

106TH CONGRESS
2D SESSION

H. R. 4607

To amend title XVIII of the Social Security Act to provide for a prescription drug benefit for Medicare beneficiaries.

IN THE HOUSE OF REPRESENTATIVES

JUNE 8, 2000

Ms. ESHOO (for herself, Mr. ENGEL, Mr. FROST, Mr. GORDON, Mr. DEUTSCH, Mrs. CAPPS, Mr. WYNN, Ms. DEGETTE, Mr. SAWYER, Ms. MCCARTHY of Missouri, Ms. WOOLSEY, Mr. RUSH, and Mr. ACKERMAN) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, 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

A BILL

To amend title XVIII of the Social Security Act to provide for a prescription drug benefit for Medicare beneficiaries.

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

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS; REF-**
4 **ERENCES TO SOCIAL SECURITY ACT.**

5 (a) SHORT TITLE.—This Act may be cited as the
6 “Medicare Prescription Drug Act of 2000”.

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

Sec. 1. Short title; table of contents; references to Social Security Act.
 Sec. 2. Providing for medicare prescription drug benefit.

“PART D—PRESCRIPTION DRUG BENEFIT FOR THE AGED AND DISABLED

“Sec. 1860. Establishment of prescription drug benefit program for the
 aged and disabled.

“Sec. 1860A. Scope of benefits.

“Sec. 1860B. Payment of benefits.

“Sec. 1860C. Eligibility and enrollment.

“Sec. 1860D. Premiums.

“Sec. 1860E. Special eligibility, enrollment, and copayment rules for low-
 income individuals.

“Sec. 1860F. Prescription Drug Insurance Account.

“Sec. 1860G. Administration of benefits.

“Sec. 1860H. Employer incentive program for employment-based retiree
 drug coverage.

“Sec. 1860I. Appropriations to cover government contributions.

“Sec. 1860J. Definition.

Sec. 3. Medicaid buy-in of medicare prescription drug coverage for certain low-
 income individuals.

Sec. 4. MedPAC studies on benefit managers.

3 (c) **REFERENCES TO SOCIAL SECURITY ACT.**—Ex-
 4 cept as otherwise expressly provided, whenever in this Act
 5 an amendment or repeal is expressed in terms of an
 6 amendment to, or repeal of, a section or other provision,
 7 the reference shall be considered to be made to a section
 8 or other provision of the Social Security Act.

9 **SEC. 2. PROVIDING FOR MEDICARE PRESCRIPTION DRUG**
 10 **BENEFIT.**

11 (a) **IN GENERAL.**—Title XVIII is amended—

12 (1) by redesignating part D as part E; and

13 (2) by inserting after part C the following new
 14 part:

1 any pharmacy participating in the program under
2 this part (and, in circumstances designated by the
3 benefit manager, by a nonparticipating pharmacy),
4 including any specifically named drug prescribed for
5 the individual by a qualified health care professional
6 regardless of whether the drug is included in a for-
7 mulary established by the benefit manager if such
8 drug is certified as medically necessary by such
9 health care professional, up to the benefit limits
10 specified in section 1860B; and

11 “(2) charging by participating pharmacies of—

12 “(A) the price for all covered prescription
13 drugs, without regard to such benefit limit; and

14 “(B) the price (if any) established with re-
15 spect to any drugs or classes of drugs described
16 in subparagraphs (A) through (D) or (F) of
17 section 1927(d)(2) that are available to individ-
18 uals receiving benefits under this title.

19 “(b) COVERED PRESCRIPTION DRUGS.—

20 “(1) IN GENERAL.—Covered prescription drugs,
21 for purposes of this part, include all prescription
22 drugs (as defined in section 1860J(1)), including
23 smoking cessation agents, except as otherwise pro-
24 vided in this subsection.

1 “(2) EXCLUSIONS FROM COVERAGE.—Covered
2 prescription drugs shall not include drugs or classes
3 of drugs described in subparagraphs (A) through
4 (D) and (F) through (H) of section 1927(d)(2) (ex-
5 cept to the extent otherwise specifically provided by
6 the Director with respect to a drug in any of such
7 classes).

8 “(3) EXCLUSION OF PRESCRIPTION DRUGS TO
9 THE EXTENT COVERED UNDER PART A OR B.—A
10 drug prescribed for an individual that would other-
11 wise be a covered prescription drug under this part
12 shall not be so considered to the extent that pay-
13 ment for such drug is available under part A or B
14 (but shall be so considered to the extent that such
15 payment is not available because benefits under part
16 A or B have been exhausted).

17 “(c) EFFECTIVE DATE OF BENEFITS.—In no case
18 shall benefits be available under this part for prescription
19 drugs for which costs are incurred before January 1,
20 2002.

21 **“SEC. 1860B. PAYMENT OF BENEFITS.**

22 “(a) PAYMENTS.—

23 “(1) IN GENERAL.—There shall be paid from
24 the Prescription Drug Insurance Account within the
25 Supplementary Medical Insurance Trust Fund

1 (hereafter in this part referred to as the ‘Prescrip-
2 tion Drug Insurance Account’ or ‘the Insurance Ac-
3 count’), in the case of each individual who is enrolled
4 in the insurance program under this part and who
5 purchases covered prescription drugs in a calendar
6 year, an amount equal to the Federal payment per-
7 centage (specified under paragraph (2)) of the price
8 for each such covered prescription drug.

9 “(2) FEDERAL PAYMENT PERCENTAGE.—For
10 purposes of paragraph (1), the ‘Federal payment
11 percentage’ with respect to purchases during a
12 year—

13 “(A) up to the initial benefit limit specified
14 in subsection (b), is equal to 50 percent or such
15 higher percentage as is proposed by a benefit
16 manager pursuant to section 1860G(c)(8), if
17 the Director finds that such percentage will not
18 increase aggregate costs to the Insurance Ac-
19 count; or

20 “(B) above the stop loss amount specified
21 in paragraph (3) (or, if greater for a year after
22 2008, the initial benefit limit specified under
23 subsection (b)(2)), is equal to 100 percent.

1 If the Federal payment percentage is increased
2 under subparagraph (A), the beneficiary payment
3 percentage is reduced accordingly.

4 “(3) STOP-LOSS AMOUNT.—The stop-loss
5 amount specified in this paragraph—

6 “(A) for 2002 is \$5,000; or

7 “(B) for a subsequent year is the stop-loss
8 amount specified in this paragraph for the pre-
9 ceding year increased by the percentage in-
10 crease (if any) in the consumer price index for
11 all urban consumers (U.S. urban average) for
12 the 12-month period ending with June of the
13 preceding year.

14 If the stop-loss amount computed under subpara-
15 graph (B) for a year is not a multiple of \$25, it
16 shall be rounded to the nearest multiple of \$25.

17 “(b) INITIAL BENEFIT LIMIT.—For purposes of sub-
18 section (a)—

19 “(1) FOR 2002 THROUGH 2008.—The initial ben-
20 efit limit specified under this subsection is—

21 “(A) \$2,000 for each of calendar years
22 2002 and 2003;

23 “(B) \$3,000 for each of calendar years
24 2004 and 2005;

1 “(C) \$4,000 for each of calendar years
2 2006 and 2007; and

3 “(D) \$5,000 for calendar year 2008.

