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Prescription Drug and Medicare Improvement Act of 2003

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Sponsor

Name: Sen. Frist, William H. [R-TN]
Party: Republican • **State:** TN • **Chamber:** Senate

Cosponsors (4 total)

Cosponsor	Party / State	Role	Date Joined
Sen. Baucus, Max [D-MT]	D · MT		Jun 11, 2003
Sen. Grassley, Chuck [R-IA]	R · IA		Jun 11, 2003
Sen. Hatch, Orrin G. [R-UT]	R · UT		Jun 17, 2003
Sen. Snowe, Olympia J. [R-ME]	R · ME		Jun 17, 2003

Committee Activity

Committee	Chamber	Activity	Date
Finance Committee	Senate	Reported By	Jun 13, 2003

Subjects & Policy Tags

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Related Bills

Bill	Relationship	Last Action
108 HR 1	Related document	**Dec 8, 2003:** Became Public Law No: 108-173.

Summary (as of Jun 13, 2003)

Prescription Drug and Medicare Improvement Act of 2003 - **Title I: Medicare Prescription Drug Benefit - Subtitle A: Medicare Voluntary Prescription Drug Delivery Program** - (Sec. 101) Amends title XVIII (Medicare) of the Social Security Act (SSA) to add a new part D (Voluntary Prescription Drug Delivery Program). Establishes a new optional Medicare prescription drug benefit program augmenting with a comprehensive, flexible, and permanent voluntary prescription drug benefit program the limited coverage of certain outpatient prescription drugs, biologicals, and vaccines currently covered under the Medicare program under its original fee-for-service component under both Medicare parts A (Hospital Insurance) and B (Supplementary Medical Insurance) and under its managed care, medical savings account (MSA), and private fee-for-service component under Medicare part C (Medicare+Choice).

Provides under this new prescription drug benefit program for offering eligible Medicare beneficiaries, regardless of income or health status, access to more coverage options, options which provide enhanced benefits, with cost-sharing, and additional beneficiary protections and assistance, such as access to negotiated prices, catastrophic coverage limits, and premium subsidies for certain low-income beneficiaries.

Provides for these options to be offered through both: (1) a new Medicare part C MedicareAdvantage (MA) program that integrates basic medical coverage with added prescription drug coverage, including, for the first time, coverage through preferred provider organizations (PPOs) and restricted use of MSAs pursuant to an MA plan serving the geographic area in which the eligible Medicare beneficiary resides; and (2) a new separate, stand-alone Medicare Prescription Drug plan (PDP) program under Medicare part D that relies on private plans to provide coverage and to bear a portion of the financial risk for drug costs.

Makes this new program effective January 1, 2006, and vests overall administrative responsibility for carrying it out in the Administrator of the Center for Medicare Choices established under title III (Centers for Medicare Choices) of this Act.

Provides that until this new permanent prescription drug benefit program is effective, the Secretary of Health and Human Services (HHS) shall under subtitle B below provide eligible beneficiaries with the opportunity to enroll in an endorsed prescription drug discount card program and eligible low-income beneficiaries with the opportunity to enroll in a prescription drug assistance card program offered by a prescription drug card sponsor and receive discounts on prescription drugs and other assistance not later than January 1, 2004. Continues prescription drug discounts and other assistance under such temporary programs until the first enrollment period under the new permanent prescription drug program ends.

Allows beneficiaries entitled to (or enrolled for) benefits under Medicare part A and enrolled under Medicare part B (eligible beneficiaries) to elect to enroll under new Medicare part D, and: (1) keep their current Medicare fee-for-service coverage and receive qualified prescription drug coverage (as described below) through enrollment in Medicare part D in a new PDP that is offered in the geographic area in which the beneficiary resides; or (2) enroll in the new Medicare part C MA program, give up their current Medicare fee-for-service coverage, and receive qualified prescription drug coverage along with basic and possibly enhanced medical coverage through health maintenance organization (HMO), revised MSA, or new PPO coverage options under the new MA program established by this Act under Medicare part C (and as otherwise provided under Medicare+Choice under Medicare part C as discussed more fully below under title II (MedicareAdvantage) of this Act). Provides an exception for: (1) MA enrollees enrolled in MSA plans to receive coverage of prescription drugs through enrollment in a PDP; and (2) MA enrollees enrolled in private-fee-for service plans to receive coverage of prescription drugs through such plans if the plan provides qualified prescription drug coverage (otherwise they shall enroll in a PDP).

Directs the Administrator to establish an enrollment process similar to that for Medicare part B. Establishes an initial open enrollment period that, for individuals who are eligible beneficiaries as of November 1, 2005, is the six month period beginning on that date. Provides that individuals becoming eligible beneficiaries after such date shall have the same initial seven month enrollment period as that established for Medicare part B. Directs the Administrator to establish a process through which an eligible beneficiary enrolled under Medicare part D but not enrolled in an MA plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage) is: (1) required to make an election to enroll in any PDP that is offered by an eligible entity and that serves the geographic area in which the beneficiary resides; and (2) allowed to make an annual election to change such election. Provides for automatic enrollment in any PDP designated by the Administrator in the area of any eligible beneficiary who is enrolled under Medicare part D but who fails to make an election of a PDP plan. Requires an eligible beneficiary enrolled in an MA plan to receive access to prescription drug coverage through the plan and be subject to plan enrollment rules, except that persons enrolled in MSA plans or private fee-for-service plans not offering qualified prescription drug coverage shall be subject to Medicare part D enrollment rules.

Directs the Administrator to conduct activities designed to broadly disseminate information to eligible beneficiaries (and prospective eligible beneficiaries) regarding coverage under Medicare part D, including information comparing the plans offered by eligible entities under Medicare part D that are available to eligible beneficiaries in an area.

Requires eligible entities offering PDPs to disclose plan information comparable to that required for MA plans. Requires an eligible entity to have in place a cost-effective drug utilization management program, quality assurance measures (including a described medication therapy management program), and a program to control fraud, abuse, and waste. Requires the eligible entity offering a PDP plan to provide that each pharmacy or other dispenser inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug and the price of the lowest cost generic drug covered under the plan that is therapeutically equivalent and bioequivalent. Provides for: (1) grievance mechanism, coverage determinations, and reconsiderations; (2) appeals; and (3) privacy, confidentiality, and accuracy of enrollee records. Requires an eligible entity to ensure that the monthly plan premium for a PDP is the same for all eligible beneficiaries enrolled in the plan.

