals, physi-
11 cians, medicare beneficiaries, manufacturers, and
12 any other interested party may present comments,
13 recommendations, and data to the clinical staff of
14 the Centers for Medicare & Medicaid Services before
15 publication of a notice of proposed rulemaking re-
16 garding whether service or technology represents a
17 substantial improvement.”.

18 (c) PREFERENCE FOR USE OF DRG ADJUSTMENT.—
19 Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is
20 further amended by adding at the end the following new
21 clause:

22 “(ix) Before establishing any add-on payment under
23 this subparagraph with respect to a new technology, the
24 Secretary shall seek to identify one or more diagnosis-re-
25 lated groups associated with such technology, based on

1 similar clinical or anatomical characteristics and the cost
2 of the technology. Within such groups the Secretary shall
3 assign an eligible new technology into a diagnosis-related
4 group where the average costs of care most closely approx-
5 imate the costs of care of using the new technology. In
6 such case, no add-on payment under this subparagraph
7 shall be made with respect to such new technology and
8 this clause shall not affect the application of paragraph
9 (4)(C)(iii).”.

10 (d) IMPROVEMENT IN PAYMENT FOR NEW TECH-
11 NOLOGY.—Section 1886(d)(5)(K)(ii)(III) (42 U.S.C.
12 1395ww(d)(5)(K)(ii)(III)) is amended by inserting after
13 “the estimated average cost of such service or technology”
14 the following: “(based on the marginal rate applied to
15 costs under subparagraph (A))”.

16 (e) EFFECTIVE DATE.—

17 (1) IN GENERAL.—The Secretary shall imple-
18 ment the amendments made by this section so that
19 they apply to classification for fiscal years beginning
20 with fiscal year 2004.

21 (2) RECONSIDERATIONS OF APPLICATIONS FOR
22 FISCAL YEAR 2003 THAT ARE DENIED.—In the case
23 of an application for a classification of a medical
24 service or technology as a new medical service or
25 technology under section 1886(d)(5)(K) of the Social

1 Security Act (42 U.S.C. 1395ww(d)(5)(K)) that was
2 filed for fiscal year 2003 and that is denied—

3 (A) the Secretary shall automatically re-
4 consider the application as an application for
5 fiscal year 2004 under the amendments made
6 by this section; and

7 (B) the maximum time period otherwise
8 permitted for such classification of the service
9 or technology shall be extended by 12 months.

10 **SEC. 404. PHASE-IN OF FEDERAL RATE FOR HOSPITALS IN**
11 **PUERTO RICO.**

12 Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is
13 amended—

14 (1) in subparagraph (A)—

15 (A) in clause (i), by striking “for dis-
16 charges beginning on or after October 1, 1997,
17 50 percent (and for discharges between October
18 1, 1987, and September 30, 1997, 75 percent)”
19 and inserting “the applicable Puerto Rico per-
20 centage (specified in subparagraph (E))”; and

21 (B) in clause (ii), by striking “for dis-
22 charges beginning in a fiscal year beginning on
23 or after October 1, 1997, 50 percent (and for
24 discharges between October 1, 1987, and Sep-
25 tember 30, 1997, 25 percent)” and inserting

1 “the applicable Federal percentage (specified in
2 subparagraph (E))”; and

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

5 “(E) For purposes of subparagraph (A), for dis-
6 charges occurring—

7 “(i) between October 1, 1987, and September
8 30, 1997, the applicable Puerto Rico percentage is
9 75 percent and the applicable Federal percentage is
10 25 percent;

11 “(ii) on or after October 1, 1997, and before
12 October 1, 2003, the applicable Puerto Rico percent-
13 age is 50 percent and the applicable Federal per-
14 centage is 50 percent;

15 “(iii) during fiscal year 2004, the applicable
16 Puerto Rico percentage is 45 percent and the appli-
17 cable Federal percentage is 55 percent;

18 “(iv) during fiscal year 2005, the applicable
19 Puerto Rico percentage is 40 percent and the appli-
20 cable Federal percentage is 60 percent;

21 “(v) during fiscal year 2006, the applicable
22 Puerto Rico percentage is 35 percent and the appli-
23 cable Federal percentage is 65 percent;

1 “(vi) during fiscal year 2007, the applicable
2 Puerto Rico percentage is 30 percent and the appli-
3 cable Federal percentage is 70 percent; and

4 “(vii) on or after October 1, 2007, the applica-
5 ble Puerto Rico percentage is 25 percent and the ap-
6 plicable Federal percentage is 75 percent.”.

7 **SEC. 405. REFERENCE TO PROVISION RELATING TO EN-**
8 **HANCED DISPROPORTIONATE SHARE HOS-**
9 **PITAL (DSH) PAYMENTS FOR RURAL HOS-**
10 **PITALS AND URBAN HOSPITALS WITH FEWER**
11 **THAN 100 BEDS.**

12 For provision enhancing disproportionate share hos-
13 pital (DSH) treatment for rural hospitals and urban hos-
14 pitals with fewer than 100 beds, see section 302.

