

107TH CONGRESS
2D SESSION

H. R. 4984

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

IN THE HOUSE OF REPRESENTATIVES

JUNE 21, 2002

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

A BILL

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

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

3 **TITLE I—MEDICARE**
4 **PRESCRIPTION DRUG BENEFIT**

5 **SEC. 101. ESTABLISHMENT OF A MEDICARE PRESCRIPTION**
6 **DRUG BENEFIT.**

7 (a) IN GENERAL.—Title XVIII is amended—

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

1 “(b) GENERAL ELECTION PROCEDURES.—

2 “(1) IN GENERAL.—An individual eligible to
3 make an election under subsection (a) may elect to
4 enroll in a prescription drug plan under this part, or
5 elect the option of qualified prescription drug cov-
6 erage under a Medicare+Choice plan under part C,
7 and to change such election only in such manner
8 and form as may be prescribed by regulations of the
9 Administrator of the Medicare Benefits Administra-
10 tion (appointed under section 1808(b)) (in this part
11 referred to as the ‘Medicare Benefits Administrator’)
12 and only during an election period prescribed in or
13 under this subsection.

14 “(2) ELECTION PERIODS.—

15 “(A) IN GENERAL.—Except as provided in
16 this paragraph, the election periods under this
17 subsection shall be the same as the coverage
18 election periods under the Medicare+Choice
19 program under section 1851(e), including—

20 “(i) annual coordinated election peri-
21 ods; and

22 “(ii) special election periods.

23 In applying the last sentence of section
24 1851(e)(4) (relating to discontinuance of a
25 Medicare+Choice election during the first year

1 of eligibility) under this subparagraph, in the
2 case of an election described in such section in
3 which the individual had elected or is provided
4 qualified prescription drug coverage at the time
5 of such first enrollment, the individual shall be
6 permitted to enroll in a prescription drug plan
7 under this part at the time of the election of
8 coverage under the original fee-for-service plan.

9 “(B) INITIAL ELECTION PERIODS.—

10 “(i) INDIVIDUALS CURRENTLY COV-
11 ERED.—In the case of an individual who is
12 entitled to benefits under part A or en-
13 rolled under part B as of November 1,
14 2004, there shall be an initial election pe-
15 riod of 6 months beginning on that date.

16 “(ii) INDIVIDUAL COVERED IN FU-
17 TURE.—In the case of an individual who is
18 first entitled to benefits under part A or
19 enrolled under part B after such date,
20 there shall be an initial election period
21 which is the same as the initial enrollment
22 period under section 1837(d).

23 “(C) ADDITIONAL SPECIAL ELECTION PE-
24 RIODS.—The Administrator shall establish spe-
25 cial election periods—

1 “(i) in cases of individuals who have
2 and involuntarily lose prescription drug
3 coverage described in subsection (c)(2)(C);

4 “(ii) in cases described in section
5 1837(h) (relating to errors in enrollment),
6 in the same manner as such section applies
7 to part B;

8 “(iii) in the case of an individual who
9 meets such exceptional conditions (includ-
10 ing conditions provided under section
11 1851(e)(4)(D)) as the Administrator may
12 provide; and

13 “(iv) in cases of individuals (as deter-
14 mined by the Administrator) who become
15 eligible for prescription drug assistance
16 under title XIX under section 1935(d).

17 “(c) GUARANTEED ISSUE; COMMUNITY RATING; AND
18 NONDISCRIMINATION.—

19 “(1) GUARANTEED ISSUE.—

20 “(A) IN GENERAL.—An eligible individual
21 who is eligible to elect qualified prescription
22 drug coverage under a prescription drug plan or
23 Medicare+Choice plan at a time during which
24 elections are accepted under this part with re-
25 spect to the plan shall not be denied enrollment

1 based on any health status-related factor (de-
2 scribed in section 2702(a)(1) of the Public
3 Health Service Act) or any other factor.

4 “(B) MEDICARE+CHOICE LIMITATIONS
5 PERMITTED.—The provisions of paragraphs (2)
6 and (3) (other than subparagraph (C)(i), relat-
7 ing to default enrollment) of section 1851(g)
8 (relating to priority and limitation on termi-
9 nation of election) shall apply to PDP sponsors
10 under this subsection.