Divides qualified prescription drug coverage into either a standard coverage benefit package or an actuarially equivalent benefit package, both with access to negotiated drug prices. Outlines the standard coverage package, which includes, for 2006, a $275 deductible, 50 percent cost-sharing for drug costs between $276 and the initial coverage limit of $4,500, then no coverage; except that the beneficiary shall have access to negotiated prices, regardless of the fact that no benefits may be payable under the coverage, until incurring out-of-pocket costs for covered drugs in a year equal $3,700, with cost-sharing thereafter of ten percent for the beneficiary and 90 percent for the Federal Government. Includes as negotiated prices all discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remuneration. Increases these amounts in future years by the annual percentage increase in average per capita aggregate expenditures for covered drugs for the year ending the previous July.

Includes among the out-of-pocket costs counting toward the annual $3,700 limit any costs paid by the individual (or by another individual such as a family member) under the Medicaid program or under a State pharmaceutical assistance program for which the individual (or other individual) is not reimbursed.

Allows a PDP or an MA plan to provide a different prescription drug benefit design from the standard prescription drug coverage as long as the Administrator approves of such benefit design.

Permits a variety of cost control mechanisms in the provision of qualified prescription drug coverage, including the use of

formularies, tiered copayments, selective contracting with providers of prescription drugs, and mail order pharmacies. Permits additional prescription drug coverage in excess of that required under such packages. Prohibits an eligible entity from offering a PDP that provides such additional benefits in an area unless the eligible entity offering the plan also offers a PDP in the area that only provides the coverage of prescription drugs that is required.

Includes in qualified prescription drug coverage all therapeutic categories and classes of covered drugs (although not necessarily for all drugs within such categories and classes) which are defined to include: (1) drugs, biological products, and insulin covered under Medicaid (SSA title XIX) and vaccines licensed under the Public Health Services Act (PHSA); and (2) any use of a covered drug for a medically accepted indication. Excludes from such coverage: (1) drugs or classes of drugs, or their medical uses, which are excluded from coverage or otherwise restricted under Medicaid, except for smoking cessation agents; (2) drugs currently covered under Medicare part A or part B to the extent payment is available under those parts; (3) drugs prescribed for an individual that shall otherwise be a covered drug if the MA or PDP plan excluded the drug and the exclusion was not successfully resolved; and (4) drugs which do not meet the Medicare definition of "reasonable and necessary" or which were not prescribed in accordance with the plan or part D.

Requires an eligible entity offering a PDP to be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a PDP. Requires entities to assume financial risk on a prospective basis for costs of benefits in excess of amounts received from premium payments and reinsurance payments. Permits entities to obtain private reinsurance for the portion of the costs for which they are at risk. Allows the Administrator to waive the requirement that the entity be licensed in the State, if the Administrator determines that grounds for approval of the application have been met. Prohibits eligible beneficiaries from electing a PDP unless the Administrator has entered into a contract with the eligible entity offering the plan. Allows a contract with an entity to cover more than one plan.

Directs the Administrator by January 1, 2005, to establish by regulation standards to implement new Medicare part D. Outlines specific provisions for the Administrator to establish and publish solvency standards for non-licensed entities. Prohibits States from imposing a premium or similar tax with respect to premiums paid to the Administrator for PDPs and any payments made to eligible entities offering such a plan.

Requires the Administrator to establish by April 15, 2005, and periodically review, service areas in which the PDPs may offer benefits. Directs the Administrator to establish service areas in a manner that maximizes the availability of PDPs to eligible beneficiaries and minimize the ability of eligible entities offering such plans to favorably select eligible beneficiaries. Requires the Administrator, in establishing the service areas, to establish at least ten service areas, which must include at least one State. Prohibits the Administrator from dividing States so that portions of a State are in different service areas. Requires, to the extent possible, the Administrator to include multistate MSAs in a single service area. Allows the Administrator to divide MSAs where it is necessary to establish service areas of such size and geography as to maximize plan participation. Allows the Administrator to conform service areas to those established for PPOs under MA.

Directs the Administrator to establish an appropriate method for adjusting payments to plans to take into account variations in costs based on the differences in actuarial risk of different enrollees being served. Allows the Administrator to take into account similar methodologies used to adjust payments for MA organizations. Requires the Administrator to publish such risk adjusters not later than April 15 of each year (beginning in 2005) to be used for computing payments to plans for standard coverage.

Requires each eligible entity to submit bids to the Administrator on an annual basis for proposed PDPs. Requires the bid

to contain information on proposed benefits, actuarial value of the qualified prescription drug coverage, the service area for the plan, and the monthly premium. Requires entities to provide information on whether the entity planned to use any funds in the plan stabilization fund that were available to the entity for the purpose of stabilizing or reducing the monthly premium.

Requires service areas to be either the entire area of one of the service areas established by the Administrator or the entire area covered by Medicare. Permits entities to submit separate bids for multiple service areas as long as each bid is for a single service area.

Requires the Administrator to apply the Federal Employees Health Benefits Program (FEHBP) standard in determining whether or not to approve or disapprove the PDP, a standard that provides that each bid submitted by an entity for a qualified plan must reasonably and equitably reflect the cost of benefits provided under the plan. Gives the Administrator the authority to: (1) negotiate the terms and conditions of the proposed monthly premiums submitted and other terms and conditions of proposed plans; (2) disapprove, or limit enrollment in, a proposed plan based on costs to beneficiaries, the quality of the coverage, and benefits under the plan; and (3) the adequacy of the network under the plan, and other factors determined appropriate by the Administrator. Requires the Administrator to approve a PDP only if it provided the required benefits and was not designed to result in favorable selection of eligible beneficiaries.

Directs the Administrator to approve at least two contracts to offer a PDP in an area for the year. Provides generally for such contracts to be awarded for a two year period. Provides that not later than September 1 of each year, beginning in 2005, and for each area, the Administrator shall determine whether or not there were two approved bids, and if not, the Administrator shall enter into an annual contract with the entity to provide Part D enrollees in the area with standard coverage (including access to negotiated prices) for the following year.

Allows an entity to be awarded a contract for more than one of the areas for which the Administrator is required to enter into a contract, but the Administrator may enter into only one such contract in each such area. Prohibits the Administrator from entering into such a contract if the Administrator received two or more qualified bids after exercise of the authority to reduce risk for entities. Requires entities to meet beneficiary protection requirements. Requires beneficiary premiums for a fallback plan to be set at a premium amount that shall apply if the plan premium equaled the applicable percent of the monthly national average premium for the year as adjusted for geographic differences in drug prices. Directs the Administrator to establish an appropriate methodology for making this calculation which takes into account geographic differences in utilization and the results of the ongoing study on spending and utilization required under the Act. Requires the contract with the plan to provide for payment to the plan for the negotiated costs of covered drugs and payment of prescription management fees tied to performance requirements established by the Administrator.

