

106TH CONGRESS
2^D SESSION

H. R. 5151

To amend the Social Security Act to establish an outpatient prescription drug assistance program for low-income Medicare beneficiaries and Medicare beneficiaries with high drug costs.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 12, 2000

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

A BILL

To amend the Social Security Act to establish an outpatient prescription drug assistance program for low-income Medicare beneficiaries and Medicare beneficiaries with high drug costs.

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.**

4 This Act may be cited as the “Medicare Beneficiary
5 Prescription Drug Assistance and Stop-Loss Protection
6 Act of 2000”.

1 **SEC. 2. OUTPATIENT PRESCRIPTION DRUG ASSISTANCE**
2 **PROGRAM.**

3 (a) ESTABLISHMENT.—The Social Security Act (42
4 U.S.C. 301 et seq.) is amended by adding at the end the
5 following new title:

6 “TITLE XXII—OUTPATIENT PRESCRIPTION
7 DRUG ASSISTANCE PROGRAM

8 “**SEC. 2201. PURPOSE; OUTPATIENT PRESCRIPTION DRUG**
9 **ASSISTANCE PLANS.**

10 “(a) PURPOSE.—The purpose of this title is to pro-
11 vide funds to States to enable States, individually or in
12 a group, to establish a program, separate from the med-
13 icaid program under title XIX, to provide assistance to
14 low-income medicare beneficiaries (as defined in section
15 2202(b)) and, at State option, medicare beneficiaries with
16 high drug costs (as defined in section 2202(c)) to obtain
17 coverage for outpatient prescription drugs.

18 “(b) OUTPATIENT PRESCRIPTION DRUG ASSISTANCE
19 PLAN REQUIRED.—A State may not receive payments
20 under section 2205 unless the State, individually or as
21 part of a group of States, submits in writing to the Sec-
22 retary an outpatient prescription drug assistance plan
23 under section 2206(a)(1) that—

24 “(1) describes how the State or group of States
25 intends to use the funds provided under this title to
26 provide outpatient prescription drug assistance to

1 low-income medicare beneficiaries and, if applicable,
2 medicare beneficiaries with high drug costs con-
3 sistent with the provisions of this title;

4 “(2) includes a description of the budget for the
5 plan (updated periodically as necessary) and details
6 on the planned use of funds, the sources of the non-
7 Federal share of plan expenditures, and any require-
8 ments for cost-sharing by beneficiaries;

9 “(3) describes the procedures to be used to en-
10 sure that the outpatient prescription drug assistance
11 provided to low-income medicare beneficiaries and, if
12 applicable, medicare beneficiaries with high drug
13 costs under the plan does not supplant privately fi-
14 nanced coverage for outpatient prescription drugs
15 available to such beneficiaries under group health
16 plans; and

17 “(4) has been approved by the Secretary under
18 section 2206(a)(2).

19 “(c) ENTITLEMENT.—Subject to subsection (d)(2),
20 this title constitutes budget authority in advance of appro-
21 priations Acts and represents the obligation of the Federal
22 Government to provide for the payment to States, groups
23 of States, and contractors described in section
24 2209(a)(2)(A), of amounts provided under section 2204.

25 “(d) PERIOD OF APPLICABILITY.—

1 “(1) IN GENERAL.—No State, group of States,
2 or contractor described in section 2209(a)(2)(A),
3 may receive payments under section 2205 for out-
4 patient prescription drug assistance provided for pe-
5 riods beginning before October 1, 2000, or after
6 September 30, 2004.

7 “(2) MEDICARE REFORM.—If medicare reform
8 legislation that includes coverage for outpatient pre-
9 scription drugs is enacted during the period that be-
10 gins on October 1, 2000, and ends on September 30,
11 2004, this title shall be repealed upon the effective
12 date of such legislation, and no State, group of
13 States, or contractor described in section
14 2209(a)(2)(A) shall be entitled to receive payments
15 for any outpatient prescription drug assistance pro-
16 vided on or after such date.

17 **“SEC. 2202. BENEFICIARY ELIGIBILITY.**

18 “(a) ELIGIBILITY.—

19 “(1) IN GENERAL.—In order for a State (indi-
20 vidually or as part of a group of States) to receive
21 payments under section 2205 with respect to an out-
22 patient prescription drug assistance program, the
23 program must provide, subject to the availability of
24 funds, outpatient prescription drug assistance to
25 each individual who—

1 “(A) resides in the State;

2 “(B) applies for such assistance; and

3 “(C) establishes that the individual is—

4 “(i) a low-income medicare beneficiary
5 (as defined in subsection (b)); or

6 “(ii) at the option of the State, a
7 medicare beneficiary with high drug costs
8 (as defined in subsection (c)).

9 “(2) RESIDENCY RULES.—In applying para-
10 graph (1), residency rules similar to the residency
11 rules applicable to the State plan under title XIX
12 shall apply.

13 “(b) LOW-INCOME MEDICARE BENEFICIARY DE-
14 FINED.—

15 “(1) IN GENERAL.—In this title, except as pro-
16 vided in section 2209(a)(2)(B), the term ‘low-income
17 medicare beneficiary’ means an individual who—

18 “(A) is entitled to benefits under part A of
19 title XVIII or enrolled under part B of such
20 title, including an individual enrolled in a
21 Medicare+Choice plan under part C of such
22 title;

23 “(B) subject to subsection (d), is not enti-
24 tled to medical assistance with respect to pre-
25 scribed drugs under title XIX or under a waiver

1 under section 1115 of the requirements of such
2 title;

3 “(C) is determined to have family income
4 that does not exceed a percentage of the pov-
5 erty line for a family of the size involved speci-
6 fied by the State that, subject to paragraph (2),
7 may not exceed 175 percent; and

8 “(D) at the option of the State, is deter-
9 mined to have resources that do not exceed a
10 level specified by the State.

11 “(2) STATE-ONLY DRUG ASSISTANCE PRO-
12 GRAMS.—

13 “(A) IN GENERAL.—In the case of a State
14 that has a State-based drug assistance program
15 described in section 2203(e) that provides out-
16 patient prescription drug coverage for individ-
17 uals described in paragraph (1)(A) who have
18 family income up to or exceeding 175 percent
19 of the poverty line, the State may specify a per-
20 centage of the poverty line under paragraph
21 (1)(C) that exceeds the income eligibility level
22 specified by the State for such program but
23 does not exceed 50 percentage points above
24 such income eligibility level.

1 “(B) ELIGIBILITY OF PROGRAM PARTICI-
2 PANTS.—Individuals participating in such a
3 State-based drug assistance program (with in-
4 come below 175 percent of the poverty line or,
5 if higher, the level specified under subpara-
6 graph (A)) are eligible to be treated as low-in-
7 come medicare beneficiaries under this title, re-
8 gardless of their participation in such a pro-
9 gram. Funds provided under this title may be
10 used to supplant funds otherwise expended by
11 the State under such a program.