11 “(2) COMMUNITY-RATED PREMIUM.—

12 “(A) IN GENERAL.—In the case of an indi-
13 vidual who maintains (as determined under sub-
14 paragraph (C)) continuous prescription drug
15 coverage since the date the individual first
16 qualifies to elect prescription drug coverage
17 under this part, a PDP sponsor or
18 Medicare+Choice organization offering a pre-
19 scription drug plan or Medicare+Choice plan
20 that provides qualified prescription drug cov-
21 erage and in which the individual is enrolled
22 may not deny, limit, or condition the coverage
23 or provision of covered prescription drug bene-
24 fits or increase the premium under the plan
25 based on any health status-related factor de-

1 scribed in section 2702(a)(1) of the Public
2 Health Service Act or any other factor.

3 “(B) LATE ENROLLMENT PENALTY.—In
4 the case of an individual who does not maintain
5 such continuous prescription drug coverage (as
6 described in subparagraph (C)), a PDP sponsor
7 or Medicare+Choice organization may (notwith-
8 standing any provision in this title) adjust the
9 premium otherwise applicable or impose a pre-
10 existing condition exclusion with respect to
11 qualified prescription drug coverage in a man-
12 ner that reflects additional actuarial risk in-
13 volved. Such a risk shall be established through
14 an appropriate actuarial opinion of the type de-
15 scribed in subparagraphs (A) through (C) of
16 section 2103(e)(4).

17 “(C) CONTINUOUS PRESCRIPTION DRUG
18 COVERAGE.—An individual is considered for
19 purposes of this part to be maintaining contin-
20 uous prescription drug coverage on and after
21 the date the individual first qualifies to elect
22 prescription drug coverage under this part if
23 the individual establishes that as of such date
24 the individual is covered under any of the fol-
25 lowing prescription drug coverage and before

1 the date that is the last day of the 63-day pe-
2 riod that begins on the date of termination of
3 the particular prescription drug coverage in-
4 volved (regardless of whether the individual
5 subsequently obtains any of the following pre-
6 scription drug coverage):

7 “(i) COVERAGE UNDER PRESCRIPTION
8 DRUG PLAN OR MEDICARE+CHOICE
9 PLAN.—Qualified prescription drug cov-
10 erage under a prescription drug plan or
11 under a Medicare+Choice plan.

12 “(ii) MEDICAID PRESCRIPTION DRUG
13 COVERAGE.—Prescription drug coverage
14 under a medicaid plan under title XIX, in-
15 cluding through the Program of All-inclu-
16 sive Care for the Elderly (PACE) under
17 section 1934, through a social health main-
18 tenance organization (referred to in section
19 4104(c) of the Balanced Budget Act of
20 1997), or through a Medicare+Choice
21 project that demonstrates the application
22 of capitation payment rates for frail elderly
23 medicare beneficiaries through the use of a
24 interdisciplinary team and through the
25 provision of primary care services to such

1 beneficiaries by means of such a team at
2 the nursing facility involved.

3 “(iii) PRESCRIPTION DRUG COVERAGE
4 UNDER GROUP HEALTH PLAN.—Any out-
5 patient prescription drug coverage under a
6 group health plan, including a health bene-
7 fits plan under the Federal Employees
8 Health Benefit Plan under chapter 89 of
9 title 5, United States Code, and a qualified
10 retiree prescription drug plan as defined in
11 section 1860H(f)(1), but only if (subject to
12 subparagraph (E)(ii)) the coverage pro-
13 vides benefits at least equivalent to the
14 benefits under a qualified prescription drug
15 plan.

16 “(iv) PRESCRIPTION DRUG COVERAGE
17 UNDER CERTAIN MEDIGAP POLICIES.—
18 Coverage under a medicare supplemental
19 policy under section 1882 that provides
20 benefits for prescription drugs (whether or
21 not such coverage conforms to the stand-
22 ards for packages of benefits under section
23 1882(p)(1)), but only if the policy was in
24 effect on January 1, 2005, and if (subject
25 to subparagraph (E)(ii)) the coverage pro-

1 vides benefits at least equivalent to the
2 benefits under a qualified prescription drug
3 plan.

4 “(v) STATE PHARMACEUTICAL ASSIST-
5 ANCE PROGRAM.—Coverage of prescription
6 drugs under a State pharmaceutical assist-
7 ance program, but only if (subject to sub-
8 paragraph (E)(ii)) the coverage provides
9 benefits at least equivalent to the benefits
10 under a qualified prescription drug plan.