Prohibits entities that submitted bids to be qualified risk-bearing entities from submitting a bid to be a fallback plan. Disallows the fallback plan from engaging in any marketing or branding. Provides that in the case of an area with only one PDP approved for the year, the plan (at the plan's option) may be offered under the rules established for risk-bearing plans. Allows eligible beneficiaries to enroll in such plan or with the fallback plan.

Requires the Administrator for each year, beginning with 2006, to compute a monthly standard prescription premium for each approved PDP plan and for each MA plan. Requires such monthly premium to equal: (1) in the case of a plan offered by an eligible entity or MA organization that provides standard prescription drug coverage or actuarially equivalent prescription drug coverage and does not provide additional prescription drug coverage, the monthly plan premium approved for the plan; and (2) in the case of a plan offered by an eligible entity or MA organization that provides additional prescription drug coverage, an amount that reflects only the actuarial value of the standard prescription drug

coverage offered under the plan, or if determined appropriate by the Administrator, the approved monthly plan premium for the year for the required qualified coverage plan offered by the entity.

Requires the Administrator, each year beginning in 2006, to compute a monthly national average premium equal to the average of the monthly standard coverage premium for each PDP and each MA plan. Requires the monthly national average premium to be a weighted average based on the number of enrollees in the plan in the previous year. Directs the Administrator to establish an appropriate methodology for making this calculation, taking into account geographic differences in prices. Requires any adjustment to be budget neutral. Requires the Administrator to establish procedures for making this calculation for 2005.

Requires the Administrator, each year beginning in 2006, to pay to each entity offering a PDP an amount equal to the full monthly approved premium, with appropriate risk adjusters. Requires a portion of total payments to plans to be subject to risk. Requires eligible entities to notify the Administrator for each year, beginning in 2007, of the total actual costs that the entity incurred in providing standard prescription drug coverage in the previous year and a breakdown of: (1) each drug paid for by the plan; (2) the negotiated price paid for each such drug, (3) the number of prescriptions; and (4) the average beneficiary coinsurance rate. Excludes from such notification spending for administrative costs, amounts spent for coverage in excess of standard coverage, or amounts for which the entity subsequently received reinsurance payments. Provides that no payment adjustment shall be made if allowable costs are not more than the first threshold upper limit or less than the first threshold lower limit for the year, if the plans were within the risk corridor. Subjects a portion of any plan spending above or below these levels to risk corridor adjustment, so that if allowable costs exceeded the first threshold upper limit, then payments shall be increased; and if allowable costs were below the first threshold lower limit, payments shall be reduced.

Directs the Administrator for each year, beginning with 2006, to establish a risk corridor for each PDP that determines the amount of risk that the PDP shall be exposed to for drug spending, and the resultant adjustment in payment attributable to this risk, including a specified range above and below the target amount at which the plans shall be subject to full risk for drug spending. Requires an eligible entity that offers a PDP that provides additional prescription drug coverage to be at full financial risk for the provision of such additional coverage. Requires for each year for the Administrator to establish as specified the allowable costs for each PDP for the year, and bases the allowable costs on actual costs reported by the plan. Requires the Administrator to adjust this amount in cases where actual costs for a covered drug exceeded the average negotiated price for such drug in a year.

Excludes from the target amount administrative expenses negotiated between the Administrator and the entity offering the plan. Requires each contract to provide that: (1) the entity offering a PDP shall provide the Administrator with such information as the Administrator determines is necessary to administer the benefit; and (2) the Administrator shall have the right to inspect and audit any books and records of the eligible entity that pertains to the information regarding costs provided to the Administrator. Requires the Administrator to establish within the Prescription Drug Account a stabilization reserve fund. Requires: (1) amounts in this fund to be made available to eligible entities beginning with their 2008 contract year; and (2) that eligible entities be permitted to use funds in the stabilization reserve fund to stabilize or reduce monthly plan premiums. Directs the Administrator to establish procedures to adjust the portion of payments made to an entity that are attributable to administrative expenses to ensure that the entity meets applicable performance requirements.

Provides for the computation of the monthly beneficiary PDP premium according to a specified formula, geographically adjusted to take into account variations in input prices in different service areas. Provides under such formula that: (1) if

the plan's monthly approved premium was equal to the monthly national weighted average premium for the year, the monthly beneficiary PDP premium for the year shall be the applicable percent (for the area) of the monthly national weighted average premium; (2) if the plan's monthly approved premium was less than the monthly national weighted average premium for the year, the monthly beneficiary PDP premium for the year shall be the applicable percent for the area minus the amount by which the monthly national average premium exceeds the amount of the monthly approved plan premium; and (3) if the plan's monthly approved premium exceeds the monthly national weighted average premium for the year, the monthly beneficiary PDP premium for the year shall be the applicable percentage (for the area) plus the amount by which the plan's monthly approved premium exceeds the amount of the monthly national weighted average premium. Specifies the formula for determining the applicable percent for an area which factors in total reinsurance payments estimated to be made during the year. Requires the adjustments to be budget neutral.

Provides for collection of the monthly beneficiary premiums in the same manner as Medicare part B premiums, with collections credited to the PDP. Requires the Administrator to: (1) establish procedures whereby the sponsor of employment based retiree coverage may pay the premium; and (2) transmit the information necessary for collection to the Commissioner of Social Security.

Provides for premium and cost-sharing subsidies for low-income individuals. Grants qualified Medicare beneficiaries and specified low income Medicare beneficiaries and qualifying individuals a full subsidy for premiums

Directs the Administrator to provide for payment to a qualifying entity of the reinsurance payment amount for costs incurred by the entity in providing prescription drug coverage for a qualifying covered individual after the individual has reached the annual out-of-pocket threshold for the year. Sets the reinsurance payment amount for a qualifying covered individual at 80 percent of the allowable costs exceeding the limit that are incurred by the qualifying entity with respect to the individual and year. Requires allowable costs to be equal to actual costs above the limit, subject to an adjustment. Requires the Administrator to reduce actual costs to the extent such amount was based on costs for specific covered drugs that are greater than the average cost for the covered drug for the year. Requires each qualifying entity to notify the Administrator of the total actual costs (if any) incurred in providing prescription drug coverage for an individual after the individual exceeded the out-of-pocket threshold. Requires the entity to provide a breakdown of: (1) each covered drug paid by the plan over the limit; (2) the negotiated price for each such drug; (3) number of prescriptions; and (4) the average beneficiary coinsurance rate. Excludes administrative costs and costs for coverage in excess of the standard benefit. Requires the Administrator to determine payment methods. Allows reinsurance payments to be made to an eligible entity offering a PDP, organizations offering an MA plan, and sponsors of qualified retiree prescription drug plans. Requires sponsors of the plan to attest annually that the coverage under the retiree plan met or exceeded the requirements for qualified coverage.