12 “(c) MEDICARE BENEFICIARY WITH HIGH DRUG
13 COSTS DEFINED.—

14 “(1) IN GENERAL.—In this title, except as pro-
15 vided in section 2209(a)(2)(C), the term ‘medicare
16 beneficiary with high drug costs’ means an
17 individual—

18 “(A) who satisfies the requirements of sub-
19 paragraphs (A) and (B) of subsection (b)(1);

20 “(B) whose family income exceeds the per-
21 centage of the poverty line specified by the
22 State in accordance with subsection (b)(1)(C);

23 “(C) at the option of the State, whose re-
24 sources exceed a level (if any) specified by the

1 State in accordance with subsection (b)(1)(D);
2 and

3 “(D) who has out-of-pocket expenses for
4 outpatient prescription drugs and biologicals
5 (including insulin and insulin supplies) for
6 which outpatient prescription drug assistance is
7 available under this title that exceed such
8 amount as the State specifies in accordance
9 with paragraph (2).

10 “(2) DETERMINATION OF OUT-OF-POCKET EX-
11 PENSES.—A State that elects to provide outpatient
12 prescription drug assistance to an individual de-
13 scribed in paragraph (1) shall provide the Secretary
14 with the methodology and standards used to deter-
15 mine the individual’s eligibility under subparagraph
16 (D) of such paragraph.

17 “(d) ACCESS FOR MEDICAID EXPANSION STATES.—

18 “(1) IN GENERAL.—Notwithstanding any other
19 provision of this title, with respect to any State that,
20 as of the date of enactment of this title, has made
21 outpatient prescription drug coverage for individuals
22 described in paragraph (2) available through the
23 State medicaid program under title XIX under a
24 section 1115 waiver, the Secretary, in consultation
25 with such State, shall establish procedures under

1 which the State shall be able to receive payments
2 from the allotment made available under section
3 2204 for such State for a fiscal year for purposes
4 of offsetting the costs of making such coverage avail-
5 able to such individuals.

6 “(2) INDIVIDUALS DESCRIBED.—Individuals de-
7 scribed in this paragraph are individuals who are—

8 “(A) entitled to benefits under part A of
9 title XVIII or enrolled under part B of such
10 title, including an individual enrolled in a
11 Medicare+Choice plan under part C of such
12 title; and

13 “(B) eligible for outpatient prescription
14 drug coverage only, under a State medicaid pro-
15 gram under title XIX as a result of a section
16 1115 waiver.

17 “(e) INDIVIDUAL NONENTITLEMENT.—Nothing in
18 this title shall be construed as providing an individual with
19 an entitlement to outpatient prescription drug assistance
20 provided under this title.

21 **“SEC. 2203. COVERAGE REQUIREMENTS.**

22 “(a) REQUIRED SCOPE OF COVERAGE.—

23 “(1) IN GENERAL.—The outpatient prescription
24 drug assistance provided under the plan may consist
25 of any of the following:

1 “(A) BENCHMARK COVERAGE.—Outpatient
2 prescription drug coverage that is equivalent to
3 the outpatient prescription drug coverage in a
4 benchmark benefit package described in sub-
5 section (b).

6 “(B) AGGREGATE ACTUARIAL VALUE
7 EQUIVALENT TO BENCHMARK PACKAGE.—Out-
8 patient prescription drug coverage that has an
9 aggregate actuarial value that is at least equiv-
10 alent to one of the benchmark benefit packages.

11 “(C) EXISTING COMPREHENSIVE STATE-
12 BASED COVERAGE.—Outpatient prescription
13 drug coverage under an existing State-based
14 program, described in subsection (e).

15 “(D) SECRETARY-APPROVED COVERAGE.—
16 Any other outpatient prescription drug coverage
17 that the Secretary determines, upon application
18 by a State or group of States, provides appro-
19 priate outpatient prescription drug coverage for
20 the population of medicare beneficiaries pro-
21 posed to be provided such coverage.

22 “(2) CONSISTENT DESIGN.—A State or group
23 of States may only select one of the options de-
24 scribed in paragraph (1) (and, if the State or group
25 chooses to provide outpatient prescription drug cov-

1 erage that is equivalent to the outpatient prescrip-
2 tion drug coverage in a benchmark benefit package,
3 only one of the benchmark benefit package options
4 described in subsection (b)) in order to provide out-
5 patient prescription drug assistance in a uniform
6 manner for the population of medicare beneficiaries
7 provided such coverage.

8 “(3) MEDICATION THERAPY MANAGEMENT.—

9 “(A) IN GENERAL.—The outpatient pre-
10 scription drug assistance provided by the plan
11 shall provide medication therapy management
12 benefits.

13 “(B) MEDICATION THERAPY MANAGEMENT
14 DEFINED.—For purposes of this title, the term
15 ‘medication therapy management’—

16 “(i) means a program designed—

17 “(I) to assure that medications
18 are used appropriately by patients;

19 “(II) to enhance patients’ under-
20 standing of the appropriate use of
21 medications;

22 “(III) to increase patients’ adher-
23 ence with prescription medication
24 regimens;

1 “(IV) to reduce the risk of poten-
2 tial adverse events associated with
3 medications; and

4 “(V) to reduce the need for other
5 costly medical services through better
6 management of medication therapy;
7 and

8 “(ii) includes services provided or co-
9 ordinated by pharmacy providers (in co-
10 operation with physicians when necessary),
11 involving case management, disease man-
12 agement, drug therapy management, pa-
13 tient training and education, counseling,
14 medication refill reminders, drug therapy
15 problem resolution, medication administra-
16 tion, the provision of special packaging, or
17 other services that enhance the use of pre-
18 scription medications.

19 “(C) PROGRAM OPERATION.—A medication
20 therapy management program should—

21 “(i) identify and provide medication
22 therapy management services to those at
23 risk for potential medication problems,
24 such as those taking multiple medications,

1 or those with complex or chronic medical
2 conditions;

3 “(ii) be developed and structured in
4 cooperation with organizations rep-
5 resenting pharmacy providers, including
6 identifying those medication therapy man-
7 agement services that will be provided, as
8 well as payment mechanisms for these
9 services;

10 “(iii) structure and update payments
11 to pharmacy providers to reflect the re-
12 sources and time involved in the provision
13 of these services; and

14 “(iv) provide for ongoing evaluation
15 and documentation of these services in im-
16 proving quality of care and reducing health
17 care costs.