11 “(vi) VETERANS’ COVERAGE OF PRE-
12 SCRIPTION DRUGS.—Coverage of prescrip-
13 tion drugs for veterans under chapter 17
14 of title 38, United States Code, but only if
15 (subject to subparagraph (E)(ii)) the cov-
16 erage provides benefits at least equivalent
17 to the benefits under a qualified prescrip-
18 tion drug plan.

19 “(D) CERTIFICATION.—For purposes of
20 carrying out this paragraph, the certifications
21 of the type described in sections 2701(e) of the
22 Public Health Service Act and in section
23 9801(e) of the Internal Revenue Code shall also
24 include a statement for the period of coverage
25 of whether the individual involved had prescrip-

1 tion drug coverage described in subparagraph
2 (C).

3 “(E) DISCLOSURE.—

4 “(i) IN GENERAL.—Each entity that
5 offers coverage of the type described in
6 clause (iii), (iv), (v), or (vi) of subpara-
7 graph (C) shall provide for disclosure, con-
8 sistent with standards established by the
9 Administrator, of whether such coverage
10 provides benefits at least equivalent to the
11 benefits under a qualified prescription drug
12 plan.

13 “(ii) WAIVER OF LIMITATIONS.—An
14 individual may apply to the Administrator
15 to waive the requirement that coverage of
16 such type provide benefits at least equiva-
17 lent to the benefits under a qualified pre-
18 scription drug plan, if the individual estab-
19 lishes that the individual was not ade-
20 quately informed that such coverage did
21 not provide such level of benefits.

22 “(F) CONSTRUCTION.—Nothing in this
23 section shall be construed as preventing the
24 disenrollment of an individual from a prescrip-
25 tion drug plan or a Medicare+Choice plan

1 based on the termination of an election de-
2 scribed in section 1851(g)(3), including for non-
3 payment of premiums or for other reasons spec-
4 ified in subsection (d)(3), which takes into ac-
5 count a grace period described in section
6 1851(g)(3)(B)(i).

7 “(3) NONDISCRIMINATION.—A PDP sponsor of-
8 fering a prescription drug plan shall not establish a
9 service area in a manner that would discriminate
10 based on health or economic status of potential en-
11 rollees.

12 “(d) EFFECTIVE DATE OF ELECTIONS.—

13 “(1) IN GENERAL.—Except as provided in this
14 section, the Administrator shall provide that elec-
15 tions under subsection (b) take effect at the same
16 time as the Administrator provides that similar elec-
17 tions under section 1851(e) take effect under section
18 1851(f).

19 “(2) NO ELECTION EFFECTIVE BEFORE 2005.—
20 In no case shall any election take effect before Janu-
21 ary 1, 2005.

22 “(3) TERMINATION.—The Administrator shall
23 provide for the termination of an election in the case
24 of—

1 “(A) termination of coverage under both
2 part A and part B; and

3 “(B) termination of elections described in
4 section 1851(g)(3) (including failure to pay re-
5 quired premiums).

6 **“SEC. 1860B. REQUIREMENTS FOR QUALIFIED PRESCRIP-**
7 **TION DRUG COVERAGE.**

8 “(a) REQUIREMENTS.—

9 “(1) IN GENERAL.—For purposes of this part
10 and part C, the term ‘qualified prescription drug
11 coverage’ means either of the following:

12 “(A) STANDARD COVERAGE WITH ACCESS
13 TO NEGOTIATED PRICES.—Standard coverage
14 (as defined in subsection (b)) and access to ne-
15 gotiated prices under subsection (d).

16 “(B) ACTUARIALLY EQUIVALENT COV-
17 ERAGE WITH ACCESS TO NEGOTIATED
18 PRICES.—Coverage of covered outpatient drugs
19 which meets the alternative coverage require-
20 ments of subsection (c) and access to negotiated
21 prices under subsection (d), but only if it is ap-
22 proved by the Administrator, as provided under
23 subsection (c).

24 “(2) PERMITTING ADDITIONAL OUTPATIENT
25 PRESCRIPTION DRUG COVERAGE.—

1 “(A) IN GENERAL.—Subject to subpara-
2 graph (B), nothing in this part shall be con-
3 strued as preventing qualified prescription drug
4 coverage from including coverage of covered
5 outpatient drugs that exceeds the coverage re-
6 quired under paragraph (1), but any such addi-
7 tional coverage shall be limited to coverage of
8 covered outpatient drugs.