15 **SEC. 406. REFERENCE TO PROVISION RELATING TO 2-YEAR**
16 **PHASED-IN INCREASE IN THE STANDARDIZED**
17 **AMOUNT IN RURAL AND SMALL URBAN**
18 **AREAS TO ACHIEVE A SINGLE, UNIFORM**
19 **STANDARDIZED AMOUNT.**

20 For provision phasing in over a 2-year period an in-
21 crease in the standardized amount for rural and small
22 urban areas to achieve a single, uniform, standardized
23 amount, see section 303.

1 **SEC. 407. REFERENCE TO PROVISION FOR MORE FRE-**
2 **QUENT UPDATES IN THE WEIGHTS USED IN**
3 **HOSPITAL MARKET BASKET.**

4 For provision providing for more frequent updates in
5 the weights used in hospital market basket, see section
6 304.

7 **SEC. 408. REFERENCE TO PROVISION MAKING IMPROVE-**
8 **MENTS TO CRITICAL ACCESS HOSPITAL PRO-**
9 **GRAM.**

10 For provision providing making improvements to crit-
11 ical access hospital program, see section 305.

12 **Subtitle B—Skilled Nursing**
13 **Facility Services**

14 **SEC. 411. PAYMENT FOR COVERED SKILLED NURSING FA-**
15 **CILITY SERVICES.**

16 (a) TEMPORARY INCREASE IN NURSING COMPONENT
17 OF PPS FEDERAL RATE.—Section 312(a) of BIPA is
18 amended by adding at the end the following new sentence:
19 “The Secretary of Health and Human Services shall in-
20 crease by 8 percent the nursing component of the case-
21 mix adjusted Federal prospective payment rate specified
22 in Tables 3 and 4 of the final rule published in the Federal
23 Register by the Health Care Financing Administration on
24 July 31, 2000 (65 Fed. Reg. 46770) and as subsequently
25 updated under section 1888(e)(4)(E)(ii) of the Social Se-
26 curity Act (42 U.S.C. 1395yy(e)(4)(E)(ii)), effective for

1 services furnished on or after October 1, 2002, and before
2 October 1, 2005.”.

3 (b) ADJUSTMENT TO RUGS FOR AIDS RESI-
4 DENTS.—

5 (1) IN GENERAL.—Paragraph (12) of section
6 1888(e) (42 U.S.C. 1395yy(e)) is amended to read
7 as follows:

8 “(12) ADJUSTMENT FOR RESIDENTS WITH
9 AIDS.—

10 “(A) IN GENERAL.—Subject to subpara-
11 graph (B), in the case of a resident of a skilled
12 nursing facility who is afflicted with acquired
13 immune deficiency syndrome (AIDS), the per
14 diem amount of payment otherwise applicable
15 shall be increased by 128 percent to reflect in-
16 creased costs associated with such residents.

17 “(B) SUNSET.—Subparagraph (A) shall
18 not apply on and after such date as the Sec-
19 retary certifies that there is an appropriate ad-
20 justment in the case mix under paragraph
21 (4)(G)(i) to compensate for the increased costs
22 associated with residents described in such sub-
23 paragraph.”.

1 “(C) advising the individual regarding ad-
2 vanced care planning.”.

3 (b) PAYMENT.—Section 1814(i) (42 U.S.C. 1395f(i))
4 is amended by adding at the end the following new para-
5 graph:

6 “(4) The amount paid to a hospice program with re-
7 spect to the services under section 1812(a)(5) for which
8 payment may be made under this part shall be equal to
9 an amount equivalent to the amount established for an
10 office or other outpatient visit for evaluation and manage-
11 ment associated with presenting problems of moderate se-
12 verity under the fee schedule established under section
13 1848(b), other than the portion of such amount attrib-
14 utable to the practice expense component.”.

15 (c) CONFORMING AMENDMENT.—Section
16 1861(dd)(2)(A)(i) (42 U.S.C. 1395x(dd)(2)(A)(i)) is
17 amended by inserting before the comma at the end the
18 following: “and services described in section 1812(a)(5)”.

19 (d) EFFECTIVE DATE.—The amendments made by
20 this section shall apply to services provided by a hospice
21 program on or after January 1, 2004.

1 **SEC. 422. 10 PERCENT INCREASE IN PAYMENT FOR HOS-**
2 **PICE CARE FURNISHED IN A FRONTIER AREA.**

3 (a) IN GENERAL.—Section 1814(i)(1) (42 U.S.C.
4 1395f(i)(1)) is amended by adding at the end the following
5 new subparagraph:

6 “(D) With respect to hospice care furnished in a fron-
7 tier area on or after January 1, 2003, and before January
8 1, 2008, the payment rates otherwise established for such
9 care shall be increased by 10 percent. For purposes of this
10 subparagraph, the term ‘frontier area’ means a county in
11 which the population density is less than 7 persons per
12 square mile.”.

13 (b) REPORT ON COSTS.—Not later than January 1,
14 2007, the Comptroller General of the United States shall
15 submit to Congress a report on the costs of furnishing
16 hospice care in frontier areas. Such report shall include
17 recommendations regarding the appropriateness of extend-
18 ing, and modifying, the payment increase provided under
19 the amendment made by subsection (a).