18 “(b) BENCHMARK BENEFIT PACKAGES.—The bench-
19 mark benefit packages are as follows:

20 “(1) MEDICAID OUTPATIENT PRESCRIPTION
21 DRUG COVERAGE.—In the case of—

22 “(A) a State, the outpatient prescription
23 drug coverage provided under the State med-
24 icaid plan under title XIX; or

1 “(B) a group of States, the outpatient pre-
2 scription drug coverage provided under the
3 State medicaid plan under such title of one of
4 the States in the group, as identified in the out-
5 patient prescription drug assistance plan.

6 “(2) FEHBP-EQUIVALENT OUTPATIENT PRE-
7 SCRIPTION DRUG COVERAGE.—The outpatient pre-
8 scription drug coverage provided under the Standard
9 Option Blue Cross and Blue Shield Service Benefit
10 Plan described in and offered under section 8903(1)
11 of title 5, United States Code.

12 “(3) STATE EMPLOYEE OUTPATIENT PRESCRIP-
13 TION DRUG COVERAGE.—In the case of—

14 “(A) a State, the outpatient prescription
15 drug coverage provided under a health benefits
16 coverage plan that is offered and generally
17 available to State employees in the State in-
18 volved; or

19 “(B) a group of States, the outpatient pre-
20 scription drug coverage provided under a health
21 benefits coverage plan that is offered and gen-
22 erally available to State employees in one of the
23 States in the group, as identified in the out-
24 patient prescription drug assistance plan.

1 “(4) OUTPATIENT PRESCRIPTION DRUG COV-
2 ERAGE OFFERED THROUGH LARGEST HMO.—In the
3 case of—

4 “(A) a State, the outpatient prescription
5 drug coverage provided under a health insur-
6 ance coverage plan that is offered by a health
7 maintenance organization (as defined in section
8 2791(b)(3) of the Public Health Service Act)
9 and has the largest insured commercial, non-
10 medicaid enrollment of covered lives of such
11 coverage plans offered by such a health mainte-
12 nance organization in the State involved; or

13 “(B) a group of States, the outpatient pre-
14 scription drug coverage provided under a health
15 insurance coverage plan that is offered by a
16 health maintenance organization (as defined in
17 section 2791(b)(3) of the Public Health Service
18 Act) and has the largest insured commercial,
19 nonmedicaid enrollment of covered lives of such
20 coverage plans offered by such a health mainte-
21 nance organization in one of the States in-
22 volved.

23 “(c) DETERMINATION OF ACTUARIAL VALUE OF
24 COVERAGE.—

1 “(1) IN GENERAL.—The actuarial value of out-
2 patient prescription drug coverage offered under
3 benchmark benefit packages and the outpatient pre-
4 scription drug assistance plan shall be set forth in
5 an opinion in a report that has been prepared—

6 “(A) by an individual who is a member of
7 the American Academy of Actuaries;

8 “(B) using generally accepted actuarial
9 principles and methodologies;

10 “(C) using a standardized set of utilization
11 and price factors;

12 “(D) using a standardized population that
13 is representative of the population to be covered
14 under the outpatient prescription drug assist-
15 ance plan;

16 “(E) applying the same principles and fac-
17 tors in comparing the value of different cov-
18 erage;

19 “(F) without taking into account any dif-
20 ferences in coverage based on the method of de-
21 livery or means of cost control or utilization
22 used; and

23 “(G) taking into account the ability of a
24 State or group of States to reduce benefits by
25 taking into account the increase in actuarial

1 value of benefits coverage offered under the
2 outpatient prescription drug assistance plan
3 that results from the limitations on cost-sharing
4 under such coverage.

5 “(2) REQUIREMENT.—The actuary preparing
6 the opinion shall select and specify in the report the
7 standardized set and population to be used under
8 subparagraphs (C) and (D) of paragraph (1).

9 “(d) PROHIBITED COVERAGE.—Nothing in this sec-
10 tion shall be construed as requiring any outpatient pre-
11 scription drug coverage offered under the plan to provide
12 coverage for an outpatient prescription drug for which
13 payment is prohibited under this title, notwithstanding
14 that any benchmark benefit package includes coverage for
15 such an outpatient prescription drug.

16 “(e) DESCRIPTION OF EXISTING COMPREHENSIVE
17 STATE-BASED COVERAGE.—

18 “(1) IN GENERAL.—A program described in
19 this paragraph is an outpatient prescription drug
20 coverage program for individuals who are entitled to
21 benefits under part A of title XVIII or enrolled
22 under part B of such title, including an individual
23 enrolled in a Medicare+Choice plan under part C of
24 such title, that—

1 “(A) is administered or overseen by the
2 State and receives funds from the State;

3 “(B) was offered as of the date of the en-
4 actment of this title;

5 “(C) does not receive or use any Federal
6 funds;

7 “(D) is certified by the Secretary as pro-
8 viding outpatient prescription drug coverage
9 that satisfies the scope of coverage required
10 under subparagraph (A), (B), or (D) of sub-
11 section (a)(1); and

12 “(E) provides medication therapy manage-
13 ment programs described in subsection (a)(3).

14 “(2) MODIFICATIONS.—A State may modify a
15 program described in paragraph (1) from time to
16 time so long as it does not reduce the actuarial value
17 (evaluated as of the time of the modification) of the
18 outpatient prescription drug coverage under the pro-
19 gram below the lower of—

20 “(A) the actuarial value of the coverage
21 under the program as of the date of enactment
22 of this title; or

23 “(B) the actuarial value described in sub-
24 section (a)(1)(B).

1 “(f) BENEFICIARY PREMIUMS AND COST-SHAR-
2 ING.—

3 “(1) DESCRIPTION; GENERAL CONDITIONS.—

4 “(A) DESCRIPTION.—

5 “(i) IN GENERAL.—An outpatient pre-
6 scription drug assistance plan shall include
7 a description, consistent with this sub-
8 section, of the amount of any premiums or
9 cost-sharing imposed under the plan.

10 “(ii) PUBLIC SCHEDULE OF
11 CHARGES.—Any premium or cost-sharing
12 described under clause (i) shall be imposed
13 under the plan pursuant to a public sched-
14 ule.

15 “(B) PROTECTION FOR BENEFICIARIES.—

16 The outpatient prescription drug assistance
17 plan may only vary premiums and cost-sharing
18 based on the family income of low-income medi-
19 care beneficiaries and, if applicable, medicare
20 beneficiaries with high drug costs, in a manner
21 that does not favor such beneficiaries with high-
22 er income over beneficiaries with low-income.

23 “(2) LIMITATIONS ON PREMIUMS AND COST-
24 SHARING.—

1 “(A) NO PREMIUMS OR COST-SHARING FOR
2 BENEFICIARIES WITH INCOME BELOW 100 PER-
3 CENT OF POVERTY LINE.—In the case of a low-
4 income medicare beneficiary whose family in-
5 come does not exceed 100 percent of the pov-
6 erty line, the outpatient prescription drug as-
7 sistance plan may not impose any premium or
8 cost-sharing.

