AMENDMENT TO THE AMENDMENT IN THE
NATURE OF A SUBSTITUTE TO H.R. 3200
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(AINS-EC_001)

[Contingent adjustment in affordability credit
table:] In section 243(d), in paragraph (1), as previously
amended, strike “paragraph (3)” and insert “paragraphs
(3) and (4)” and add at the end the following:

1  (4) CONTINGENT ADJUSTMENT FOR ADDI-
2   TIONAL SAVINGS.—
3    (A) IN GENERAL.—Before the beginning of
4       each year beginning with Y2—
5       (i) the Chief Actuary of the Centers of
6       Medicare & Medicaid Services shall esti-
7       mate the amount of savings in the previous
year under this division resulting from the application of the provisions described in subparagraph (B) and shall report such estimate to the Commissioner; and

(ii) the Commissioner, based upon such estimate, shall provide for an appropriate increase in the initial and final premium percentages in the table specified in paragraph (1) in a manner that is designed to result an increase in aggregate affordability credits equivalent to the amount so estimated.

(B) PROVISIONS DESCRIBED.—The provisions described in this subparagraph are as follows:

(i) FORMULARY UNDER PUBLIC OPTION.—Section 223(a)(4).

(ii) PBM TRANSPARENCY.—Section 133(d).

(iii) ACO IN MEDICAID.—Section 1726.

(iv) ADMINISTRATIVE SIMPLIFICATION.—

(I) Section 1173A of the Social Security Act, as added by section 163(a)(1).
(II) Section 163(c).

(III) Section 164.

[Formulary under Public Option:]

In section 223(a)(2)(A), strike “and subsection (b)(1)” and insert “, paragraph (4), and subtitle (b)(1)”.

Amend section 223(a)(4) to read as follows:

(4) Prescription Drugs.—Notwithstanding any other provision of law, the Secretary shall negotiate with pharmaceutical manufacturers the payment rates (including discounts, rebates, and other price concessions) that may be charged for prescription drugs for individuals who are enrolled under the public health insurance option and shall establish a particular formulary for prescription drugs under such option.

[PBM Transparency:]

Add at the end of section 133 the following:

(d) Pharmacy Benefit Managers Transparency Requirements.—

(1) In general.—Notwithstanding any other provision of law, a qualified health benefits plan shall enter into a contract with a pharmacy benefit managers (in this subsection referred to as a
“PBM”) to manage the prescription drug coverage
provided under such plan, or to control the costs of
such prescription drug coverage, only if as a condi-
tion of such contract the PBM is required to provide
at least annually to the Commissioner and to the
QHP offering entity offering such plan the fol-
lowing information:

(A) Information on the volume of prescrip-
tions under the contract that are filled via mail
order and at retail pharmacies.

(B) An estimate of aggregate average pay-
ments under the contract, per prescription
(weighted by prescription volume), made to mail
order and retail pharmacists, and and the aver-
age amount, per prescription, that the PBM
was paid by the plan for prescriptions filled at
mail order and retail pharmacists.

(C) An estimate of the aggregate average
payment per prescription (weighted by prescrip-
tion volume) under the contract received from
pharmaceutical manufacturers, including all re-
bates, discounts, prices concessions, or adminis-
trative, and other payments from phar-
aceutical manufacturers, and a description of the
types of payments, and the amount of these
payments that were shared with the plan, and
a description of the percentage of prescriptions
for which the PBM received such payments.

(D) Information on the overall percentage
of generic drugs dispensed under the contract
at retail and mail order pharmacies, and the
percentage of cases in which a generic drug is
dispensed when available.

(E) Information on the percentage and
number of cases under the contract in which in-
dividuals were switched from a prescribed drug
that was less expensive to a drug that was more
expensive, the rationale for these switches, and
a description of the PBM policies governing
such switches.

(2) CONFIDENTIALITY OF INFORMATION.—Not-
withstanding any other provision of law, information
disclosed by a PBM to the Commissioner or a
QHBP offering entity under this subsection is con-
fidential and shall not be disclosed by the Commiss-
ioner or the QHBP offering entity in a form which
discloses the identity of a specific PBM or prices
charged by such PBM or a specific retailer, manu-
facturer, or wholesaler, except—
(A) as the Commissioner determines to be necessary to carry out this subsection;

(B) to permit the Comptroller General to review the information provided;

(C) to permit the Director of the Congressional Budget Office to review the information provided; and

(D) to permit the Commissioner to disclose industry-wide aggregate or average information to be used in assessing the overall impact of PBMs on prescription drug prices and spending.

[ACO in Medicaid:]

In subtitle C of title VII of division B, insert at the end the following new section:

SEC. 1726. ACCOUNTABLE CARE ORGANIZATION PILOT PROGRAM.