4 “(2) FOR 2009 AND SUBSEQUENT YEARS.—The
5 initial benefit limit specified under this subsection
6 for 2009 and each subsequent year is equal to the
7 amount specified under this subsection for the pre-
8 ceding year increased by the percentage increase (if
9 any) in the consumer price index for all urban con-
10 sumers (U.S. urban average) for the 12-month pe-
11 riod ending with June of the preceding year.

12 “(c) ELECTION OF BENEFIT MANAGER.—

13 “(1) IN GENERAL.—The Director shall establish
14 a process (based upon the process under which a
15 Medicare+Choice eligible individual may elect cov-
16 erage under a Medicare+Choice plan under part C)
17 under which an individual enrolled under this part
18 elects a specific benefit manager (under section
19 1860G) that will be responsible for the provision of
20 benefits under this part on behalf of the individual.

21 “(2) CHANGES IN ELECTION.—Such process
22 shall permit a change in election at least annually
23 and at such other times as the Director may specify,
24 based upon the type of circumstances for which a
25 change would be permitted under part C.

1 “(3) NONDISCRIMINATION.—Such process shall
2 not permit a benefit manager to refuse the election
3 of any individual, except as the Director may permit
4 in a nondiscriminatory manner based upon legiti-
5 mate capacity limitations.

6 “(4) INFORMATION.—The Director shall pro-
7 vide for dissemination of such information as will
8 enable individuals enrolled under this part to make
9 informed decisions about the election of benefit man-
10 agers.

11 **“SEC. 1860C. ELIGIBILITY AND ENROLLMENT.**

12 “(a) ELIGIBILITY.—Every individual who, in or after
13 2002, is entitled to hospital insurance benefits under part
14 A or enrolled in the medical insurance program under part
15 B is eligible to enroll, in accordance with the provisions
16 of this section, in the program under this part, during an
17 enrollment period prescribed in or under this section, in
18 such manner and form as may be prescribed by the Sec-
19 retary in regulations.

20 “(b) ENROLLMENT.—

21 “(1) IN GENERAL.—Each individual who satis-
22 fies subsection (a) shall be enrolled (or eligible to en-
23 roll) in the program under this part in accordance
24 with the provisions of section 1837, as if that section

1 applied to this part, except as otherwise explicitly
2 provided in this part.

3 “(2) ENROLLMENT PERIOD.—Except as pro-
4 vided in section 1860E or 1860H, or as otherwise
5 explicitly provided, no individual shall be entitled to
6 enroll in the program under this part at any time
7 after the initial enrollment period.

8 “(3) SPECIAL ENROLLMENT PERIOD FOR
9 2002.—

10 “(A) IN GENERAL.—An individual who
11 first satisfies subsection (a) in 2002 may, at
12 any time on or before December 31, 2002—

13 “(i) enroll in the program under this
14 part; and

15 “(ii) enroll or re-enroll in such pro-
16 gram after having previously declined or
17 terminated enrollment in such program.

18 “(B) EFFECTIVE DATE OF COVERAGE.—
19 An individual who enrolls under the program
20 under this part pursuant to subparagraph (A)
21 shall be entitled to benefits under this part be-
22 ginning on the first day of the month following
23 the month in which such enrollment occurs.

24 “(e) PERIOD OF COVERAGE.—

1 “(1) IN GENERAL.—Except as otherwise pro-
2 vided in this part, an individual’s coverage under the
3 program under this part shall be effective for the pe-
4 riod provided in section 1838, as if that section ap-
5 plied to the program under this part.

6 “(2) PART D COVERAGE TERMINATED BY TER-
7 MINATION OF COVERAGE UNDER PARTS A AND B.—
8 In addition to the causes of termination specified in
9 section 1838, an individual’s coverage under this
10 part shall be terminated when the individual retains
11 coverage under neither the program under part A
12 nor the program under part B, effective on the effec-
13 tive date of termination of coverage under part A or
14 (if later) under part B.

15 **“SEC. 1860D. PREMIUMS.**

16 “(a) ANNUAL ESTABLISHMENT OF MONTHLY PRE-
17 MIUM RATES.—

18 “(1) IN GENERAL.—The Director in coordina-
19 tion with the Secretary shall, during September of
20 2001 and of each succeeding year, determine and
21 promulgate a monthly premium rate for the suc-
22 ceeding year in accordance with the provisions of
23 this subsection.

24 “(2) ACTUARIAL DETERMINATIONS.—

1 “(A) DETERMINATION OF ANNUAL BEN-
2 EFIT COSTS.—The Director in coordination
3 with the Secretary shall estimate annually for
4 the succeeding year the amount equal to the
5 total of the benefits that will be payable from
6 the Insurance Account for prescription drugs
7 dispensed in such calendar year with respect to
8 enrollees in the program under this part. In cal-
9 culating such amount, the Director in coordina-
10 tion with the Secretary shall include an appro-
11 priate amount for a contingency margin.

12 “(B) DETERMINATION OF MONTHLY PRE-
13 MIUM RATES.—

14 “(i) IN GENERAL.—The Director in
15 coordination with the Secretary shall deter-
16 mine the monthly premium rate with re-
17 spect to such enrollees for such succeeding
18 year, which shall be one-twelfth of the
19 share specified in clause (ii) of the amount
20 determined under subparagraph (A), di-
21 vided by the total number of such enroll-
22 ees, and rounded (if such rate is not a
23 multiple of 10 cents) to the nearest mul-
24 tiple of 10 cents.

1 “(ii) ENROLLEE AND EMPLOYER PER-
2 CENTAGE SHARES.—The share specified in
3 this clause, for purposes of clause (i), shall
4 be—

5 “(I) one-half, in the case of pre-
6 miums paid by an individual enrolled
7 in the program under this part; and

8 “(II) two-thirds, in the case of
9 premiums paid for such an individual
10 by a former employer (as defined in
11 section 1860H(f)(2)).

12 “(3) PUBLICATION OF ASSUMPTIONS.—The Di-
13 rector in coordination with the Secretary shall pub-
14 lish, together with the promulgation of the monthly
15 premium rates for the succeeding year, a statement
16 setting forth the actuarial assumptions and bases
17 employed in arriving at the amounts and rates deter-
18 mined under paragraphs (1) and (2).

19 “(b) PAYMENT OF PREMIUMS.—

20 “(1) PAYMENTS BY DEDUCTION FROM SOCIAL
21 SECURITY, RAILROAD RETIREMENT BENEFITS, OR
22 BENEFITS ADMINISTERED BY OPM.—

23 “(A) DEDUCTION FROM BENEFITS.—In
24 the case of an individual who is entitled to or
25 receiving benefits as described in subsection (a),

1 (b), or (d) of section 1840, premiums payable
2 under this part shall be collected by deduction
3 from such benefits at the same time and in the
4 same manner as premiums payable under part
5 B are collected pursuant to section 1840.

6 “(B) TRANSFERS TO INSURANCE AC-
7 COUNT.—The Secretary of the Treasury shall,
8 from time to time, but not less often than quar-
9 terly, transfer premiums collected pursuant to
10 subparagraph (A) to the Insurance Account
11 from the appropriate funds and accounts de-
12 scribed in subsections (a)(2), (b)(2), and (d)(2)
13 of section 1840, on the basis of the certifi-
14 cations described in such subsections. The
15 amounts of such transfers shall be appro-
16 priately adjusted to the extent that prior trans-
17 fers were too great or too small.