9 “(B) OTHER BENEFICIARIES.—For low-in-
10 come medicare beneficiaries not described in
11 subparagraph (A) and, if applicable, medicare
12 beneficiaries with high drug costs, any pre-
13 miums or cost-sharing imposed under the out-
14 patient prescription drug assistance plan may
15 be imposed, subject to paragraph (1)(B), on a
16 sliding scale related to income, except that the
17 total annual aggregate of such premiums and
18 cost-sharing with respect to all such bene-
19 ficiaries in a family under this title may not ex-
20 ceed 5 percent of such family’s income for the
21 year involved.

22 “(g) RESTRICTION ON APPLICATION OF PRE-
23 EXISTING CONDITION EXCLUSIONS.—The outpatient pre-
24 scription drug assistance plan shall not permit the imposi-
25 tion of any preexisting condition exclusion for covered ben-

1 efits under the plan and may not discriminate in the prie-
2 ing of premiums under such plan because of health status,
3 claims experience, receipt of health care, or medical condi-
4 tion.

5 **“SEC. 2204. ALLOTMENTS.**

6 “(a) APPROPRIATION.—

7 “(1) IN GENERAL.—For the purpose of pro-
8 viding allotments under this section to States, there
9 is appropriated, out of any money in the Treasury
10 not otherwise appropriated—

11 “(A) for fiscal year 2001, \$2,600,000,000;

12 “(B) for fiscal year 2002, \$6,100,000,000;

13 “(C) for fiscal year 2003,
14 \$12,200,000,000; and

15 “(D) for fiscal year 2004,
16 \$16,000,000,000.

17 “(2) AVAILABILITY.—Amounts appropriated
18 under paragraph (1) shall only be available for pro-
19 viding the allotments described in such paragraph
20 during the fiscal year for which such amounts are
21 appropriated. Any amounts that have not been obli-
22 gated by the Secretary for the purposes of making
23 payments from such allotments under section 2205,
24 or under contracts entered into under section
25 2209(b)(2)(B), on or before September 30 of fiscal

1 year 2001, 2002, 2003, or 2004 (as applicable),
2 shall be returned to the Treasury.

3 “(b) ALLOTMENTS TO 50 STATES AND DISTRICT OF
4 COLUMBIA.—

5 “(1) IN GENERAL.—Subject to paragraph (3),
6 of the amount available for allotment under sub-
7 section (a) for a fiscal year, reduced by the amount
8 of allotments made under subsection (c) for the fis-
9 cal year, the Secretary shall allot to each State
10 (other than a State described in such subsection)
11 with an outpatient prescription drug assistance plan
12 approved under this title the same proportion as the
13 ratio of—

14 “(A) the number of medicare beneficiaries
15 with family income that does not exceed 175
16 percent of the poverty line residing in the State
17 for the fiscal year; to

18 “(B) the total number of such beneficiaries
19 residing in all such States.

20 “(2) DETERMINATION OF NUMBER OF MEDI-
21 CARE BENEFICIARIES WITH INCOME THAT DOES NOT
22 EXCEED 175 PERCENT OF POVERTY.—For purposes
23 of paragraph (1), a determination of the number of
24 medicare beneficiaries with family income that does
25 not exceed 175 percent of the poverty line residing

1 in a State for the calendar year in which such fiscal
2 year begins shall be made on the basis of the arith-
3 metic average of the number of such medicare bene-
4 ficiaries, as reported and defined in the 5 most re-
5 cent March supplements to the Current Population
6 Survey of the Bureau of the Census before the be-
7 ginning of the fiscal year.

8 “(3) MINIMUM ALLOTMENT.—In no case shall
9 the amount of the allotment under this subsection
10 for one of the 50 States or the District of Columbia
11 for a fiscal year be less than an amount equal to 0.5
12 percent of the amount provided for allotments under
13 subsection (a) for that fiscal year (reduced by the
14 amount of allotments made under subsection (c) for
15 the fiscal year). To the extent that the application
16 of the previous sentence results in an increase in the
17 allotment to a State or the District of Columbia
18 above the amount otherwise provided, the allotments
19 for the other States and the District of Columbia
20 under this subsection shall be reduced in a pro rata
21 manner (but not below the minimum allotment de-
22 scribed in such preceding sentence) so that the total
23 of such allotments in a fiscal year does not exceed
24 the amount otherwise provided for allotment under
25 subsection (a) for that fiscal year (as so reduced).

1 “(c) ALLOTMENTS TO TERRITORIES.—

2 “(1) IN GENERAL.—Of the amount available for
3 allotment under subsection (a) for a fiscal year, the
4 Secretary shall allot 0.25 percent among each of the
5 commonwealths and territories described in para-
6 graph (3) in the same proportion as the percentage
7 specified in paragraph (2) for such commonwealth or
8 territory bears to the sum of such percentages for all
9 such commonwealths or territories so described.

10 “(2) PERCENTAGE.—The percentage specified
11 in this paragraph for—

12 “(A) Puerto Rico is 91.6 percent;

13 “(B) Guam is 3.5 percent;

14 “(C) the United States Virgin Islands is
15 2.6 percent;

16 “(D) American Samoa is 1.2 percent; and

17 “(E) the Northern Mariana Islands is 1.1
18 percent.

19 “(3) COMMONWEALTHS AND TERRITORIES.—A
20 commonwealth or territory described in this para-
21 graph is any of the following if it has an outpatient
22 prescription drug assistance plan approved under
23 this title:

24 “(A) Puerto Rico.

25 “(B) Guam.

1 “(C) The United States Virgin Islands.

2 “(D) American Samoa.

3 “(E) The Northern Mariana Islands.

4 “(d) TRANSFER OF CERTAIN ALLOTMENTS AND
5 PORTIONS OF ALLOTMENTS.—

6 “(1) TRANSFER AND REDISTRIBUTION.—

7 “(A) IN GENERAL.—Subject to subpara-
8 graph (B), not later than 30 days after the date
9 described in paragraph (2)—

10 “(i) 90 percent of the allotment deter-
11 mined for a fiscal year under subsection
12 (b) or (c) for a State shall be transferred
13 and made available in such fiscal year to
14 the Secretary, acting through the Adminis-
15 trator of the Health Care Financing Ad-
16 ministration, for purposes of carrying out
17 the default program established under sec-
18 tion 2209; and

19 “(ii) 10 percent of such allotment
20 shall be redistributed in accordance with
21 subsection (e).

22 “(B) APPLICABILITY.—Subparagraph (A)
23 shall not apply if, not later than the date de-
24 scribed in paragraph (2) for such fiscal year, a
25 State submits a plan or is part of a group of

1 States that submits a plan to the Secretary that
2 the Secretary finds meets the requirements of
3 section 2201(b).

4 “(2) DATE DESCRIBED.—The date described in
5 this paragraph is—

6 “(A) in the case of fiscal year 2001, De-
7 cember 31, 2000; and

8 “(B) in the case of fiscal year 2002, 2003,
9 or 2004, September 1 of the fiscal year pre-
10 ceding such fiscal year.