Requires the Administrator to provide for the payment to a sponsor of a qualified retiree prescription drug plan for each individual who is enrolled in the plan but who is not enrolled in Part D. Requires the amount of the payment to equal the direct subsidy percent of the monthly national average premium for the year, as adjusted by risk adjusters. Requires the direct subsidy percent to be 100 percent minus the applicable percent. Requires payments to be based on such a method as the Administer determines. Requires payments to be made from the PDP.

Makes: (1) the costs of coverage through MA or PDP plans and of otherwise operating the new part D program payable from the Prescription Drug Account which is created by this Act within the Federal Supplementary Medical Insurance Trust Fund under Medicare part B; and (2) fiscal year appropriations to the Account, out of any monies in the Treasury not otherwise appropriated, to cover program benefits and administrative costs.

Permits sponsors of employee based retiree coverage that offer a PDP to restrict enrollment in the plan to eligible beneficiaries enrolled in such coverage. Prohibits sponsors from offering enrollment in the PDP based on the health status of eligible beneficiaries. Allows entities offering a PDP or an MA organization offering a MA plan to enter into an agreement with a State pharmaceutical assistance program to coordinate coverage.

(Sec. 102) Directs the Administrator of the Center for Medicare Choices to study and report to Congress on the need for rules relating to permitting individuals who are enrolled under Medicare part B (Supplementary Medical Insurance), but are not entitled to benefits under Medicare part A, to buy into the new Medicare prescription drug program.

(Sec. 103) Outlines rules relating to Medicare supplemental health insurance (Medigap) policies that provide prescription drug coverage, such as rules prohibiting sale, issuance, and renewal of policies that provide prescription drug coverage to enrollees under the new program, and allowing for issuance of substitute policies if the policyholder obtains prescription drug coverage under the program.

(Sec. 104) Amends SSA title XIX to require States, for purposes of the prescription drug assistance card program for eligible low-income beneficiaries, to submit an eligibility plan to the Secretary under which the State: (1) establishes eligibility standards consistent with such program; (2) establishes procedures for providing presumptive eligibility determinations (similar to that in which presumptive eligibility determinations are provided with respect to children and pregnant women under Medicaid); (3) makes eligibility determinations; and (4) communicates to the Secretary information on eligibility determinations or discontinuations.

Requires States, for purposes of premium and cost-sharing subsidies for low-income individuals under the new Medicare part D prescription drug benefit program, to: (1) make eligibility determinations; (2) establish procedures for providing presumptive eligibility determinations; (3) inform the Administrator of the Center for Medicare Choices of cases where eligibility is established; and (4) otherwise provide the Administrator with such information as may be required to carry out such program.

Requires States to enter into an agreement with the Commissioner of Social Security to use all Social Security field offices located in the State as informational and enrollment sites for making such eligibility determinations.

Requires the Federal Government to pay an enhanced match for FY 2004 through 2008 for administrative costs associated with making eligibility determinations. Provides that beginning November 1, 2005, the rate is 100 percent for eligibility determinations for subsidy-eligible individuals under the new Medicare part D prescription drug program. Entitles States to enhanced matching for 2004 through 2006 for the costs associated with designing, developing, acquiring, and installing improved eligibility determination systems, including hardware and software, for low-income subsidy programs. Provides that beginning January 1, 2006, in the case of States that provide a drug benefit (meeting certain minimum standards) under new Medicare part D to their dual eligible population, the Secretary shall be responsible for paying 100 percent of the Medicare cost-sharing for qualified Medicare eligibles between 74 and 100 percent of the Federal poverty line.

Provides that beginning January 1, 2004, if a State on the enactment of this Act provided medical assistance to aged and disabled persons up to 100 percent of the Federal poverty level, the Secretary shall be responsible for paying 100 percent of the Medicare part A cost-sharing for that population for as long as the State maintained the expanded coverage.

Sets forth special rules for treatment of the territories whose residents shall not be eligible for low-income subsidies under the new Medicare part D drug benefit program. Provides that if they choose to provide drug coverage assistance to their

low-income residents they shall receive an increase in amounts otherwise paid to them under Medicaid.

Exempts prices negotiated by PDP and other qualified plans offering Medicare prescription drug coverage from the calculation of "best price" under Medicaid.

Extends Medicare cost-sharing for the Medicare part B premium for qualifying individuals through 2008, with total annual allocations of $400 million through FY 2008 and $100 million for the first quarter of FY 2009.

Expands outreach requirements for the Commissioner of Social Security to include outreach to low-income subsidy individuals.

Provides that not later than January 1, 2005, the Secretary shall report to Congress legislative recommendations for establishing a voluntary option for dual eligibles to enroll under Medicare part D for prescription drug coverage.

(Sec. 105) Amends SSA title XVIII to: (1) increase from 17 to 19 the number of members composing the Medicare Payment Advisory Commission (MEDPAC); (2) include among the specified categories of individuals which may be MEDPAC members experts in the area of pharmacology and prescription drug benefit programs; (3) provide for staggering the initial terms of MEDPAC members; and (4) expand the area of MEDPAC review to cover, with respect to the voluntary prescription drug delivery program under new Medicare part D, competition among eligible entities offering PDP plans and beneficiary access to such plans and covered drugs, particularly in rural areas.

(Sec. 106) Directs the Secretary to study and report to Congress on variations in spending and drug utilization under the new program for covered drugs to determine their impact on premiums imposed by eligible entities offering PDP plans.

Subtitle B: Medicare Prescription Drug Discount Card and Transitional Assistance for Low-Income Beneficiaries - (Sec. 111) Amends SSA title XVIII to establish a Medicare prescription drug discount card endorsement program under which the Secretary shall: (1) endorse prescription drug discount card programs offered by prescription drug card sponsors meeting certain requirements; and (2) make available information on endorsed programs to any individual who is entitled to, or enrolled for, benefits under Medicare part A and enrolled under Medicare part B (eligible beneficiaries).

Directs the Secretary to establish procedures for identifying eligible beneficiaries who may elect to enroll or disenroll in any prescription drug discount programs endorsed under this subtitle. Restricts a beneficiary to enrollment in one prescription drug discount card program at any one time. Allows card sponsors to charge annual enrollment fees, not to exceed $25. Requires the fee to be uniform for all eligible Medicare beneficiaries enrolled in the program.