20 **SEC. 423. RURAL HOSPICE DEMONSTRATION PROJECT.**

21 (a) IN GENERAL.—The Secretary shall conduct a
22 demonstration project for the delivery of hospice care to
23 medicare beneficiaries in rural areas. Under the project
24 medicare beneficiaries who are unable to receive hospice
25 care in the home for lack of an appropriate caregiver are
26 provided such care in a facility of 20 or fewer beds which

1 offers, within its walls, the full range of services provided
2 by hospice programs under section 1861(dd) of the Social
3 Security Act (42 U.S.C. 1395x(dd)).

4 (b) SCOPE OF PROJECT.—The Secretary shall con-
5 duct the project under this section with respect to no more
6 than 3 hospice programs over a period of not longer than
7 5 years each.

8 (c) COMPLIANCE WITH CONDITIONS.—Under the
9 demonstration project—

10 (1) the hospice program shall comply with oth-
11 erwise applicable requirements, except that it shall
12 not be required to offer services outside of the home
13 or to meet the requirements of section
14 1861(dd)(2)(A)(iii) of the Social Security Act; and

15 (2) payments for hospice care shall be made at
16 the rates otherwise applicable to such care under
17 title XVIII of such Act.

18 The Secretary may require the program to comply with
19 such additional quality assurance standards for its provi-
20 sion of services in its facility as the Secretary deems ap-
21 propriate.

22 (d) REPORT.—Upon completion of the project, the
23 Secretary shall submit a report to Congress on the project
24 and shall include in the report recommendations regarding

1 extension of such project to hospice programs serving
2 rural areas.

3 **Subtitle D—Other Provisions**

4 **SEC. 431. DEMONSTRATION PROJECT FOR USE OF RECOV-** 5 **ERY AUDIT CONTRACTORS.**

6 (a) IN GENERAL.—The Secretary of Health and
7 Human Services shall conduct a demonstration project
8 under this section (in this section referred to as the
9 “project”) to demonstrate the use of recovery audit con-
10 tractors under the Medicare Integrity Program in identi-
11 fying and recouping overpayments under the medicare
12 program for services for which payment is made under
13 part A of title XVIII of the Social Security Act. Under
14 the project—

15 (1) payment may be made to such a contractor
16 on a contingent basis;

17 (2) a percentage of the amount recovered may
18 be retained by the Secretary and shall be available
19 to the program management account of the Centers
20 for Medicare & Medicaid Services; and

21 (3) the Secretary shall examine the efficacy of
22 such use with respect to duplicative payments, accu-
23 racy of coding, and other payment policies in which
24 overpayments arise.

1 (b) SCOPE AND DURATION.—The project shall cover
2 at least 2 States and at least 3 contractors and shall last
3 for not longer than 3 years.

4 (c) WAIVER.—The Secretary of Health and Human
5 Services shall waive such provisions of title XVIII of the
6 Social Security Act as may be necessary to provide for
7 payment for services under the project in accordance with
8 subsection (a).

9 (d) QUALIFICATIONS OF CONTRACTORS.—

10 (1) IN GENERAL.—The Secretary shall enter
11 into a recovery audit contract under this section
12 with an entity only if the entity has staff that has
13 knowledge of and experience with the payment rules
14 and regulations under the medicare program or the
15 entity has or will contract with another entity that
16 has such knowledgeable and experienced staff.

17 (2) INELIGIBILITY OF CERTAIN CONTRAC-
18 TORS.—The Secretary may not enter into a recovery
19 audit contract under this section with an entity to
20 the extent that the entity is a fiscal intermediary
21 under section 1816 of the Social Security Act (42
22 U.S.C. 1395h), a carrier under section 1842 of such
23 Act (42 U.S.C. 1395u), or a Medicare Administra-
24 tive Contractor under section 1874A of such Act, or
25 any other entity that carries out the type of activi-

1 ties with respect to providers of services under part
2 A that would constitute a conflict of interest, as de-
3 termined by the Secretary.

4 (3) PREFERENCE FOR ENTITIES WITH DEM-
5 ONSTRATED PROFICIENCY WITH PRIVATE INSUR-
6 ERS.—In awarding contracts to recovery audit con-
7 tractors under this section, the Secretary shall give
8 preference to those entities that the Secretary deter-
9 mines have demonstrated proficiency in recovery au-
10 dits with private insurers or under the medicaid pro-
11 gram under title XIX of such Act.

12 (e) REPORT.—The Secretary of Health and Human
13 Services shall submit to Congress a report on the project
14 not later than 6 months after the date of its completion.
15 Such reports shall include information on the impact of
16 the project on savings to the medicare program and rec-
17 ommendations on the cost-effectiveness of extending or ex-
18 panding the project.

Union Calendar No. 331

107TH CONGRESS
2^D SESSION

H. R. 4985

[Report No. 107-550, Part 1]

A BILL

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.

JUNE 28, 2002

Committee on Ways and Means discharged; committed to the Committee of the Whole House on the State of the Union and ordered to be printed