9 “(B) DISAPPROVAL AUTHORITY.—The Ad-
10 ministrator shall review the offering of qualified
11 prescription drug coverage under this part or
12 part C. If the Administrator finds that, in the
13 case of a qualified prescription drug coverage
14 under a prescription drug plan or a
15 Medicare+Choice plan, that the organization or
16 sponsor offering the coverage is engaged in ac-
17 tivities intended to discourage enrollment of
18 classes of eligible medicare beneficiaries obtain-
19 ing coverage through the plan on the basis of
20 their higher likelihood of utilizing prescription
21 drug coverage, the Administrator may termi-
22 nate the contract with the sponsor or organiza-
23 tion under this part or part C.

24 “(3) APPLICATION OF SECONDARY PAYOR PRO-
25 VISIONS.—The provisions of section 1852(a)(4) shall

1 apply under this part in the same manner as they
2 apply under part C.

3 “(b) STANDARD COVERAGE.—For purposes of this
4 part, the ‘standard coverage’ is coverage of covered out-
5 patient drugs (as defined in subsection (f)) that meets the
6 following requirements:

7 “(1) DEDUCTIBLE.—The coverage has an an-
8 nual deductible—

9 “(A) for 2005, that is equal to \$250; or

10 “(B) for a subsequent year, that is equal
11 to the amount specified under this paragraph
12 for the previous year increased by the percent-
13 age specified in paragraph (5) for the year in-
14 volved.

15 Any amount determined under subparagraph (B)
16 that is not a multiple of \$10 shall be rounded to the
17 nearest multiple of \$10.

18 “(2) LIMITS ON COST-SHARING.—

19 “(A) IN GENERAL.—The coverage has
20 cost-sharing (for costs above the annual deduct-
21 ible specified in paragraph (1) and up to the
22 initial coverage limit under paragraph (3)) as
23 follows:

24 “(i) FIRST COPAYMENT RANGE.—For
25 costs above the annual deductible specified

1 in paragraph (1) and up to amount speci-
2 fied in subparagraph (C), the cost-
3 sharing—

4 “(I) is equal to 20 percent; or

5 “(II) is actuarially equivalent
6 (using processes established under
7 subsection (e)) to an average expected
8 payment of 20 percent of such costs.

9 “(ii) SECONDARY COPAYMENT
10 RANGE.—For costs above the amount spec-
11 ified in subparagraph (C) and up to the
12 initial coverage limit, the cost-sharing—

13 “(I) is equal to 50 percent; or

14 “(II) is actuarially consistent
15 (using processes established under
16 subsection (e)) with an average ex-
17 pected payment of 50 percent of such
18 costs.

19 “(B) USE OF TIERED COPAYMENTS.—

20 Nothing in this part shall be construed as pre-
21 venting a PDP sponsor from applying tiered co-
22 payments, so long as such tiered copayments
23 are consistent with subparagraph (A).

24 “(C) INITIAL COPAYMENT THRESHOLD.—

25 The amount specified in this subparagraph—

1 “(i) for 2005, is equal to \$1,000; or

2 “(ii) for a subsequent year, is equal to
3 the amount specified in this subparagraph
4 for the previous year, increased by the an-
5 nual percentage increase described in para-
6 graph (5) for the year involved.

7 Any amount determined under clause (ii) that
8 is not a multiple of \$10 shall be rounded to the
9 nearest multiple of \$10.

10 “(3) INITIAL COVERAGE LIMIT.—Subject to
11 paragraph (4), the coverage has an initial coverage
12 limit on the maximum costs that may be recognized
13 for payment purposes (above the annual deduct-
14 ible)—

15 “(A) for 2005, that is equal to \$2,000; or

16 “(B) for a subsequent year, that is equal
17 to the amount specified in this paragraph for
18 the previous year, increased by the annual per-
19 centage increase described in paragraph (5) for
20 the year involved.

21 Any amount determined under subparagraph (B)
22 that is not a multiple of \$25 shall be rounded to the
23 nearest multiple of \$25.

24 “(4) CATASTROPHIC PROTECTION.—

1 “(A) IN GENERAL.—Notwithstanding para-
2 graph (3), the coverage provides benefits with
3 no cost-sharing after the individual has in-
4 curred costs (as described in subparagraph (C))
5 for covered outpatient drugs in a year equal to
6 the annual out-of-pocket threshold specified in
7 subparagraph (B).