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish under this section an accountable care program under which a State may apply to the Secretary for approval of an accountable care organization pilot program described in subsection (b) (in this section referred to as a “pilot program”) for the applica-
tion of the accountable care organization concept under
title XIX of the Social Security Act.

(b) PILOT PROGRAM DESCRIBED.—

(1) IN GENERAL.—The pilot program described
in this subsection is a program that applies one or
more of the accountable care organization models
described in section 1866D of the Social Security
Act, as added by section 1301 of this Act.

(2) LIMITATION.—The pilot program shall op-
erate for a period of not more than 5 years.

(c) ADDITIONAL INCENTIVES.—In the case of the
pilot program under this section, the Secretary may

(1) waive the requirements of—

(A) section 1902(a)(1) of the Social Secu-

ity Act (relating to statewideness);

(B) section 1902(a)(10)(B) of such Act

(relating to comparability); and

(2) increase matching percentage for adminis-
trative expenditures up to—

(A) 90 percent (for the first 2 years of the

pilot program); and

(B) 75 percent (for the next 3 years).

(d) EVALUATION; REPORT.—

(1) EVALUATION.—The Secretary, using the
criteria described in section 1866D(f)(1) of the So-
cial Security Act (as inserted by section 1301 of this Act), shall conduct an evaluation of the pilot program under this section.

(2) REPORT.—Not later than 60 days after the date of completion of the evaluation under paragraph (1), the Secretary shall submit to Congress and make available to the public a report on the findings of the evaluation under such paragraph.

[Administrative simplification:]

In section 137, insert after "Social Security Act" the following: "and the operating rules under section 1173B of such Act".

In part C of title XI of the Social Security Act, as added by section 163(a)(1), insert after section 1173A the following new section:

"SEC. 1173B. OPERATING RULES.

"(a) IN GENERAL.—The Secretary shall adopt operating rules for each transaction described in section 1173(a)(2) of the Social Security Act (42 U.S.C. 1320d-2(a)).

"(b) OPERATING RULES DEVELOPMENT.—In adopting such rules, the Secretary shall take into account the development of operating rules that have been developed by a nonprofit entity that meets the following criteria:
"(1) The entity focuses its mission on administrative simplification.

"(2) The entity demonstrates a established multi-stakeholder process that creates consensus based operating rules using a voting policy with balanced representation by the critical stakeholders (including health plans and health care providers) so that no one group dominates the entity and shall include others such as standards development organizations, and relevant Federal agencies.

"(3) The entity has in place a public set of guiding principles that ensure the operating rules and process are open and transparent.

"(4) The entity shall coordinate its activities with the HIT Policy Committee and the HIT Standards Committee (established under title XXX of the Public Health Service Act) and complements the efforts of the Office of the National Healthcare Coordinator and its related health information exchange goals.

"(5) The entity incorporates national standards, including the transaction standards issued under Health Insurance Portability and Accountability Act of 1996.
“(6) The entity uses existing market research and proven best practices.

“(7) The entity has a set of measures that allow for the evaluation of their market impact and public reporting of aggregate stakeholder impact.

“(8) The entity supports nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory practices.

“(9) The entity allows for public reviews and updates of the operating rules.

“(e) IMPLEMENTATION.—The Secretary shall adopt operating rules under this section, by regulation or otherwise, only after taking into account the rules developed by the entity under subsection (b) and having ensured consultation with providers. The first set of operating rules for the transactions for eligibility for health plan and health claims status under this section shall be adopted not later than October 1, 2011, in a manner such that such set of rules is effective beginning not later than January 1, 2013. The second set of operating rules for the remainder of the transactions described in section 1173(a)(2) of the Social Security Act (42 U.S.C. 1320d-2(a)) shall be adopted not later than October 1, 2012, in
a manner such that such set of rules is effective beginning not later than January 1, 2014.”.

At the end of section 163 insert the following:

c) UNIQUE HEALTH PLAN IDENTIFIER.—Not later than 2 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall promulgate a final rule to establish a unique health plan identifier described in section 1173(b) of the Social Security Act (42 U.S.C. 1320d-2(b)) based on the input of the National Committee of Vital and Health Statistics and consultation with health plans. The Secretary may do so on an interim final basis and effective not later than October 1, 2012.

At the end of section 163 insert the following new section (and redesignate the succeeding sections accordingly):

SEC. 164. EXPANSION OF ELECTRONIC TRANSACTIONS IN MEDICARE.

(a) IN GENERAL.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended (1) in paragraph (23), by striking the “or” at the end;

(2) in paragraph (24), by striking the period and inserting “; or”; and
(3) by inserting after paragraph (24) the following new paragraph:

"(25) subject to subsection (h), not later than January 1, 2015, for which the payment is other than by electronic funds transfer (EFT) or an electronic remittance in a form as specified in ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard."

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect upon the date of the enactment of this Act.