Directs the Secretary to provide for the dissemination of information which compares the costs and benefits of the endorsed prescription drug discount card programs in order to promote informed choice among such programs. Requires each prescription drug card sponsor to make available to each eligible beneficiary (through the Internet and otherwise) information: (1) that the Secretary identifies as being necessary to promote informed choice among endorsed prescription drug discount card programs by eligible beneficiaries; and (2) on how any formulary used by such sponsor functions.

Directs the Secretary to provide through the 1-800-MEDICARE toll free telephone number for the receipt and response to inquiries and complaints concerning the Medicare prescription drug discount card endorsement program and prescription drug discount card programs endorsed under such programs.

Requires each endorsed prescription drug discount card program, and card sponsor, to meet specified beneficiary protection requirements. Requires sponsors to secure the participation of a sufficient number of pharmacies that dispense drugs directly to patients to ensure convenient access for enrolled beneficiaries. Prohibits: (1) card sponsors

from recommending switching an eligible beneficiary to a drug with a higher negotiated price, unless a licensed health professional recommended a switch based on a clinical indication; and (2) negotiated prices from changing more than once every 60 days.

Requires card sponsors to provide enrolled eligible beneficiaries with access to negotiated prices used by the sponsor with respect to prescription drugs dispensed to eligible beneficiaries. Provides that Medicaid best price rules shall not apply. Requires each prescription drug discount card program to provide pharmaceutical support services, including services to prevent adverse drug interactions. Outlines a process for sponsors seeking endorsement of a card program to submit the required application information to the Secretary for approval and endorsement. Allows sponsors to use formularies. Directs the Secretary to provide appropriate oversight to ensure compliance of endorsed programs with applicable requirements of this section, and authorizes the Secretary to revoke the endorsement of a program that the Secretary determines no longer meets the requirements of this subtitle and take other specified action to prevent fraud and abuse under card programs.

Establishes a program under which the Secretary shall award contracts to prescription drug card sponsors offering a prescription drug discount card through an endorsed program, including a prescription drug assistance card program for eligible low-income beneficiaries, which include qualified Medicare beneficiaries. Waives enrollment fees, which shall be paid by the Secretary. Requires each sponsor offering a prescription drug assistance card program to permit the enrollment of any eligible low-income beneficiary residing in the geographic area it serves. Provides that an eligible low-income beneficiary enrolled in the prescription drug assistance card program shall be simultaneously enrolled in the sponsor's prescription drug discount card program.

Grants eligible low-income enrollees access, through their prescription drug discount card, to $600 per year for prescription drug expenses, with any balance remaining on the card in a year to be carried forward. Subjects enrollees to cost-sharing requirements which must be at least ten percent of the negotiated price for a drug. Provides that cost-sharing charges shall not be counted against the $600. Requires card sponsors to provide enrollees with a minimum 20 percent discount from the average wholesale price for each covered drug.

Establishes a mechanism to resolve grievances between sponsors and enrollees. Requires the prescription drug card sponsor to notify each enrollee periodically of the amount of coverage remaining.

Prohibits the Secretary from determining that convenient access has been provided unless an appropriate arrangement was in place for eligible low-income beneficiaries in long-term care facilities to receive prescription drug benefits under the program. Requires sponsors to require pharmacies to inform the low-income enrollee at the time of purchase of any difference between the price of the prescribed drug and the lowest cost generic drug that is therapeutically equivalent and bioequivalent and available at the pharmacy.

Applies to the prescription drug assistance card program the coverage determination, reconsideration, and appeals requirements of Medicare part C.

Directs the Secretary to pay to each prescription drug card sponsor offering a prescription drug assistance card program an amount agreed to in their contract. Makes the costs of providing benefits under this subtitle payable from the Medicare Federal Supplementary Medical Insurance Trust Fund.

Makes necessary appropriations.

Excludes prescription drug assistance card costs from determination of the Medicare part B monthly premium.

Subtitle C: Standards for Electronic Prescribing - (Sec. 121) Amends SSA title XI to: (1) direct the Secretary to develop or adopt standards for transactions and data elements for such transactions to enable the electronic transmission of medication history, eligibility, benefit, and other prescription information among prescribing and dispensing professionals at the point of care; and (2) require all individuals and entities that transmit or receive prescriptions electronically to comply with such standards.

Authorizes the Secretary to make grants to applicant health care providers for the purpose of assisting such entities to implement electronic prescription programs that comply with such standards. Authorizes appropriations.

Subtitle D: Other Provisions - (Sec. 131) Amends SSA title XVIII to direct the Board of Trustees of the Federal Hospital Insurance Trust Fund to submit an annual combined report to Congress on the operation and status of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, including the Prescription Drug Account within such Trust Fund. Requires the report to include: (1) a statement of total amounts obligated during the preceding fiscal year from the General Revenues of the Treasury to the Trust Funds, separately stated in terms of the total amount and in terms of the percentage such amount bears to all other amounts obligated from such General Revenues during such fiscal year, specifically for both Medicare benefits and administrative and other expenses not related to Medicare benefits; (2) this information for each fiscal year beginning with the inception of Medicare; (3) ten-year and 50-year projections of amounts required to be obligated for payment of covered benefits; and (4) a comparison of the rates of growth for both benefits and administrative costs to the rates of growth in the gross domestic product, health insurance costs in the private sector, employment-based health insurance costs in the public and private sectors, and other areas as determined appropriate by the Board of Trustees.

Expresses the sense of Congress that the committees of jurisdiction of Congress shall hold hearings on such reports.

(Sec. 132) Requires the annual reports to Congress by the Boards of Trustees of the Federal Hospital Insurance Trust Fund and of the Federal Supplementary Medical Insurance Trust Fund for 2004 to include an analysis of the total amount of the unfunded obligations of the Medicare program. Requires the analysis to compare the long-term obligations of the Medicare program to the dedicated funding sources for that program (other than general revenues).

Title II: MedicareAdvantage - Subtitle A: MedicareAdvantage Competition - (Sec. 201) Amends SSA title XVIII part C (Medicare+Choice) to replace the current Medicare+Choice program with the MedicareAdvantage (MA) program.

Entitles an individual entitled to (or enrolled for) benefits under Medicare part A and enrolled in both Medicare parts B and D to elect to receive Medicare benefits through: (1) the original Medicare fee-for-service program under Medicare parts A and B and the voluntary prescription drug delivery program and Medicare PDP under Medicare part D; or (2) enrollment in an MA plan under Medicare part C. Allows: (1) individuals no longer residing in the plan service area to continue enrollment as long as the plan provides reasonable access within that geographic area to the full range of basic benefits; and (2) individuals residing in a service area where the payment area of an MA plan has been eliminated to continue enrollment in an MA plan that allows such individuals to continue enrollment and receive the full range of basic benefits at designated facilities in the plan service area if there are no other MA plans offered in the area.