18 “(2) DIRECT PAYMENTS TO SECRETARY.—

19 “(A) ADDITIONAL PAYMENT BY EN-
20 ROLLEE.—An individual to whom paragraph
21 (1) applies (other than an individual receiving
22 benefits as described in section 1840(d)) and
23 who estimates that the amount that will be
24 available for deduction under such paragraph
25 for any premium payment period will be less

1 than the amount of the monthly premiums for
2 such period may (under regulations) pay to the
3 Secretary the estimated balance, or such great-
4 er portion of the monthly premium as the indi-
5 vidual chooses.

6 “(B) PAYMENTS BY OTHER ENROLLEES.—
7 An individual enrolled in the program under
8 this part with respect to whom none of the pre-
9 ceeding provisions of this subsection applies (or
10 to whom section 1840(c) applies) shall pay pre-
11 miums to the Secretary at such times and in
12 such manner as the Secretary shall by regula-
13 tions prescribe in coordination with the Sec-
14 retary.

15 “(C) DEPOSIT OF PREMIUMS.—Amounts
16 paid to the Secretary under this paragraph
17 shall be deposited in the Treasury to the credit
18 of the Prescription Drug Insurance Account in
19 the Supplementary Medical Insurance Trust
20 Fund.

21 **“SEC. 1860E. SPECIAL ELIGIBILITY, ENROLLMENT, AND CO-
22 PAYMENT RULES FOR LOW-INCOME INDIVID-
23 UALS.**

24 “(a) STATE AGREEMENTS FOR COVERAGE.—

1 “(1) IN GENERAL.—The Secretary shall, at the
2 request of a State, enter into an agreement with the
3 State under which all individuals described in para-
4 graph (2) are enrolled in the program under this
5 part, without regard to whether any such individual
6 has previously declined the opportunity to enroll in
7 such program.

8 “(2) ELIGIBILITY GROUPS.—The individuals de-
9 scribed in this paragraph, for purposes of paragraph
10 (1), are individuals who satisfy section 1860C(a)
11 and who are—

12 “(A)(i) eligible individuals within the
13 meaning of section 1843, and

14 “(ii) in a coverage group or groups per-
15 mitted under section 1843 (as selected by the
16 State and specified in the agreement); or

17 “(B) qualified medicare drug beneficiaries
18 (as defined in section 1905(v)(1)).

19 “(3) COVERAGE PERIOD.—The period of cov-
20 erage under this part of an individual enrolled under
21 an agreement under this subsection shall be as fol-
22 lows:

23 “(A) INDIVIDUALS ELIGIBLE (AT STATE
24 OPTION) FOR PART B BUY-IN.—In the case of
25 an individual described in subsection (a)(2)(A),

1 the coverage period shall be the same period
2 that applies (or would apply) pursuant to sec-
3 tion 1843(d).

4 “(B) QUALIFIED MEDICARE DRUG BENE-
5 FICIARIES.—In the case of an individual de-
6 scribed in subsection (a)(2)(B)—

7 “(i) the coverage period shall begin on
8 the latest of—

9 “(I) January 1, 2002,

10 “(II) the first day of the third
11 month following the month in which
12 the State agreement is entered into;
13 or

14 “(III) the first day of the first
15 month following the month in which
16 the individual satisfies section
17 1860C(a); and

18 “(ii) the coverage period shall end on
19 the last day of the month in which the in-
20 dividual is determined by the State to have
21 become ineligible for medicare drug cost-
22 sharing.

23 “(b) SPECIAL PART D ENROLLMENT OPPORTUNITY
24 FOR INDIVIDUALS LOSING MEDICAID ELIGIBILITY.—In
25 the case of an individual who—

1 “(1) satisfies section 1860C(a), and

2 “(2) loses eligibility for benefits under the State
3 plan under title XIX after having been enrolled
4 under such plan or having been determined eligible
5 for such benefits,

6 the Secretary (in coordination with the Director) shall pro-
7 vide an opportunity for enrollment under the program
8 under this part during the period that begins on the date
9 that such individual loses such eligibility and ends on the
10 date specified by the Secretary.

11 “(c) DEFINITION.—For purposes of this section, the
12 term ‘State’ has the meaning given such term under sec-
13 tion 1101(a) for purposes of title XIX.

14 **“SEC. 1860F. PRESCRIPTION DRUG INSURANCE ACCOUNT.**

15 “(a) IN GENERAL.—There is created within the Fed-
16 eral Supplemental Medical Insurance Trust Fund estab-
17 lished by section 1841 an account to be known as the ‘Pre-
18 scription Drug Insurance Account’ (hereafter in this sec-
19 tion referred to as the ‘Account’). The Account shall con-
20 sist of such gifts and bequests as may be made as provided
21 in section 201(i)(1), and such amounts as may be depos-
22 ited in, or appropriated to, such fund as provided in this
23 part. Funds provided under this part to the Account shall
24 be kept separate from all other funds within the Federal
25 Supplemental Medical Insurance Trust Fund.

1 “(b) PAYMENTS FROM ACCOUNT.—The Managing
2 Trustee shall pay from time to time from the Account such
3 amounts as the Director certifies are necessary to make
4 the payments provided for by this part, and the payments
5 with respect to administrative expenses in accordance with
6 section 201(g), including expenses of the Director and the
7 Secretary in carry out this part. Any reference in such
8 section to the Secretary in relation to carrying out this
9 part shall be construed to include a reference to the Direc-
10 tor.

11 “(c) CONSTRUCTION.—Nothing in this part shall be
12 construed as authorizing any expenditures from the Ac-
13 count for activities under chapter 89 of title 5, United
14 States Code (relating to the Federal employees health ben-
15 efits program). No funds appropriated to carry out such
16 chapter shall be used to carry out this part.

17 **“SEC. 1860G. ADMINISTRATION OF BENEFITS.**

18 “(a) IN GENERAL.—The Director shall provide for
19 administration of the benefits under this part through con-
20 tracts with benefit managers approved in accordance with
21 subsection (b) for enrolled individuals (other than such in-
22 dividuals enrolled in a Medicare+Choice program under
23 part C) in accordance with the provisions of this section.

24 “(b) APPROVAL OF BENEFIT MANAGERS.—

1 “(1) AWARD AND DURATION OF CONTRACT.—

2 Each contract shall be awarded for a period of not
3 less than three nor more than five years.

4 “(2) ELIGIBLE ENTITIES.—Any entity that
5 meets the following criteria is eligible to serve as a
6 benefit manager:

7 “(A) TYPE.—The entity shall be any entity
8 that the Director determines is capable of ad-
9 ministering a prescription drug benefit pro-
10 gram.

11 “(B) PERFORMANCE CAPABILITY.—The
12 entity shall have sufficient expertise, personnel,
13 and resources to perform effectively and effi-
14 ciently the benefit administration functions.

15 “(C) INTEGRITY; FISCAL SOUNDNESS.—
16 The entity and its officers, directors, agents,
17 and managing employees shall have a satisfac-
18 tory record of professional competence and pro-
19 fessional and financial integrity, and the entity
20 shall have financial resources the Director de-
21 termines to be adequate to perform services
22 under the contract without risk of insolvency.