11 “(e) REDISTRIBUTION OF PORTION OF ALLOT-
12 MENTS.—With respect to a fiscal year, not later than 30
13 days after the date described in subsection (d)(2) for such
14 fiscal year, the Secretary shall redistribute the total
15 amount made available for redistribution for such fiscal
16 year under subsection (d)(1)(A)(ii) to each State that sub-
17 mits a plan or is part of a group of States that submits
18 a plan to the Secretary that the Secretary finds meets the
19 requirements of this title. Such amount shall be redistrib-
20 uted in the same manner as allotments are determined
21 under subsections (b) and (c) and shall be available only
22 to the extent consistent with subsection (a)(2).

23 **“SEC. 2205. PAYMENTS TO STATES.**

24 “(a) IN GENERAL.—Subject to the succeeding provi-
25 sions of this section, the Secretary shall pay to each State

1 with a plan approved under section 2206(a)(2) (individ-
2 ually or as part of a group of States) from the State’s
3 allotment under section 2204, an amount for each quarter
4 equal to the applicable percentage of expenditures in the
5 quarter—

6 “(1) for outpatient prescription drug assistance
7 under the plan for low-income medicare beneficiaries
8 and, if applicable, medicare beneficiaries with high
9 drug costs in the form of providing coverage for out-
10 patient prescription drugs that meets the require-
11 ments of section 2203; and

12 “(2) only to the extent permitted consistent
13 with subsection (c), for reasonable costs incurred to
14 administer the plan.

15 “(b) APPLICABLE PERCENTAGE.—For purposes of
16 subsection (a), the applicable percentage is—

17 “(1) for low-income medicare beneficiaries with
18 family incomes that do not exceed 135 percent of
19 the poverty line, 100 percent; and

20 “(2) for all other low-income medicare bene-
21 ficiaries and for medicare beneficiaries with high
22 drug costs, the enhanced FMAP (as defined in sec-
23 tion 2105(b)).

24 “(c) LIMITATION ON PAYMENTS FOR CERTAIN EX-
25 PENDITURES.—

1 “(1) GENERAL LIMITATIONS.—Funds provided
2 to a State or group of States under this title shall
3 only be used to carry out the purposes of this title.

4 “(2) ADMINISTRATIVE EXPENDITURES.—

5 “(A) IN GENERAL.—Subject to subpara-
6 graph (B), payment shall not be made under
7 subsection (a) for expenditures described in
8 subsection (a)(2) for a fiscal year to the extent
9 the total of such expenditures (for which pay-
10 ment is made under such subsection) exceeds
11 10 percent of the total expenditures described
12 in subsection (a)(1) made by—

13 “(i) in the case of a State that is not
14 part of a group of States, the State for
15 such fiscal year; and

16 “(ii) in the case of a group of States,
17 the group for such fiscal year.

18 “(B) SPECIAL RULE.—With respect to the
19 first fiscal year that a State or group of States
20 provides outpatient prescription drug assistance
21 under a plan approved under this title, the 10
22 percent limitation described in subparagraph
23 (A) shall be applied—

24 “(i) in the case of a State that is not
25 part of a group of States, to the allotment

1 available for such State for such fiscal
2 year; and

3 “(ii) in the case of a group of States,
4 to the aggregate of the State allotments
5 available for all the States in such group
6 for such fiscal year.

7 “(3) USE OF NON-FEDERAL FUNDS FOR STATE
8 MATCHING REQUIREMENT.—Amounts provided by
9 the Federal Government, or services assisted or sub-
10 sidized to any significant extent by the Federal Gov-
11 ernment, may not be included in determining the
12 amount of the non-Federal share of plan expendi-
13 tures required under the plan.

14 “(4) OFFSET OF RECEIPTS ATTRIBUTABLE TO
15 PREMIUMS OR COST-SHARING.—For purposes of sub-
16 section (a), the amount of the expenditures under
17 the plan shall be reduced by the amount of any pre-
18 miums or cost-sharing received by a State.

19 “(5) PREVENTION OF DUPLICATIVE PAY-
20 MENTS.—

21 “(A) OTHER HEALTH PLANS.—No pay-
22 ment shall be made under this section for ex-
23 penditures for outpatient prescription drug as-
24 sistance provided under an outpatient prescrip-
25 tion drug assistance plan to the extent that a

1 private insurer (as defined by the Secretary by
2 regulation and including a group health plan, a
3 service benefit plan, and a health maintenance
4 organization) would have been obligated to pro-
5 vide such assistance but for a provision of its
6 insurance contract which has the effect of lim-
7 iting or excluding such obligation because the
8 beneficiary is eligible for or is provided out-
9 patient prescription drug assistance under the
10 plan.

11 “(B) OTHER FEDERAL GOVERNMENTAL
12 PROGRAMS.—Except as otherwise provided by
13 law (including section 2202(b)(2)(B) and
14 2202(d)(1)), no payment shall be made under
15 this section for expenditures for outpatient pre-
16 scription drug assistance provided under an
17 outpatient prescription drug assistance plan to
18 the extent that payment has been made or can
19 reasonably be expected to be made promptly (as
20 determined in accordance with regulations)
21 under any other federally operated or financed
22 health care insurance program identified by the
23 Secretary. For purposes of this paragraph,
24 rules similar to the rules for overpayments
25 under section 1903(d)(2) shall apply.

1 “(6) MEDICATION THERAPY MANAGEMENT.—A
2 State shall allocate a reasonable percentage of total
3 program expenditures allocated under subsection
4 (a)(1) for the purpose of establishing and compen-
5 sating pharmacy providers for medication therapy
6 management services described in section
7 2203(a)(3).

8 “(d) ADVANCE PAYMENT; RETROSPECTIVE ADJUST-
9 MENT.—The Secretary may make payments under this
10 section for each quarter on the basis of advance estimates
11 of expenditures submitted by a State or group of States
12 and such other investigation as the Secretary may find
13 necessary, and may reduce or increase the payments as
14 necessary to adjust for any overpayment or underpayment
15 for prior quarters.

16 “(e) FLEXIBILITY IN SUBMITTAL OF CLAIMS.—
17 Nothing in this section shall be construed as preventing
18 a State or group of States from claiming as expenditures
19 in any quarter of a fiscal year expenditures that were in-
20 curred in a previous quarter of such fiscal year.

21 “(f) NO MAINTENANCE OF EFFORT REQUIRED.—
22 Nothing in this title shall be construed as requiring a
23 State that has a medicare pharmaceutical assistance pro-
24 gram in effect before the effective date of this title to
25 maintain such a program or to maintain the level of effort

1 or expenditure made under such program before this title
2 was enacted.