8 “(B) ANNUAL OUT-OF-POCKET THRESH-
9 OLD.—For purposes of this part, the ‘annual
10 out-of-pocket threshold’ specified in this
11 subparagraph—

12 “(i) for 2005, is equal to \$3,700; or

13 “(ii) for a subsequent year, is equal to
14 the amount specified in this subparagraph
15 for the previous year, increased by the an-
16 nual percentage increase described in para-
17 graph (5) for the year involved.

18 Any amount determined under clause (ii) that
19 is not a multiple of \$100 shall be rounded to
20 the nearest multiple of \$100.

21 “(C) APPLICATION.—In applying subpara-
22 graph (A)—

23 “(i) incurred costs shall only include
24 costs incurred for the annual deductible
25 (described in paragraph (1)), cost-sharing

1 (described in paragraph (2)), and amounts
2 for which benefits are not provided because
3 of the application of the initial coverage
4 limit described in paragraph (3); and

5 “(ii) such costs shall be treated as in-
6 curred only if they are paid by the indi-
7 vidual (or by another individual, such as a
8 family member, on behalf of the indi-
9 vidual), under section 1860G, or under
10 title XIX and the individual (or other indi-
11 vidual) is not reimbursed through insur-
12 ance or otherwise, a group health plan, or
13 other third-party payment arrangement for
14 such costs.

15 “(5) ANNUAL PERCENTAGE INCREASE.—For
16 purposes of this part, the annual percentage increase
17 specified in this paragraph for a year is equal to the
18 annual percentage increase in average per capita ag-
19 gregate expenditures for covered outpatient drugs in
20 the United States for medicare beneficiaries, as de-
21 termined by the Administrator for the 12-month pe-
22 riod ending in July of the previous year.

23 “(c) ALTERNATIVE COVERAGE REQUIREMENTS.—A
24 prescription drug plan or Medicare+Choice plan may pro-
25 vide a different prescription drug benefit design from the

1 standard coverage described in subsection (b) so long as
2 the Administrator determines (based on an actuarial anal-
3 ysis by the Administrator) the following requirements are
4 met and the plan applies for, and receives, the approval
5 of the Administrator for such benefit design:

6 “(1) ASSURING AT LEAST ACTUARIALLY EQUIV-
7 ALENT COVERAGE.—

8 “(A) ASSURING EQUIVALENT VALUE OF
9 TOTAL COVERAGE.—The actuarial value of the
10 total coverage (as determined under subsection
11 (e)) is at least equal to the actuarial value (as
12 so determined) of standard coverage.

13 “(B) ASSURING EQUIVALENT UNSUB-
14 SIDIZED VALUE OF COVERAGE.—The unsub-
15 sidized value of the coverage is at least equal to
16 the unsubsidized value of standard coverage.
17 For purposes of this subparagraph, the unsub-
18 sidized value of coverage is the amount by
19 which the actuarial value of the coverage (as
20 determined under subsection (e)) exceeds the
21 actuarial value of the subsidy payments under
22 section 1860H with respect to such coverage.

23 “(C) ASSURING STANDARD PAYMENT FOR
24 COSTS AT INITIAL COVERAGE LIMIT.—The cov-
25 erage is designed, based upon an actuarially

1 representative pattern of utilization (as deter-
2 mined under subsection (e)), to provide for the
3 payment, with respect to costs incurred that are
4 equal to the initial coverage limit under sub-
5 section (b)(3), of an amount equal to at least
6 the sum of the following products:

7 “(i) FIRST COPAYMENT RANGE.—The
8 product of—

9 “(I) the amount by which the ini-
10 tial copayment threshold described in
11 subsection (b)(2)(C) exceeds the de-
12 ductible described in subsection
13 (b)(1); and

14 “(II) 100 percent minus the cost-
15 sharing percentage specified in sub-
16 section (b)(2)(A)(i)(I).

17 “(ii) SECONDARY COPAYMENT
18 RANGE.—The product of—

19 “(I) the amount by which the ini-
20 tial coverage limit described in sub-
21 section (b)(3) exceeds the initial co-
22 payment threshold described in sub-
23 section (b)(2)(C); and

1 “(II) 100 percent minus the cost-
2 sharing percentage specified in sub-
3 section (b)(2)(A)(ii)(I).

4 “(2) CATASTROPHIC PROTECTION.—The cov-
5 erage provides for beneficiaries the catastrophic pro-
6 tection described in subsection (b)(4).