23 “(D) BENEFICIARY PROTECTIONS.—The
24 entity shall have in place safeguards to protect
25 beneficiaries who receive benefits under this

1 part through the entity, including the following
2 protections:

3 “(i) CONFIDENTIALITY OF HEALTH
4 INFORMATION.—Have in effect systems to
5 safeguard the confidentiality of health care
6 information on enrolled individuals, which
7 comply with section 1106 and with section
8 552a of title 5, United States Code, and
9 meet such additional standards as the Di-
10 rector may prescribe.

11 “(ii) GRIEVANCE AND APPEALS PRO-
12 CEDURES.—Have in place such procedures
13 as the Director may specify for hearing
14 and resolving grievances and appeals
15 brought by enrolled individuals against the
16 benefit manager or a pharmacy concerning
17 benefits under this part, which shall, to the
18 extent the Director finds necessary and ap-
19 propriate, include procedures equivalent to
20 those specified in subsections (f) and (g) of
21 section 1852.

22 “(iii) CLINICAL QUALITY.—Have in
23 place systems for improving clinical qual-
24 ity, including the prevention of drug-drug
25 interactions, assessment of clinical rel-

1 evance, monitoring and improving compli-
2 ance, and adoption of information tech-
3 nologies proven to reduce prescription er-
4 rors.

5 “(iv) NONDISCRIMINATION IN ELEC-
6 TIONS.—Not to refuse elections, except as
7 may be specifically permitted under section
8 1860B(e)(3).

9 “(3) PROPOSAL REQUIREMENTS.—An entity’s
10 proposal for award or renewal of a contract under
11 this section shall—

12 “(A) include a cost proposal setting forth
13 the entity’s proposed charges for administration
14 of the prescription drug benefit;

15 “(B) include a proposal for the prices of
16 drugs and annual increases in such prices, in-
17 cluding differentials between formulary and
18 non-formulary prices, if applicable (and at the
19 entity’s election, include a proposal described in
20 subsection (d)(8));

21 “(C) specify details of proposed cost and
22 utilization management, prescription error re-
23 duction, clinical quality, and quality assurance
24 measures;

1 “(D) be accompanied by such information
2 as the Director may require on the entity’s past
3 performance;

4 “(E) disclose ownership and shared finan-
5 cial interests with other entities involved in the
6 delivery of the benefit as proposed;

7 “(F) include such other material and infor-
8 mation as the Director may require; and

9 “(G) specify a mechanism to control gov-
10 ernment and beneficiary costs once the stop-loss
11 provision is triggered.

12 “(4) EXCEPTIONS TO CONFLICT OF INTEREST
13 RULES.—In awarding contracts under this sub-
14 section, the Director may waive conflict of interest
15 rules generally applicable to Federal acquisitions
16 (subject to such safeguards as the Director may find
17 necessary to impose) in circumstances where the Di-
18 rector finds that such waiver—

19 “(A) is not inconsistent with the purposes
20 of the programs under this title and the best in-
21 terests of enrolled individuals; and

22 “(B) will permit a sufficient level of com-
23 petition for such contracts, promote efficiency
24 of benefits administration, or otherwise serve
25 the objectives of the program under this part.

1 “(c) FUNCTIONS OF BENEFIT MANAGER.—The ben-
2 efit manager shall (or in the case of the function described
3 in paragraph (8), may) perform some or all of the fol-
4 lowing functions, as specified by the Director:

5 “(1) PARTICIPATION AGREEMENTS, PRICES,
6 AND FEES.—

7 “(A) SCHEDULE OF COVERED DRUG
8 PRICES.—Establish a schedule of prices for cov-
9 ered prescription drugs for beneficiaries. Such
10 prices shall not be subject to administrative or
11 judicial review.

12 “(B) AGREEMENTS WITH PHARMACIES.—
13 Enter into participation agreements with quali-
14 fying pharmacies on terms that—

15 “(i) secure the participation of suffi-
16 cient numbers of pharmacies to ensure
17 convenient access (including adequate
18 emergency access) for enrolled individuals
19 obtaining benefits through the entity; and

20 “(ii) permit the participation of any
21 pharmacy that meets the participation re-
22 quirements described in subsection (e).

23 “(C) LISTS OF PRICES AND PARTICIPATING
24 PHARMACIES.—Ensure that the prices estab-
25 lished under subparagraph (A), formulary re-

1 restrictions, and the list of participating phar-
2 macies are regularly updated and readily avail-
3 able to health care professionals authorized to
4 prescribe drugs, participating pharmacies, and
5 enrolled individuals.

6 “(2) TRACKING OF COVERED ENROLLED INDI-
7 VIDUALS.—Maintain accurate, updated records of all
8 enrolled individuals (other than individuals enrolled
9 in a plan under part C) who are receiving benefits
10 through the entity.

11 “(3) PAYMENT AND COORDINATION OF BENE-
12 FITS.—

13 “(A) IN GENERAL.—Administer claims for
14 payment of benefits under this part; determine
15 amounts of benefit payments to be made; and
16 receive, disburse, and account for funds used in
17 making such payments, including through the
18 activities specified in the provisions of this
19 paragraph.

20 “(B) COORDINATION AND PAYMENT OF
21 BENEFITS.—Coordinate with the Director,
22 other benefit managers, pharmacies and other
23 relevant entities as necessary to ensure appro-
24 priate coordination of benefits with respect to
25 enrolled individuals, including coordination of

1 access to and payment for covered prescription
2 drugs according to an individual's plan provi-
3 sions, when such individual is traveling outside
4 the home service area, and under such other
5 circumstances as the Director may specify.

6 “(C) EXPLANATION OF BENEFITS.—Fur-
7 nish to enrolled individuals receiving benefits
8 through the entity an explanation of benefits in
9 accordance with section 1806(a), and a notice
10 of the balance of benefits remaining for the cur-
11 rent year, whenever prescription drug benefits
12 are provided under this part (except that such
13 notice need not be provided more often than
14 monthly).

15 “(4) COST AND UTILIZATION MANAGEMENT;
16 QUALITY ASSURANCE.—Have in place effective cost
17 and utilization management, quality assurance meas-
18 ures, and systems to reduce prescription errors, in-
19 cluding at least the following, together with such ad-
20 ditional measures as the Director may specify:

21 “(A) DRUG UTILIZATION REVIEW.—A drug
22 utilization review program conforming to the
23 standards provided in section 1927(g)(2) (with
24 such modifications as the Director finds appro-

1 appropriate for operation of such program by an enti-
2 ty other than a State).

3 “(B) CLINICAL QUALITY.—Have in place
4 clinical quality systems consistent with sub-
5 section (b)(3)(C).

6 “(C) FRAUD AND ABUSE CONTROL.—Ac-
7 tivities to control fraud, abuse, and waste.

8 “(5) EDUCATION AND INFORMATION ACTIVI-
9 TIES.—Have in place mechanisms for disseminating
10 educational and informational materials to enrolled
11 individuals and health care providers designed to en-
12 courage effective and cost-effective use of prescrip-
13 tion drug benefits and to ensure that enrolled indi-
14 viduals understand their rights and obligations
15 under the program.

16 “(6) BENEFICIARY PROTECTIONS.—Have in ef-
17 fect beneficiary protections consistent with para-
18 graph (2)(D)(i).