3 **“SEC. 2206. PROCESS FOR SUBMISSION, APPROVAL, AND**
4 **AMENDMENT OF OUTPATIENT PRESCRIP-**
5 **TION DRUG ASSISTANCE PLANS.**

6 “(a) INITIAL PLAN.—

7 “(1) SUBMISSION.—A State may receive pay-
8 ments under section 2205 with respect to a fiscal
9 year if the State, individually or as part of a group
10 of States, has submitted to the Secretary, not later
11 than the date described in section 2204(d)(2), an
12 outpatient prescription drug assistance plan that the
13 Secretary has found meets the applicable require-
14 ments of this title.

15 “(2) APPROVAL.—Except as the Secretary may
16 provide under subsection (c), a plan submitted under
17 paragraph (1)—

18 “(A) shall be approved for purposes of this
19 title; and

20 “(B) shall be effective beginning with a
21 calendar quarter that is specified in the plan,
22 but in no case earlier than October 1, 2000.

23 “(3) STREAMLINED TREATMENT OF CURRENT
24 STATE-BASED PROGRAMS.—In the case of such a
25 plan that is based on an existing state-based com-

1 preprehensive prescription drug program, the Secretary
2 shall provide for the expediting review of the plan
3 under this section.

4 “(b) PLAN AMENDMENTS.—Within 30 days after a
5 State or group of States amends an outpatient prescrip-
6 tion drug assistance plan submitted pursuant to sub-
7 section (a), the State or group shall notify the Secretary
8 of the amendment.

9 “(c) DISAPPROVAL OF PLANS AND PLAN AMEND-
10 MENTS.—

11 “(1) PROMPT REVIEW OF PLAN SUBMITTALS.—
12 The Secretary shall promptly review plans and plan
13 amendments submitted under this section to deter-
14 mine if they substantially comply with the require-
15 ments of this title.

16 “(2) 45-DAY APPROVAL DEADLINES.—A plan or
17 plan amendment is considered approved unless the
18 Secretary notifies the State or group of States in
19 writing, within 45 days after receipt of the plan or
20 amendment, that the plan or amendment is dis-
21 approved (and the reasons for the disapproval) or
22 that specified additional information is needed.

23 “(3) CORRECTION.—In the case of a dis-
24 approval of a plan or plan amendment, the Secretary
25 shall provide a State or group of States with a rea-

1 sonable opportunity for correction before taking fi-
2 nancial sanctions against the State or group on the
3 basis of such disapproval.

4 “(d) PROGRAM OPERATION.—

5 “(1) IN GENERAL.—A State or group of States
6 shall conduct the program in accordance with the
7 plan (and any amendments) approved under this
8 section and with the requirements of this title.

9 “(2) VIOLATIONS.—The Secretary shall estab-
10 lish a process for enforcing requirements under this
11 title. Such process shall provide for the withholding
12 of funds in the case of substantial noncompliance
13 with such requirements. In the case of an enforce-
14 ment action against a State or group of States
15 under this paragraph, the Secretary shall provide a
16 State or group of States with a reasonable oppor-
17 tunity for correction and for administrative and judi-
18 cial appeal of the Secretary’s action before taking fi-
19 nancial sanctions against the State or group of
20 States on the basis of such an action.

21 “(e) CONTINUED APPROVAL.—Subject to section
22 2201(d), an approved outpatient prescription drug assist-
23 ance plan shall continue in effect unless and until the
24 State or group of States amends the plan under subsection
25 (b) or the Secretary finds, under subsection (d), substan-

1 tial noncompliance of the plan with the requirements of
2 this title.

3 **“SEC. 2207. PLAN ADMINISTRATION; APPLICATION OF CER-**
4 **TAIN GENERAL PROVISIONS.**

5 “(a) PLAN ADMINISTRATION.—An outpatient pre-
6 scription drug assistance plan shall include an assurance
7 that the State or group of States administering the plan
8 will collect the data, maintain the records, afford the Sec-
9 retary access to any records or information relating to the
10 plan for the purposes of review or audit, and furnish re-
11 ports to the Secretary, at the times and in the standard-
12 ized format the Secretary may require in order to enable
13 the Secretary to monitor program administration and
14 compliance and to evaluate and compare the effectiveness
15 of plans under this title.

16 “(b) APPLICATION OF CERTAIN GENERAL PROVI-
17 SIONS.—The following sections of this Act shall apply to
18 the program established under this title in the same man-
19 ner as they apply to a State under title XIX:

20 “(1) TITLE XIX PROVISIONS.—

21 “(A) Section 1902(a)(4)(C) (relating to
22 conflict of interest standards).

23 “(B) Paragraphs (2), (16), and (17) of
24 section 1903(i) (relating to limitations on pay-
25 ment).

1 “(C) Section 1903(w) (relating to limita-
2 tions on provider taxes and donations).

3 “(2) TITLE XI PROVISIONS.—

4 “(A) Section 1115 (relating to waiver au-
5 thority).

6 “(B) Section 1116 (relating to administra-
7 tive and judicial review), but only insofar as
8 consistent with this title.

9 “(C) Section 1124 (relating to disclosure
10 of ownership and related information).

11 “(D) Section 1126 (relating to disclosure
12 of information about certain convicted individ-
13 uals).

14 “(E) Section 1128A (relating to civil mon-
15 etary penalties).

16 “(F) Section 1128B(d) (relating to crimi-
17 nal penalties for certain additional charges).

18 **“SEC. 2208. REPORTS.**

19 “(a) IN GENERAL.—Each State or group of States
20 administering a plan under this title shall annually—

21 “(1) assess the operation of the outpatient pre-
22 scription drug assistance plan under this title in
23 each fiscal year; and

24 “(2) report to the Secretary on the result of the
25 assessment.

1 “(b) REQUIRED INFORMATION.—The annual report
2 required under subsection (a) shall include the following:

3 “(1) An assessment of the effectiveness of the
4 plan in providing outpatient prescription drug assist-
5 ance to low-income medicare beneficiaries and, if ap-
6 plicable, medicare beneficiaries with high drug costs.

7 “(2) A description and analysis of the effective-
8 ness of elements of the plan, including—

9 “(A) the characteristics of the low-income
10 medicare beneficiaries and, if applicable, medi-
11 care beneficiaries with high drug costs assisted
12 under the plan, including family income and ac-
13 cess to, or coverage by, other health insurance
14 prior to the plan and after eligibility for the
15 plan ends;

16 “(B) the amount and level of assistance
17 provided under the plan; and

18 “(C) the sources of the non-Federal share
19 of plan expenditures.