Allows an MA plan to be: (1) (as under the current Medicare+Choice program) a coordinated care plan such as a health maintenance organization (HMO) plan or a provider-sponsored organization (PSO) plan; (2) a medical savings account (MSA) plan, with a contribution into a medical savings account (MSA); (3) a private fee-for-service plan (PFFS); or (4) (an option not under the current Medicare+Choice program) a PPO plan (as discussed more fully below under Subtitle B).

Excludes: (1) from the MA program any individuals with end-stage renal disease (ESRD), except those who develop

ESRD while enrolled; and (2) from the MSA component of the MA program any Federal civilian and military retirees until such time as the Director of the Office of Management and Budget certifies to the Secretary that the Office of Personnel Management has adopted policies which will ensure that the enrollment of such individuals in MSA plans will not result in increased expenditures for the Federal Government.

Makes an individual eligible to elect an MA plan offered by an MA organization only if the plan serves the geographic area in which the individual resides. Makes a qualified Medicare beneficiary, a qualified disabled and working individual, or an individual otherwise entitled to Medicare cost-sharing under a State Medicaid plan ineligible to enroll in an MSA plan. Makes an individual ineligible to enroll in an MSA plan on or after January 1, 2004, unless the enrollment is a continuation on a demonstration basis in effect as of such date, or as of any date if the number of such individuals so enrolled as of such date has reached 390,000. Provides that under rules established by the Secretary, an individual is ineligible 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. Directs the Secretary to evaluate and report regularly to Congress on the impact of permitting enrollment in MSA plans on selection, use of preventive care, access to care, and the financial status of the Medicare trust funds.

Directs the Secretary to establish a process through which an eligible individual makes or changes an election to receive Medicare prescription drug benefits through a Medicare PDP or an MA plan. Allows such elections only during specified coverage election periods starting in 2003. Provides that, beginning in 2007, the annual coordinated election period shall be the month of November. Directs the Secretary, beginning with 2006, in conjunction with the annual coordinated election period, to provide for a nationally coordinated educational and publicity campaign to inform MA-eligible individuals about MA plans and the election processes. Sets forth special rules governing elections for MSA plans.

(Sec. 202) Requires each MA plan (except an MSA, and in the case of qualified prescription drug coverage, a private fee-for-service (PFFS) plan) to offer: (1) the Medicare part A and B benefits (except for hospice care) available to individuals residing in the area served by the plan; (2) qualified prescription drug coverage under Medicare part D to individuals residing in the area served by the plan; (3) a maximum limitation on out-of-pocket expenses and a unified deductible; and (4) any required additional benefits. Defines unified deductible as an annual deductible amount applied in lieu of the inpatient hospital deductible and the part B deductible. Provides that this shall not prevent an MA organization from requiring coinsurance or a copayment for inpatient hospital services, after the unified deductible is satisfied, subject to statutory limitations.

Permits a PFFS plan to choose not to offer qualified prescription drug coverage under Medicare part D. Allows beneficiaries enrolling in a PFFS plan to enroll with an eligible entity under Medicare part D to receive their prescription drug coverage. Permits MA plans to choose to provide enrollees with enhanced medical benefits that the Secretary may approve. Requires the Secretary to approve any such enhanced benefits unless they shall substantially discourage enrollment by MA-eligible individuals within the organization.

Prohibits the Secretary from approving any enhanced medical benefit that provides for the coverage of any prescription drug other than those relating to prescription drugs covered under the original Medicare fee-for-service program. Gives the Secretary the authority to disapprove any MA plan designed to attract a population that is healthier than the average population residing in the plan service area. Requires MA plans to provide, in addition to any currently required, information pertaining to: (1) the maximum limitation on out-of-pocket expenses and the unified deductible; (2) qualified prescription drug coverage under Medicare part D; and (3) enhanced medical benefits. Requires the quality assurance programs of an organization, in addition to current law requirements, to provide access to: (1) disease management and

chronic care services; and (2) preventive benefits and related information.

(Sec. 203) Directs the Secretary to pay each MA organization, with respect to an individual, and according to a specified formula, separate monthly payments for benefits under Medicare parts A and B, and for benefits under the voluntary prescription drug program under Medicare part D.

Provides that: (1) beginning in 2005, the Secretary shall announce annually the bench mark amount for each MA payment area and the factors to be used under the comprehensive risk adjustment methodology; (2) for purposes of making payments before 2006, the payment shall be the same as under current law, the highest of the blend, minimum amount, or minimum percentage increase; and (3) beginning in 2006, MA plans shall be based on a new methodology under which each plan shall submit a bid including assumptions with respect to the enrollment capacity in relation to the plan and each payment area and the expected mix, by health status, of enrolled individuals.

Prescribes a formula for determining payment amounts, incorporating a weighted service area benchmark amount for the benefits under the original Medicare fee-for-service program option.

(Sec. 204) Requires each MA organization to submit information to the Secretary by the second Monday in September, including (1) notice of intent and information on the plan service area; (2) the plan type for each plan; (3) specified information for coordinated care and private fee-for-service plans with respect to each payment area, including information with respect to benefits under the original Medicare fee-for-service program; (4) the enrollment capacity (if any) in relation to the plan and each payment area; and (5) the expected mix, by health status, of enrolled individuals.

Requires coordinated care and private fee-for-service plans to submit a plan bid (the total amount that the plan is willing to accept for providing benefits under the original Medicare fee-for-service program not taking into account the application of the comprehensive risk adjustment) and the assumptions used in preparing the plan bid with respect to the number of enrollees in each payment area and the mix, by health status, of such individuals.

Requires any enhanced medical benefit package a plan offers to provide: (1) the adjusted community rate; (2) the portion of the actuarial value of such benefits package (if any) that shall be applied toward satisfying the requirement for additional benefits; (3) the MA monthly beneficiary premium for enhanced benefits; (4) a description of the cost-sharing; (5) whether the unified deductible has been lowered or the maximum out-of-pocket limitation has been decreased; and (6) such other information as the Secretary considers necessary.

Allows the Secretary to disapprove a plan bid if the Secretary determines that the deductibles, coinsurance, or copayments discourage access to covered services or are likely to result in favorable selection of MA-eligible individuals. Requires each bid amount to reasonably and equitably reflect the cost of benefits provided under that plan.

Requires the monthly amount of the premium, if any, charged to an MA enrollee to be the sum of any MA monthly basic beneficiary premium, any premium for enhanced medical benefits, and any obligation for qualified prescription drug coverage. Requires that the MA monthly basic beneficiary premium, the MA monthly beneficiary obligation for qualified prescription drug coverage, and the MA monthly beneficiary premium for enhanced medical benefits be uniform among individuals enrolled in the plan.