19 “(7) RECORDS, REPORTS, AND AUDITS OF BEN-
20 EFIT MANAGERS.—

21 “(A) RECORDS AND AUDITS.—Maintain
22 adequate records, and afford the Director ac-
23 cess to such records (including for audit pur-
24 poses).

1 “(B) REPORTS.—Make such reports and
2 submissions of financial and utilization data as
3 the Director may require taking into account
4 standard commercial practices.

5 “(8) PROPOSAL FOR REDUCED BENEFICIARY CO-
6 INSURANCE.—At the benefit manager’s election, pro-
7 vide a proposal for increased Federal cost sharing
8 percentage (and a reduction in beneficiary cost shar-
9 ing percentage) for generic prescription drugs, pre-
10 scription drugs on the benefit manager’s formulary,
11 or prescription drugs obtained through mail order
12 pharmacies, which includes evidence that such in-
13 creased Federal cost sharing percentage would not
14 result in an increase in aggregate costs to the Ac-
15 count.

16 “(9) OTHER REQUIREMENTS.—Meet such other
17 requirements as the Director may specify.

18 “(d) PHARMACY PARTICIPATION AGREEMENTS.—

19 “(1) IN GENERAL.—A pharmacy that meets the
20 requirements of this subsection shall be eligible to
21 enter an agreement with a benefit manager to fur-
22 nish covered prescription drugs to enrolled individ-
23 uals. The benefit manager may offer preferential fi-
24 nancial terms to pharmacies that agree to be in-
25 cluded for the purposes of the initial bid.

1 “(2) TERMS OF AGREEMENT.—An agreement
2 under this subsection shall include the following
3 terms and requirements:

4 “(A) LICENSING.—The pharmacy shall
5 meet (and throughout the contract period will
6 continue to meet) all applicable State and local
7 licensing requirements.

8 “(B) ACCESS AND QUALITY STANDARDS.—
9 The pharmacy shall comply with such standards
10 as the Director and the benefit manager shall
11 establish concerning the quality of, and enrolled
12 individuals’ access to, pharmacy services under
13 this part.

14 “(C) ADHERENCE TO ESTABLISHED
15 PRICES.—The total charge for each drug dis-
16 pensed to an enrolled individual, without regard
17 to whether such individual is financially respon-
18 sible for any or all of such charge, shall not ex-
19 ceed the price for the drug, as established
20 under subsection (c)(1)(A).

21 “(D) MANAGEMENT SYSTEMS AND PROCE-
22 DURES.—The pharmacy shall—

23 “(i) have in effect management sys-
24 tems (including electronic systems) and

1 procedures for carrying out functions
2 under the agreement; and

3 “(ii) maintain adequate records, af-
4 ford the benefit manager access to such
5 records for audit purposes, and make such
6 reports as the benefit manager may require
7 to meet its responsibilities under this sec-
8 tion.

9 “(E) COST AND UTILIZATION MANAGE-
10 MENT; QUALITY ASSURANCE.—The pharmacy
11 shall implement effective measures for quality
12 assurance, cost management, and reduction of
13 medical errors with respect to drugs dispensed
14 under the agreement, including maintenance of
15 utilization records and participation in the drug
16 utilization review program described in sub-
17 section (d)(4)(A).

18 “(F) CONFIDENTIALITY PROTECTIONS.—
19 The pharmacy shall have in effect systems to
20 ensure compliance with the confidentiality
21 standards applicable under subsection
22 (b)(2)(D)(i).

23 “(G) OTHER REQUIREMENTS.—The phar-
24 macy shall meet such other requirements as the
25 Director may impose.

1 “(3) CONSTRUCTION.—Nothing in this section
2 shall be construed as requiring a benefit manager to
3 pay a particular level of dispensing fees to partici-
4 pating pharmacies or as guaranteeing such a level as
5 would provide for the participation by all phar-
6 macies.

7 “(e) LIMITATION OF LIABILITY.—The provisions of
8 section 1157(b) shall apply with respect to activities of
9 benefit managers and their officers, employees, and agents
10 under a contract under this section.

11 “(f) INCENTIVES FOR COST AND UTILIZATION MAN-
12 AGEMENT AND QUALITY IMPROVEMENT.—

13 “(1) CONTRACT PROVISIONS.—The Director is
14 authorized to include in a contract awarded under
15 subsection (c) such incentives for cost and utilization
16 management and quality improvement as the Direc-
17 tor may deem appropriate, including—

18 “(A) bonus and penalty incentives to en-
19 courage administrative efficiency;

20 “(B) incentives under which benefit man-
21 agers share in any benefit savings achieved;

22 “(C) risk sharing arrangements related to
23 benefit payments; and

1 “(D) any other incentive that the Director
2 deems appropriate and likely to be effective in
3 managing costs or utilization.

4 “(2) ESTABLISHMENT OF A SECONDARY INSUR-
5 ANCE MARKET FOR RISK.—Insofar as the Director
6 provides for a risk sharing arrangement in contracts
7 under subsection (c), the Director shall enter into or
8 promote arrangements (including the establishment
9 of a secondary insurance market or pooling mecha-
10 nism) for the appropriate distribution of excess risk
11 among entities offering such contracts.

12 “(3) CONSTRUCTION.—Nothing in this part
13 shall be construed as limiting the ability of a benefit
14 manager, subject to provisions of the contract under
15 subsection (c), to utilize such cost containment and
16 utilization management strategies as necessary, in-
17 cluding generic substitution, formulary limits, dif-
18 ferential copayment structures, and mail order pre-
19 scription services, or as limiting the ability of benefit
20 managers to offer to enrolled individuals multiple
21 products offering different formulary and copayment
22 structures.

23 “(g) FLEXIBILITY IN ASSIGNING WORKLOAD AMONG
24 BENEFIT MANAGERS.—During the period after the Direc-
25 tor has given notice of intent to terminate a contract

1 “(b) SPONSOR REQUIREMENTS.—In order to be eligi-
2 ble to receive an incentive payment under this section with
3 respect to coverage of an individual under a qualified re-
4 tiree prescription drug plan (as defined in subsection
5 (f)(3)), a sponsor shall meet the following requirements:

6 “(1) ASSURANCES.—The sponsor shall—

7 “(A) annually attest, and provide such as-
8 surances as the Director may require, that the
9 coverage offered by the sponsor is a qualified
10 retiree prescription drug plan, and will remain
11 such a plan for the duration of the sponsor’s
12 participation in the program under this section;
13 and

14 “(B) guarantee that it will give notice to
15 the Director and covered retirees—

16 “(i) at least 120 days before termi-
17 nating its plan, and

18 “(ii) immediately upon determining
19 that the actuarial value of the prescription
20 drug benefit under the plan falls below the
21 actuarial value of the benefit under this
22 part.

23 “(2) BENEFICIARY INFORMATION.—The spon-
24 sor shall report to the Director, for each calendar
25 quarter for which it seeks an incentive payment

1 under this section the names and social security
2 numbers of all retirees (and their spouses and de-
3 pendents) covered under such plan during such
4 quarter and the dates (if less than the full quarter)
5 during which each such individual was covered.