20 “(c) ANNUAL REPORT OF THE SECRETARY.—The
21 Secretary shall submit to Congress and make available to
22 the public an annual report based on the reports required
23 under subsection (a) and section 2209(b)(5), containing
24 any conclusions and recommendations the Secretary con-
25 siders appropriate.

1 **“SEC. 2209. ESTABLISHMENT OF DEFAULT PROGRAM.**

2 “(a) PROGRAM AUTHORITY.—

3 “(1) IN GENERAL.—With respect to a fiscal
4 year, in the case of a State that fails to submit (in-
5 dividualy or as part of a group of States) an ap-
6 proved outpatient prescription drug assistance plan
7 to the Secretary by the date described in section
8 2204(d)(2) for such fiscal year, outpatient prescrip-
9 tion drug assistance to low-income medicare bene-
10 ficiaries and, subject to the availability of funds,
11 medicare beneficiaries with high drug costs, who re-
12 side in such State shall be provided during such fis-
13 cal year by the Secretary, through the Administrator
14 of the Health Care Financing Administration, in ac-
15 cordance with this section.

16 “(2) DEFINITIONS.—In this section:

17 “(A) CONTRACTOR.—The term ‘contractor’
18 means a pharmaceutical benefit manager or
19 other entity that meets standards established by
20 the Administrator of the Health Care Financing
21 Administration for the provision of outpatient
22 prescription drug assistance under a contract
23 entered into under this section.

24 “(B) LOW-INCOME MEDICARE BENE-
25 FICIARY.—The term ‘low-income medicare bene-
26 ficiary’ means an individual who—

1 “(i) satisfies the requirements of sub-
2 paragraphs (A) and (B) of section
3 2202(b)(1);

4 “(ii) is determined to have family in-
5 come that does not exceed a percentage of
6 the poverty line for a family of the size in-
7 volved specified by the Administrator of
8 the Health Care Financing Administration
9 that may not exceed 135 percent; and

10 “(iii) at the option of the Adminis-
11 trator of the Health Care Financing Ad-
12 ministration, is determined to have re-
13 sources that do not exceed a level specified
14 by such Administrator.

15 “(C) MEDICARE BENEFICIARY WITH HIGH
16 DRUG COSTS.—The term ‘medicare beneficiary
17 with high drug costs’ means an individual—

18 “(i) who satisfies the requirements of
19 subparagraphs (A) and (B) of section
20 2202(b)(1);

21 “(ii) whose family income exceeds the
22 percentage of the poverty line specified by
23 the Administrator of the Health Care Fi-
24 nancing Administration under subpara-

1 graph (B)(ii) for a low-income medicare
2 beneficiary residing in the same State;

3 “(iii) whose resources exceed a level
4 (if any) specified by the Administrator of
5 the Health Care Financing Administration
6 under subparagraph (B)(iii) for a low-in-
7 come medicare beneficiary residing in the
8 same State; and

9 “(iv) with respect to any 3-month pe-
10 riod, who has out-of-pocket expenses for
11 outpatient prescription drugs and
12 biologicals (including insulin and insulin
13 supplies) for which outpatient prescription
14 drug assistance is available under this title
15 that exceed a level specified by such Ad-
16 ministrator (consistent with the availability
17 of funds for the operation of the program
18 established under this section in the State
19 where the beneficiary resides).

20 “(b) ADMINISTRATION.—In administering the default
21 program established under this section, the Administrator
22 of the Health Care Financing Administration shall—

23 “(1) establish procedures to determine the eligi-
24 bility of the low-income medicare beneficiaries and
25 medicare beneficiaries with high drug costs described

1 in subsection (a) for outpatient prescription drug as-
2 sistance;

3 “(2) establish a process for accepting bids to
4 provide outpatient prescription drug assistance to
5 such beneficiaries, awarding contracts under such
6 bids, and making payments under such contracts;

7 “(3) establish policies and procedures for over-
8 seeing the provision of outpatient prescription drug
9 assistance under such contracts;

10 “(4) develop and implement quality and service
11 assessment measures that include beneficiary quality
12 surveys and annual quality and service rankings for
13 contractors awarded a contract under this section;

14 “(5) annually assess the program established
15 under this section and submit a report to the Sec-
16 retary containing the information required under
17 section 2208(b); and

18 “(6) carry out such other responsibilities as are
19 necessary for the administration of the provision of
20 outpatient prescription drug assistance under this
21 section.

22 “(c) CONTRACT REQUIREMENTS.—

23 “(1) AUTHORITY; TERM.—

24 “(A) USE OF COMPETITIVE PROCE-
25 DURES.—

1 “(i) FISCAL YEAR 2001.—With respect
2 to fiscal year 2001, the Administrator of
3 the Health Care Financing Administration
4 may enter into contracts under this section
5 without using competitive procedures, as
6 defined in section 4(5) of the Office of
7 Federal Procurement Policy Act (41
8 U.S.C. 403(5)), or any other provision of
9 law requiring competitive bidding.

10 “(ii) FISCAL YEARS 2002, 2003, AND
11 2004.—With respect to fiscal years 2002,
12 2003, and 2004, the Administrator of the
13 Health Care Financing Administration
14 shall award contracts under this section
15 using competitive procedures (as so de-
16 fined).

17 “(B) TERM.—Each contract shall be for a
18 uniform term of at least 1 year, but may be
19 made automatically renewable from term to
20 term in the absence of notice of termination by
21 either party.

22 “(2) BENEFIT.—The contract shall require the
23 contractor to provide a low-income medicare bene-
24 ficiary and, if applicable, a medicare beneficiary with
25 high drug costs, outpatient prescription drug assist-

1 ance that is equivalent to the FEHBP-equivalent
2 benchmark benefit package described in section
3 2203(b)(2) and provide medication therapy manage-
4 ment benefits as described in section 2203(a)(3) in
5 a manner that is consistent with the provisions of
6 this title as such provisions apply to a State that
7 provides such assistance. Net aggregate expenditures
8 for medication therapy management services shall be
9 consistent with required allocations for such services
10 under section 2205(c)(6).

11 “(3) QUALITY AND SERVICE ASSESSMENT.—
12 The contract shall require the contractor to cooper-
13 ate with the quality and service assessment meas-
14 ures implemented in accordance with subsection
15 (b)(4).

16 “(4) PAYMENTS.—The contract shall specify
17 the amount and manner by which payments (includ-
18 ing any administrative fees) shall be made to the
19 contractor for the provision of outpatient prescrip-
20 tion drug assistance to low-income medicare bene-
21 ficiaries and, if applicable, medicare beneficiaries
22 with high drug costs.