Provides that if the Secretary determines that the weighted service area benchmark exceeds the plan bid, the Secretary shall require the plan to provide additional benefits; and if the Secretary determines that the plan bid exceeds the weighted service area benchmark, the amount of such excess shall be the MA monthly basic beneficiary premium.

Requires the MA monthly basic beneficiary premium and the actuarial value of the deductibles, coinsurance, and copayments to equal the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals who have elected to receive benefits under the original Medicare fee-for-service option if such individuals were not members of an MA organization (adjusted to account for geographic differences and for plan cost and utilization differences).

Requires the sum of the MA monthly beneficiary premium for enhanced medical benefits (multiplied by 12), and the actuarial value of the deductible, coinsurance, and copayments for a year, to equal the adjusted community rate for such benefits for the year minus the actuarial value of required additional benefits.

Requires the Secretary to study and report to Congress on the extent to which Medicare+Choice cost-sharing discourages access to covered services or discriminates based on the health status of Medicare+Choice eligible individuals.

(Sec. 205) Establishes special rules for prescription drug benefits under the MA program. Provides that beginning on January 1, 2006, MA plans, other than private fee-for-service plans, shall be required to offer each enrollee qualified prescription drug coverage that meets the requirements for such coverage under the MA program and under part D of Medicare. Allows private fee-for-service plans to provide qualified prescription drug coverage under Medicare part D. Permits an MA plan to offer qualified prescription drug coverage that exceeds the coverage required under Medicare part D as long as it also offers an MA plan in the area that provides only the required coverage.

Prohibits an MA plan that provides qualified prescription drug coverage from making available coverage of any prescription drugs (other than that relating to prescription drugs covered under the original Medicare fee-for-service program option) to an enrollee as an additional benefit or as an enhanced medical benefit.

Establishes payments to each MA organization offering an MA plan that provides qualified prescription drug coverage. Directs the Secretary for each year, beginning with 2006, to pay such organization an amount equal to the full amount of the monthly premium for the year, as adjusted using the risk adjusters that apply to standard prescription drug coverage. Provides that payment to MA organizations shall be made from the Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.

(Sec. 206) Permits employers to sponsor a plan or pay premiums for qualified retirees who enroll in a PPO.

(Sec. 207) Provides that beginning on January 1, 2006, the MA program shall be administered by the Center for Medicare Choices established under title III of this Act.

(Sec. 209) Applies the amendments made by this title (except for MSA plans) to plan years beginning on or after January 1, 2006.

Subtitle B: Preferred Provider Organizations - (Sec. 211) Amends SSA title XVIII part C to establish, beginning January 1, 2006, a preferred provider program under which preferred provider organization (PPO) plans are offered to MA-eligible individuals in preferred provider regions. Requires the PPO plan to: (1) have a network of providers that have agreed to contractually specified reimbursement for covered benefits with the organization offering the plan; and (2) provide for reimbursement for all covered benefits regardless of whether they are provided within such network of providers.

Establishes at least ten preferred provider regions. Requires each region to include at least one State. Prohibits the

Secretary from dividing States so that portions are in different regions. Directs the Secretary, to the extent possible, to include multistate MSAs in a single region. Permits the Secretary, however, to divide MSAs where it is necessary to establish regions of such size and geography as to maximize the participation of PPO plans. Permits the Secretary to use the same regions established for the voluntary prescription drug benefit program under Medicare part D. Applies also to PPO plans MA program requirements concerning eligibility, election, and enrollment, and benefits and beneficiary protections that apply to coordinated care plans. Requires the service area of a PPO plan to be a preferred provider region. Allows the Secretary to disapprove any PPO believed to attract a population healthier than the average population of the region serviced by the plan. Requires PPOs to establish a sufficient number and range of health care professionals and providers willing to provide services under the plan's terms.

Directs the Secretary to: (1) make separate monthly payment with respect to benefits under the Medicare fee-for-service program and benefits under the voluntary prescription drug program under Medicare part D; (2) establish separate rates of payment for individuals with ESRD; (3) apply the comprehensive risk adjustment methodology to 100 percent of the plan payment; and (4) establish a methodology for adjusting spending variations within a region, similar to the method for equalizing the Federal contribution with respect to payment to the MA organization for each enrollee.

Requires the Secretary, beginning in 2006, to calculate a benchmark amount for each preferred provider region.

Requires the Secretary to: (1) review each plan bid submitted for benefits coverage under the original Medicare fee-for-service program option to ensure that such bids are based on the proper assumptions; (2) calculate a regional benchmark amount for that plan equal to the regional benchmark adjusted for the number of enrollees assumed in the plan bid; and (3) determine the difference between each adjusted plan bid and the plan's regional benchmark amount to determine the payment amount, the additional benefits required, and the MA monthly basic beneficiary premium.

Requires the payment to a PPO under this section to be made from the Medicare Trust Funds.

Directs the Secretary to accept the three lowest-cost credible bids in a region that meet or exceed the quality and minimum standards.

Requires that the amount of the monthly premium charged to an individual enrolled in a PPO plan equal the sum of any MA monthly basic beneficiary premium, any MA monthly beneficiary premium for enhanced medical benefits, and any MA monthly obligation for qualified prescription drug coverage. Prohibits premiums from varying among MA-eligibles in a region. Bans price gouging by requiring each bid to reasonably and equitably reflect the cost of benefits provided. Prohibits PPOs from segmenting a region.

Requires the Secretary to: (1) review the adjusted community rates, the amounts of the MA monthly basic premium, and the MA monthly beneficiary premium for enhanced medical benefits and to approve or disapprove such rates and amounts; and (2) review the actuarial assumptions and data used by the PPO with respect to such rates and amounts so submitted to determine the appropriateness of such assumptions and data.

Prescribes requirements for establishment of PPO plan risk corridors and payment calculations. Places PPOs at full risk for all enhanced medical benefits. Provides that an eligible beneficiary's obligation for payment of MA basic premiums shall not be affected by these risk corridors for a given year. Requires a PPO to be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State within the preferred provider region in which it offers a PPO plan.

Subtitle C: Other Managed Care Reforms - (Sec. 221) Amends SSA title XVIII to allow a reasonable cost contract to be

extended or renewed until December 31, 2009. Requires such contracts, beginning in 2004, to comply with certain requirements of the Medicare+Choice program (and beginning in 2006 with the MA program), including requirements relating to ongoing quality assurance programs, limitations on physician incentive plans, and requirements of uniform premium amounts for plan enrollees.

Requires the Secretary to approve a new application for an HMO to enter into a reasonable cost contract if, as of January 1, 2004, the HMO: (1) provided at least 85 percent of the services of a physician which are provided as basic health services through a medical group (or groups); and (2) met other applicable requirements for such entities.