6 “(3) AUDITS.—The sponsor and the employ-
7 ment-based retiree health coverage plan seeking in-
8 centive payments under this section shall agree to
9 maintain, and to afford the Director access to, such
10 records as the Director may require for purposes of
11 audits and other oversight activities necessary to en-
12 sure the adequacy of prescription drug coverage, the
13 accuracy of incentive payments made, and such
14 other matters as may be appropriate.

15 “(4) OTHER REQUIREMENTS.—The sponsor
16 shall provide such other information, and comply
17 with such other requirements, as the Director may
18 find necessary to administer the program under this
19 section.

20 “(c) INCENTIVE PAYMENT.—

21 “(1) IN GENERAL.—A sponsor that meets the
22 requirements of subsection (b) with respect to a
23 quarter in a calendar year shall be entitled to have
24 payment made on a quarterly basis (to the sponsor
25 or, at the sponsor’s direction, to the appropriate em-

1 ployment-based health plan) of an incentive pay-
2 ment, in the amount determined as described in
3 paragraph (2), for each retired individual (or
4 spouse) who—

5 “(A) was covered under the sponsor’s
6 qualified retiree prescription drug plan during
7 such quarter; and

8 “(B) was eligible for but was not enrolled
9 in the program under this part.

10 “(2) AMOUNT OF INCENTIVE.—The payment
11 under this section with respect to each individual de-
12 scribed in paragraph (1) for a month shall be equal
13 to two-thirds of the monthly premium amount pay-
14 able by an enrolled individual, as set for the cal-
15 endar year pursuant to section 1860D(a)(2).

16 “(3) PAYMENT DATE.—The incentive under
17 this section with respect to a calendar quarter shall
18 be payable as of the end of the next succeeding cal-
19 endar quarter.

20 “(d) CIVIL MONEY PENALTIES.—A sponsor, health
21 plan, or other entity that the Director determines has, di-
22 rectly or through its agent, provided information in con-
23 nection with a request for an incentive payment under this
24 section that the entity knew or should have known to be
25 false shall be subject to a civil monetary penalty in an

1 amount up to three times the total incentive amounts
2 under subsection (c) that were paid (or would have been
3 payable) on the basis of such information.

4 “(e) PART D ENROLLMENT FOR CERTAIN INDIVID-
5 UALS COVERED BY EMPLOYMENT-BASED RETIREE
6 HEALTH COVERAGE PLANS.—

7 “(1) ELIGIBLE INDIVIDUALS.—An individual
8 shall be given the opportunity to enroll in the pro-
9 gram under this part during the period specified in
10 paragraph (2) if—

11 “(A) the individual declined enrollment in
12 the program under this part at the time the in-
13 dividual first satisfied section 1860C(a);

14 “(B) at that time, the individual was cov-
15 ered under a qualified retiree prescription drug
16 plan for which an incentive payment was paid
17 under this section; and

18 “(C)(i) the sponsor subsequently ceased to
19 offer such plan; or

20 “(ii) the value of prescription drug cov-
21 erage under such plan became less than the
22 value of the coverage under the program under
23 this part.

24 “(2) SPECIAL ENROLLMENT PERIOD.—An indi-
25 vidual described in paragraph (1) shall be eligible to

1 enroll in the program under this part during the six-
2 month period beginning on the first day of the
3 month in which—

4 “(A) the individual receives a notice that
5 coverage under such plan has terminated (in
6 the circumstance described in paragraph
7 (1)(C)(i)) or notice that a claim has been de-
8 nied because of such a termination; or

9 “(B) the individual received notice of the
10 change in benefits (in the circumstance de-
11 scribed in subparagraph (1)(C)(ii)).

12 “(f) DEFINITIONS.—As used in this section, terms
13 have the following meanings:

14 “(1) EMPLOYMENT-BASED RETIREE HEALTH
15 COVERAGE.—The term ‘employment-based retiree
16 health coverage’ means health insurance or other
17 coverage of health care costs for retired individuals
18 (or for such individuals and their spouses and de-
19 pendants) based on their status as former employees
20 or labor union members.

21 “(2) EMPLOYER.—The term ‘employer’ has the
22 meaning given such term by section 3(5) of the Em-
23 ployee Retirement Income Security Act of 1974 (ex-
24 cept that such term shall include only employers of
25 two or more employees).

1 “(3) QUALIFIED RETIREE PRESCRIPTION DRUG
2 PLAN.—The term ‘qualified retiree prescription drug
3 plan’ means health insurance coverage included in
4 employment-based retiree health coverage that—

5 “(A) provides coverage of the cost of pre-
6 scription drugs whose actuarial value (as de-
7 fined by the Director) to each retired bene-
8 ficiary equals or exceeds the actuarial value of
9 the benefits provided to an individual enrolled
10 in the program under this part; and

11 “(B) does not deny, limit, or condition the
12 coverage or provision of prescription drug bene-
13 fits for retired individuals based on age or any
14 health status-related factor described in section
15 2702(a)(1) of the Public Health Service Act.

16 “(4) SPONSOR.—The term ‘sponsor’ means
17 plan sponsor as defined in section 3(16) of the Em-
18 ployer Retirement Income Security Act of 1974.

19 “(g) APPROPRIATIONS TO COVER INCENTIVES FOR
20 EMPLOYMENT-BASED RETIREE DRUG COVERAGE.—
21 There are authorized to be appropriated from time to
22 time, out of any moneys in the Treasury not otherwise
23 appropriated such sums as may be necessary for payment
24 of incentive payments under subsection (c).

1 **“SEC. 1860I. APPROPRIATIONS TO COVER GOVERNMENT**
2 **CONTRIBUTIONS.**

3 “There are authorized to be appropriated from time
4 to time, out of any moneys in the Treasury not otherwise
5 appropriated, to the Prescription Drug Insurance Ac-
6 count, a Government contribution equal to—

7 “(1) the aggregate premiums payable for a
8 month pursuant to section 1860D(a)(2) by individ-
9 uals enrolled in the program under this part, plus

10 “(2) one-half the aggregate premiums payable
11 for a month pursuant to such section for such indi-
12 viduals by former employers.

13 **“SEC. 1860J. DEFINITION.**

14 “As used in this part, the term ‘prescription drug’
15 means—

16 “(A) a drug that may be dispensed only upon
17 a prescription, and that is described in subpara-
18 graph (A)(i), (A)(ii), or (B) of section 1927(k)(2);
19 and

20 “(B) insulin certified under section 506 of the
21 Federal Food, Drug, and Cosmetic Act, and needles,
22 syringes, and disposable pumps for the administra-
23 tion of such insulin.”.

24 (b) **STUDY OF ANNUAL OPEN ENROLLMENT.—**

25 (1) **STUDY.**—During 2002 and 2003, the Direc-
26 tor of the Office of Personnel Management shall

1 study the feasibility and advisability of establishing
2 an annual open enrollment period for the program
3 under part D (as added by subsection (a)). Such
4 study shall reflect data reported by benefit managers
5 administering benefits under such part and shall
6 include—

7 (A) a review of the costs, effectiveness, and
8 administrative feasibility of an annual open en-
9 rollment period for beneficiaries who previously
10 declined enrollment or who previously
11 disenrolled and desire to re-enroll;

12 (B) an evaluation of a premium penalty for
13 late enrollment based on actuarially determined
14 costs to the program of late enrollment; and

15 (C) a projection of the costs to the pro-
16 gram under such part through 2010 of an an-
17 nual open enrollment period.