23 “(5) ENSURING PATIENT ACCESS AND CHOICE
24 OF PHARMACY PROVIDERS.—The contract shall re-
25 quire the contractor—

1 “(A) to allow any licensed pharmacy or
2 pharmacist to participate as a pharmacy pro-
3 vider in providing benefits under this section so
4 long as the pharmacy or pharmacist is willing
5 to abide by the terms and conditions the con-
6 tractor establishes to participate;

7 “(B) to establish reimbursement rates to
8 pharmacy providers that are reasonable and
9 adequate to cover the costs of items and related
10 pharmacy services, including the costs of the
11 product, all costs associated with the dispensing
12 of the product, and the costs of providing medi-
13 cation therapy management services described
14 in section 2203(a)(3);

15 “(C) not to vary pharmacy payment
16 amounts based upon the size of the entity dis-
17 pensing the prescription or factors commonly
18 associated with the size of the entity such as
19 annual prescription volume; and

20 “(D) not to vary beneficiary cost-sharing
21 amounts based upon the source of dispensing or
22 method of distribution of the prescription.

23 “(d) FUNDING.—

24 “(1) AGGREGATE OF TRANSFERRED
25 AMOUNTS.—The Secretary, through the Adminis-

1 trator of the Health Care Financing Administration,
2 shall use the aggregate of the amounts transferred
3 and made available under section 2204(d)(1)(A)(i)
4 for purposes of carrying out the default program es-
5 tablished under this section. Such aggregate may be
6 used to provide outpatient prescription drug assist-
7 ance to any low-income medicare beneficiary, and,
8 subject to the availability of funds, medicare bene-
9 ficiary with high drug costs, who resides in a State
10 described in subsection (a)(1).

11 “(2) LIMITATION ON ADMINISTRATIVE COSTS.—
12 Administrative expenditures incurred by the Sec-
13 retary or the Administrator of the Health Care Fi-
14 nancing Administration for a fiscal year to carry out
15 this section (other than administrative fees paid to
16 a contractor under a contract meeting the require-
17 ments of subsection (c))—

18 “(A) shall be paid out of the aggregate
19 amounts described in paragraph (1); and

20 “(B) may not exceed an amount equal to
21 1 percent of all premiums imposed for such fis-
22 cal year to provide outpatient prescription drug
23 assistance to low-income medicare beneficiaries
24 and medicare beneficiaries with high drug costs
25 under this section.

1 “(e) **TERMINATION.**—Except as provided in section
2 2201(d)(2), the program established under this section
3 shall terminate on September 30, 2004.

4 **“SEC. 2210. DEFINITIONS.**

5 “In this title:

6 “(1) **COST-SHARING.**—The term ‘cost-sharing’
7 means a deductible, coinsurance, copayment, or simi-
8 lar charge, and includes an enrollment fee.

9 “(2) **OUTPATIENT PRESCRIPTION DRUG ASSIST-**
10 **ANCE.**—

11 “(A) **IN GENERAL.**—The term ‘outpatient
12 prescription drug assistance’ means, subject to
13 subparagraph (B), payment for part or all of
14 the cost of coverage of self-administered out-
15 patient prescription drugs and biologicals (in-
16 cluding insulin and insulin supplies) for low-in-
17 come medicare beneficiaries and, if applicable,
18 medicare beneficiaries with high drug costs.

19 “(B) **EXCLUSIONS.**—Such term does not
20 include payment or coverage with respect to—

21 “(i) items covered under title XVIII;

22 or

23 “(ii) items for which coverage is not
24 available under a State plan under title
25 XIX.

1 “(3) OUTPATIENT PRESCRIPTION DRUG ASSIST-
2 ANCE PLAN; PLAN.—Unless the context otherwise re-
3 quires, the terms ‘outpatient prescription drug as-
4 sistance plan’ and ‘plan’ mean an outpatient pre-
5 scription drug assistance plan approved under sec-
6 tion 2206.

7 “(4) GROUP HEALTH PLAN; GROUP HEALTH IN-
8 SURANCE COVERAGE; ETC.—The terms ‘group health
9 plan’, ‘group health insurance coverage’, and ‘health
10 insurance coverage’ have the meanings given such
11 terms in section 2791 of the Public Health Service
12 Act (42 U.S.C. 300gg–91).

13 “(5) POVERTY LINE.—The term ‘poverty line’
14 has the meaning given such term in section 673(2)
15 of the Community Services Block Grant Act (42
16 U.S.C. 9902(2)), including any revision required by
17 such section.

18 “(6) PREEXISTING CONDITION EXCLUSION.—
19 The term ‘preexisting condition exclusion’ has the
20 meaning given such term in section 2701(b)(1)(A) of
21 the Public Health Service Act (42 U.S.C.
22 300gg(b)(1)(A)).

23 “(7) STATE.—The term ‘State’ has the mean-
24 ing given such term for purposes of title XIX.”.

25 (b) CONFORMING AMENDMENTS.—

1 (1) DEFINITION OF STATE.—Section
2 1101(a)(1) of the Social Security Act (42 U.S.C.
3 1301(a)(1)) is amended in the first and fourth sen-
4 tences, by striking “and XXI” each place it appears
5 and inserting “XXI, and XXII”.

6 (2) TREATMENT AS STATE HEALTH CARE PRO-
7 GRAM.—Section 1128(h) of such Act (42 U.S.C.
8 1320a–7(h)) is amended—

9 (A) in paragraph (3), by striking “or” at
10 the end;

11 (B) in paragraph (4), by striking the pe-
12 riod at the end and inserting “, or”; and

13 (C) by adding at the end the following new
14 paragraph:

15 “(5) an outpatient prescription drug assistance
16 plan approved under title XXII.”.

17 **SEC. 3. ELECTION BY LOW-INCOME MEDICARE BENE-**
18 **FICIARIES AND MEDICARE BENEFICIARIES**
19 **WITH HIGH DRUG COSTS TO SUSPEND**
20 **MEDIGAP INSURANCE.**

21 Section 1882(q) of the Social Security Act (42 U.S.C.
22 1395ss(q)) is amended—

23 (1) in paragraph (5)(C), by striking “this para-
24 graph or paragraph (6)” and inserting “this para-
25 graph, or paragraph (6) or (7)”; and

1 (2) by adding at the end the following new
2 paragraph:

3 “(7) Each medicare supplemental policy shall
4 provide that benefits and premiums under the policy
5 shall be suspended at the request of the policyholder
6 if the policyholder is entitled to benefits under sec-
7 tion 226 and is covered under an outpatient pre-
8 scription drug assistance plan (as defined in section
9 2210(3)) or provided outpatient prescription drug
10 assistance under the program established under sec-
11 tion 2209. If such suspension occurs and if the pol-
12 icyholder or certificate holder loses coverage under
13 such plan or program, such policy shall be automati-
14 cally reinstated (effective as of the date of such
15 loss of coverage) under terms described in subsection
16 (n)(6)(A)(ii) as of the loss of such coverage if the
17 policyholder provides notice of loss of such coverage
18 within 90 days after the date of such loss.”.

○