(Sec. 222) Amends SSA title XVIII part C to establish as a new Medicare+Choice option specialized Medicare+Choice plans for special needs beneficiaries. Defines special needs beneficiaries as those Medicare+Choice eligible individuals who are institutionalized, entitled to Medicaid, or meet other requirements of the Secretary. Allows specialized Medicare+Choice plans to limit enrollment to special needs beneficiaries until January 1, 2008. Requires the Secretary, not later than December 31, 2006, to report to Congress on the impact of specialized Medicare+Choice plans for special needs beneficiaries on the cost and quality of services provided to enrollees.

(Sec. 223) Amends SSA title XVIII to apply limitations on balance billing to PACE (Program of All-Inclusive Care for the Elderly) providers, individuals enrolled with such PACE providers, and non-contract physicians and other entities.

Amends SSA title XIX with respect to services covered under the State Medicaid plan (but not under Medicare) that are furnished to a PACE enrollee by a Medicaid provider that does not have a contract with the PACE provider. Prohibits such a Medicaid provider from requiring the PACE program to pay the Medicaid provider more than the amount otherwise payable for the service to the Medicaid provider under the Medicaid plan for the State where the PACE provider is located.

(Sec. 224) Directs the Secretary to arrange with the Institute of Medicine of the National Academy of Sciences to evaluate leading health care performance measures and options to implement policies that align performance with payment under the Medicare program. Requires the Institute to report to the Secretary and specified congressional committees its findings and recommendations. Authorizes appropriations.

(Sec. 225) Amends SSA title XI to expand the work of Medicare quality improvement organizations with respect to quality improvement assistance relating to prescription drug therapy provided to providers, practitioners, prescription drug card sponsors and eligible entities under Medicare part D, Medicare+Choice, and MA plans.

Title III: Centers for Medicare Choices - (Sec. 301) Amends SSA title XVIII to direct the Secretary to establish within HHS the Center for Medicare Choices, which shall be separate from the Center for Medicare & Medicaid Services and be headed by an Administrator to carry out the MA and PDP programs, including negotiating, entering into, and enforcing, contracts with plans for the offering of MA plans under part C, as well as contracts with eligible entities for the offering of Medicare PDP plans under part D.

Directs the Secretary to: (1) establish within the Center for Medicare Choices an Office of Beneficiary Assistance to carry out functions relating to Medicare beneficiaries, including eligibility determinations and information dissemination; and (2) appoint a Medicare Ombudsman within the Office of Beneficiary Assistance to receive complaints, grievances, and requests for information submitted by a Medicare beneficiary with respect to any aspect of the Medicare program, and to provide assistance with respect to such matters. Authorizes appropriations.

Directs the Secretary to provide through the toll-free number 1-800-MEDICARE for a means by which individuals phoning

for information about, or assistance with, Medicare programs are transferred without charge to appropriate entities for such information or assistance.

Title IV: Medicare Fee-For-Service Improvements - Subtitle A: Provisions Relating to Part A - (Sec. 401) Amends SSA title XVIII part A to require Medicare, for discharges during the last three quarters of FY 2004, to pay hospitals in rural and small urban areas an increased operating standardized amount equal to half the difference between the amount paid to hospitals in large urban areas and the amount paid to hospitals in other areas. Requires the Secretary, for FY 2005 and ensuing fiscal year discharges, to compute an operating standardized amount for hospitals in any area within the United States and within each region equal to the operating standardized amount computed for the previous year for hospitals in large urban areas (or, beginning with FY 2006, applicable for all hospitals in the previous fiscal year) increased by the applicable percentage increase for the fiscal year involved.

(Sec. 402) Requires the Secretary, with respect to adjustment to the Medicare inpatient hospital prospective payment system (PPS) wage index, to decrease the labor-related share to 68 percent of the standardized amount for each hospital discharge adjusted by the area wage index only if such change results in higher total payments to the hospital for discharges occurring on or after Octob

Actions Timeline

- **Jul 7, 2003:** Senate incorporated this measure in H.R. 1 as an amendment.
- **Jul 7, 2003:** Senate passed companion measure H.R. 1 in lieu of this measure by Unanimous Consent.
- **Jul 7, 2003:** Senate vitiated previous passage pursuant to the order of June 26, 2003.
- **Jul 7, 2003:** Returned to the Calendar. Calendar No. 138.
- **Jul 7, 2003:** See also H.R.1.
- **Jun 27, 2003:** The committee substitute as amended agreed to by Unanimous Consent.
- **Jun 27, 2003:** Passed/agreed to in Senate: Passed Senate with an amendment and an amendment to the Title by Yea-Nay Vote. 76 - 21. Record Vote Number: 262.
- **Jun 27, 2003:** Passed Senate with an amendment and an amendment to the Title by Yea-Nay Vote. 76 - 21. Record Vote Number: 262.
- **Jun 27, 2003:** Senate ordered measure printed as passed.
- **Jun 26, 2003:** Considered by Senate. (consideration: CR S8605-8633, S8635-8678, S8679-8685, S8686-8707)
- **Jun 25, 2003:** Considered by Senate. (consideration: CR S8479-8546)
- **Jun 24, 2003:** Considered by Senate. (consideration: CR S8386-8426, S8429-8431)
- **Jun 23, 2003:** Considered by Senate. (consideration: CR S8323-8356)
- **Jun 20, 2003:** Considered by Senate. (consideration: CR S8265-8295)
- **Jun 19, 2003:** Considered by Senate. (consideration: CR S8169-8201, S8202-8216)
- **Jun 18, 2003:** Considered by Senate. (consideration: CR S8013-8116; text of measure as reported in Senate with modification: CR S8020-8088)
- **Jun 17, 2003:** Considered by Senate. (consideration: CR S7947-7974)
- **Jun 16, 2003:** Measure laid before Senate by unanimous consent. (consideration: CR S7906-7922)
- **Jun 13, 2003:** Committee on Finance. Reported by Senator Grassley with an amendment in the nature of a substitute and an amendment to the title. Without written report.
- **Jun 13, 2003:** Committee on Finance. Reported by Senator Grassley with an amendment in the nature of a substitute and an amendment to the title. Without written report.
- **Jun 13, 2003:** Placed on Senate Legislative Calendar under General Orders. Calendar No. 138.
- **Jun 12, 2003:** Committee on Finance. Ordered to be reported with an amendment in the nature of a substitute favorably.
- **Jun 11, 2003:** Introduced in Senate
- **Jun 11, 2003:** Read twice and referred to the Committee on Finance. (text of measure as introduced: CR S7720)