18 (2) REPORT.—The Director shall prepare a re-
19 port setting forth the outcome of the study, and may
20 include in the report a recommendation as to wheth-
21 er an annual open enrollment period should be im-
22 plemented under such part.

23 (c) AMENDMENTS TO MEDICARE+CHOICE PRO-
24 GRAM.—Part C of title XVIII of the Social Security Act

1 is amended by inserting after section 1857 the following
2 new section:

3 “COVERAGE OF PRESCRIPTION DRUGS

4 “SEC. 1858. (a) AVAILABILITY.—

5 “(1) IN GENERAL.—In accordance with rules
6 established by the Director of the Office of Per-
7 sonnel Management, in coordination with the Sec-
8 retary, each Medicare+Choice plan shall provide, to
9 each individual enrolled under part D, prescription
10 drug benefits described in part D (or equivalent ben-
11 efits as authorized by the Director).

12 “(2) SPECIAL RULE FOR PROVISION OF PART D
13 BENEFITS.—In no event may a Medicare+Choice or-
14 ganization include as part of a plan for such benefits
15 a requirement that an enrollee pay a deductible or
16 pay a higher coinsurance percentage than the per-
17 centage applicable under part D for the expenses in-
18 volved.

19 “(3) AVAILABILITY OF PRICES.—Each contract
20 under section 1857 shall provide that enrollees enti-
21 tled to benefits made available under this section
22 who exhaust the plan’s prescription drug benefits
23 will continue to have access to prescription drugs at
24 prices equivalent to the total combined cost of such
25 drugs to the plan and the enrollee prior to such ex-
26 haustion of benefits.

1 “(b) INFORMATION.—Information respecting the
2 benefits made available under subsection (a) shall be pro-
3 vided in the same manner as information on other benefits
4 provided under this part is made available.

5 “(c) PAYMENT.—

6 “(1) IN GENERAL.—In the case of a
7 Medicare+Choice plan that provides prescription
8 drug coverage described in subsection (a), the
9 amount of monthly payment otherwise made to the
10 Medicare+Choice organization offering the plan
11 under section 1853 shall be increased by the amount
12 described in paragraph (2). Such payments shall be
13 made in the same manner and time as the amount
14 otherwise paid under section 1853, but such amount
15 shall be payable from the Prescription Drug Insur-
16 ance Account in the Federal Supplementary Medical
17 Insurance Trust Fund.

18 “(2) AMOUNT.—The amount described in this
19 paragraph is the monthly premium rate under sec-
20 tion 1860D(a)(2)(B), but subject to adjustment
21 under paragraph (3). Such amount shall be uniform
22 geographically and shall not vary based on the
23 Medicare+Choice payment area involved.

24 “(3) RISK ADJUSTMENT.—The Director of the
25 Office of Personnel Management may establish a

1 methodology for the adjustment of the payment
2 amount under this subsection in a budget-neutral
3 manner that takes into account the relative risks for
4 use of outpatient prescription drugs by
5 Medicare+Choice enrollees.

6 “(d) SEPARATE APPLICATION OF ACR TO PRESCRIP-
7 TION DRUG COVERAGE.—In applying section 1854 with
8 respect to prescription drug benefits provided under this
9 section, the Secretary shall apply the provisions of such
10 section (including the computation of the adjusted commu-
11 nity rate) separately with respect to such benefits.”.

12 (d) MEDIGAP CHANGES.—For purposes of applying
13 section 1882(p)(1)(E) of the Social Security Act (42
14 U.S.C. 1395ss(p)(1)(E))—

15 (1) the Secretary of Health and Human Serv-
16 ices shall be deemed to have made the determination
17 described in such section; and

18 (2) in modifying standards under such section,
19 notwithstanding the provisions of section
20 1882(p)(3)(A) of such Act, any coverage for out-
21 patient prescription drugs shall be designed in a
22 manner that does not substantially eliminate any
23 cost-sharing with respect to prescription drug cov-
24 erage.

25 (e) CONFORMING AMENDMENTS.—

1 (1) AMENDMENTS TO FEDERAL SUPPLE-
2 MENTARY HEALTH INSURANCE TRUST FUND.—Sec-
3 tion 1841 (42 U.S.C. 1395t) is amended—

4 (A) in the last sentence of subsection (a)—

5 (i) by striking “and such amounts”
6 and replacing it with “such amounts”; and

7 (ii) by adding the following before the
8 period: “and such amounts as may be de-
9 posited in, or appropriated to, the Pre-
10 scription Drug Insurance Account estab-
11 lished by section 1860F”;

12 (B) in subsection (g), by inserting after
13 “by this part,” the following: “the payments
14 provided for under part D (in which case the
15 payments shall come from the Prescription
16 Drug Insurance Account in the Supplementary
17 Medical Insurance Trust Fund),”;

18 (C) in subsection (h), by adding at the end
19 of the first sentence: “and section 1860D(b)(4)
20 (in which case the payments shall come from
21 the Prescription Drug Insurance Account in the
22 Supplementary Medical Insurance Trust
23 Fund)”;

24 (D) in subsection (i), by inserting after
25 “section 1840(b)(1)” the following: “, section

1 1860D(b)(2) (in which case the payments shall
2 come from the Prescription Drug Insurance Ac-
3 count in the Supplementary Medical Insurance
4 Trust Fund),”.

5 (2) EXCLUSIONS FROM COVERAGE.—

6 (A) APPLICATION TO PART D.—Section
7 1862(a) (42 U.S.C. 1395y(a)) is amended in
8 the matter preceding paragraph (1) by striking
9 “part A or part B” and inserting “part A, B,
10 or D”.

11 (B) PRESCRIPTION DRUGS NOT EXCLUDED
12 FROM COVERAGE IF APPROPRIATELY PRE-
13 SCRIBED.—Section 1862(a)(1) (42 U.S.C.
14 1395y(a)(1)) is amended—

15 (i) by striking “and” at the end of
16 subparagraph (H);

17 (ii) by striking the semicolon at the
18 end of subparagraph (I) and inserting “,
19 and”; and

20 (iii) by adding after subparagraph (I)
21 the following new subparagraph:

22 “(J) in the case of prescription drugs cov-
23 ered under part D, which are not prescribed in
24 accordance with such part;

1 **SEC. 3. MEDICAID BUY-IN OF MEDICARE PRESCRIPTION**
2 **DRUG COVERAGE FOR CERTAIN LOW-INCOME**
3 **INDIVIDUALS.**

4 (a) STATE OPTION TO BUY-IN DUALY ELIGIBLE
5 INDIVIDUALS.—

6 (1) COVERAGE OF PREMIUMS AS MEDICAL AS-
7 SISTANCE.—Section 1905(a) (42 U.S.C. 1396d(a))
8 is amended in the fourth sentence by striking
9 “under part B” the first place it appears and insert-
10 ing “under parts B and D”.

11 (2) STATE COMMITMENT TO CONTINUE PAR-
12 TICIPATION IN PART D AFTER BENEFIT LIMIT
13 REACHED.—Section 1902(a) (42 U.S.C. 1396a(a))
14 is amended—

15 (A) by striking “and” at the end of para-
16 graph (64);

17 (B) by striking the period at the end of
18 paragraph (65) and inserting “; and”; and

19 (C) by adding after paragraph (65) the fol-
20 lowing new paragraph:

21 “(66) that, in the case of any individual whose
22 eligibility for medical assistance is not limited to
23 medicare or medicare drug cost sharing and for
24 whom the State elects to pay premiums under part
25 D of title XVIII pursuant to section 1860E, the
26 State will purchase all prescription drugs for such

1 individual in accordance with the provisions of such
2 part D, without regard to whether the benefit limit
3 for such individual under section 1860B(b) has been
4 reached.”.

5 (b) MEDICARE COST SHARING REQUIRED FOR
6 QUALIFIED MEDICARE BENEFICIARIES.—Section
7 1905(p)(3) (42 U.S.C. 1396d(p)(3)) is amended—

8 (1) in subparagraph (A)—

9 (A) by striking “and” at the end of clause
10 (i);

11 (B) by inserting “and” at the end of clause
12 (ii); and

13 (C) by adding after clause (ii) the fol-
14 lowing:

15 “(iii) premiums under section
16 1860D,”;

17 (2) in subparagraph (D)—

18 (A) by inserting “(i)” after “(D)”;

19 (B) by adding at the end the following:

20 “(ii) The difference between the
21 amount that is paid under section 1860B
22 and the amount that would be paid under
23 such section if any reference to ‘50 per-
24 cent’ therein were deemed a reference to
25 ‘100 percent’ (or, if the Director approves

1 a higher percentage under such section, if
2 any reference to such percentage were
3 deemed to be multiplied by two).

4 (c) MEDICARE DRUG COST SHARING REQUIRED FOR
5 MEDICARE-ELIGIBLE INDIVIDUALS WITH INCOMES BE-
6 TWEEN 100 AND 150 PERCENT OF POVERTY LINE.—

7 (1) DEFINITIONS OF ELIGIBLE BENEFICIARIES
8 AND COVERAGE.—Section 1905 (42 U.S.C. 1396d)
9 is amended by adding at the end the following new
10 subsection:

11 “(v)(1) The term ‘qualified medicare drug bene-
12 ficiary’ means an individual—

13 “(A) who is entitled to hospital insurance bene-
14 fits under part A of title XVIII (including an indi-
15 vidual entitled to such benefits pursuant to an en-
16 rollment under section 1818, but not including an
17 individual entitled to such benefits only pursuant to
18 an enrollment under section 1818A),

19 “(B) whose income (as determined under sec-
20 tion 1612 for purposes of the supplemental security
21 income program, except as provided in subsection
22 (p)(2)(D)) is above 100 percent but below 150 per-
23 cent of the official poverty line (as defined by the
24 Office of Management and Budget, and revised an-
25 nually in accordance with section 673(2) of the Om-

1 nibus Budget Reconciliation Act of 1981) applicable
2 to a family of the size involved; and

3 “(C) whose resources (as determined under sec-
4 tion 1613 for purposes of the supplemental security
5 income program) do not exceed twice the maximum
6 amount of resources that an individual may have
7 and obtain benefits under that program.

8 “(2) The term ‘medicare drug cost-sharing’ means
9 the following costs incurred with respect to a qualified
10 medicare drug beneficiary, without regard to whether the
11 costs incurred were for items and services for which med-
12 ical assistance is otherwise available under the plan:

13 “(A) In the case of a qualified medicare drug
14 beneficiary whose income (as determined under
15 paragraph (1)) is less than 135 percent of the offi-
16 cial poverty line—

17 “(i) premiums under section 1860D; and

18 “(ii) the difference between the amount
19 that is paid under section 1860B and the
20 amount that would be paid under such section
21 if there were no coinsurance.

22 “(B) In the case of a qualified medicare drug
23 beneficiary whose income (as determined under
24 paragraph (1)) is at least 135 percent but less than
25 150 percent of the official poverty line, a percentage

1 of premiums under section 1860D, determined on a
2 linear sliding scale ranging from 100 percent for in-
3 dividuals with incomes at 135 percent of such line
4 to 0 percent for individuals with incomes at 150 per-
5 cent of such line.

6 “(3) In the case of any State which is providing med-
7 ical assistance to its residents under a waiver granted
8 under section 1115, the Secretary shall require the State
9 to meet the requirement of section 1902(a)(10)(E) in the
10 same manner as the State would be required to meet such
11 requirement if the State had in effect a plan approved
12 under this title.”.

13 (2) STATE PLAN REQUIREMENT.—Section
14 1902(a)(10)(E) (42 U.S.C. 1396(a)(10)(E)) is
15 amended—

16 (A) by striking “and” at the end of clause
17 (iii);

18 (B) by adding at the end the following new
19 clause:

20 “(v) for making medical assistance
21 available for medicare drug cost sharing
22 (as defined in section 1905(v)(2)) for
23 qualified medicare drug beneficiaries de-
24 scribed in section 1905(v)(1); and”.

1 (3) 100 PERCENT FEDERAL MATCHING OF
2 STATE MEDICAL ASSISTANCE COSTS FOR MEDICARE
3 DRUG COST SHARING.—Section 1903(a) (42 U.S.C.
4 1396b(a)) is amended—

5 (A) by redesignating paragraph (7) as
6 paragraph (8); and

7 (B) by adding after paragraph (6) the fol-
8 lowing new paragraph:

9 “(7) an amount equal to 100 percent of
10 amounts as expended as medicare drug cost sharing
11 for qualified medicare drug beneficiaries (as defined
12 in section 1905(v)) (except that this paragraph shall
13 not apply to amounts expended with respect to any
14 individual whose eligibility for medical assistance is
15 not limited to medicare or medicare drug cost shar-
16 ing); and”.

17 (d) MEDICAID DRUG PRICE REBATES UNAVAILABLE
18 WITH RESPECT TO DRUGS PURCHASED THROUGH MEDI-
19 CARE BUY-IN.—Section 1927 (42 U.S.C. 1396r–8) is
20 amended by adding at the end the following new sub-
21 section:

22 “(1) DRUGS PURCHASED THROUGH MEDICARE BUY-
23 IN.—The provisions of this section shall not apply to pre-
24 scription drugs purchased under part D of title XVIII pur-
25 suant to an agreement with the Director under section

1 1860E (including any drugs so purchased after the initial
2 benefit limit under section 1860B(b) has been exceeded).”.

3 (e) EFFECTIVE DATE.—The amendments made by
4 this section apply to prescription drugs purchased on or
5 after January 1, 2002.

6 **SEC. 4. MEDPAC STUDIES ON BENEFIT MANAGERS.**

7 (a) STUDIES.—The Medicare Payment Advisory
8 Commission shall conduct a study on—

9 (1) the ability of benefit managers to improve
10 quality and reduce costs and to assume risk;

11 (2) strategies to improve risk assumption by
12 such managers;

13 (3) the likely effect of allowing benefit man-
14 agers to vary aspects of the benefit package (such as
15 type of cost-sharing, premium levels, and stop-loss
16 provisions) based on costs, utilization, and access;
17 and

18 (4) the use of the stop-loss provision, including
19 analysis of benefit manager data on beneficiary utili-
20 zation and the effectiveness of cost constraints once
21 the stop-loss is triggered.

22 (b) REPORTS.—The Commission shall submit a re-
23 port to Congress not later than 1 year after the date of

- 1 the enactment of this Act on the studies under subsection
- 2 (a).

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