7 “(d) ACCESS TO NEGOTIATED PRICES.—

8 “(1) IN GENERAL.—Under qualified prescrip-
9 tion drug coverage offered by a PDP sponsor or a
10 Medicare+Choice organization, the sponsor or orga-
11 nization shall provide beneficiaries with access to ne-
12 gotiated prices (including applicable discounts) used
13 for payment for covered outpatient drugs, regardless
14 of the fact that no benefits may be payable under
15 the coverage with respect to such drugs because of
16 the application of cost-sharing or an initial coverage
17 limit (described in subsection (b)(3)). Insofar as a
18 State elects to provide medical assistance under title
19 XIX for a drug based on the prices negotiated by a
20 prescription drug plan under this part, the require-
21 ments of section 1927 shall not apply to such drugs.
22 The prices negotiated by a prescription drug plan
23 under this part, by a Medicare+Choice plan with re-
24 spect to covered outpatient drugs, or by a qualified
25 retiree prescription drug plan (as defined in section

1 1860H(f)(1)) with respect to such drugs on behalf
2 of individuals entitled to benefits under part A or
3 enrolled under part B, shall (notwithstanding any
4 other provision of law) not be taken into account for
5 the purposes of establishing the best price under sec-
6 tion 1927(c)(1)(C).

7 “(2) DISCLOSURE.—The PDP sponsor or
8 Medicare+Choice organization shall disclose to the
9 Administrator (in a manner specified by the Admin-
10 istrator) the extent to which discounts or rebates
11 made available to the sponsor or organization by a
12 manufacturer are passed through to enrollees
13 through pharmacies and other dispensers or other-
14 wise. The provisions of section 1927(b)(3)(D) shall
15 apply to information disclosed to the Administrator
16 under this paragraph in the same manner as such
17 provisions apply to information disclosed under such
18 section.

19 “(e) ACTUARIAL VALUATION; DETERMINATION OF
20 ANNUAL PERCENTAGE INCREASES.—

21 “(1) PROCESSES.—For purposes of this section,
22 the Administrator shall establish processes and
23 methods—

24 “(A) for determining the actuarial valu-
25 ation of prescription drug coverage, including—

1 “(i) an actuarial valuation of standard
2 coverage and of the reinsurance subsidy
3 payments under section 1860H;

4 “(ii) the use of generally accepted ac-
5 tuarial principles and methodologies; and

6 “(iii) applying the same methodology
7 for determinations of alternative coverage
8 under subsection (c) as is used with re-
9 spect to determinations of standard cov-
10 erage under subsection (b); and

11 “(B) for determining annual percentage in-
12 creases described in subsection (b)(5).

13 “(2) USE OF OUTSIDE ACTUARIES.—Under the
14 processes under paragraph (1)(A), PDP sponsors
15 and Medicare+Choice organizations may use actu-
16 arial opinions certified by independent, qualified ac-
17 tuaries to establish actuarial values, but the Admin-
18 istrator shall determine whether such actuarial val-
19 ues meet the requirements under subsection (c)(1).

20 “(f) COVERED OUTPATIENT DRUGS DEFINED.—

21 “(1) IN GENERAL.—Except as provided in this
22 subsection, for purposes of this part, the term ‘cov-
23 ered outpatient drug’ means—

24 “(A) a drug that may be dispensed only
25 upon a prescription and that is described in

1 subparagraph (A)(i) or (A)(ii) of section
2 1927(k)(2); or

3 “(B) a biological product described in
4 clauses (i) through (iii) of subparagraph (B) of
5 such section or insulin described in subpara-
6 graph (C) of such section,

7 and such term includes a vaccine licensed under sec-
8 tion 351 of the Public Health Service Act and any
9 use of a covered outpatient drug for a medically ac-
10 cepted indication (as defined in section 1927(k)(6)).

11 “(2) EXCLUSIONS.—

12 “(A) IN GENERAL.—Such term does not
13 include drugs or classes of drugs, or their med-
14 ical uses, which may be excluded from coverage
15 or otherwise restricted under section
16 1927(d)(2), other than subparagraph (E) there-
17 of (relating to smoking cessation agents), or
18 under section 1927(d)(3).

19 “(B) AVOIDANCE OF DUPLICATE COV-
20 ERAGE.—A drug prescribed for an individual
21 that would otherwise be a covered outpatient
22 drug under this part shall not be so considered
23 if payment for such drug is available under part
24 A or B for an individual entitled to benefits
25 under part A and enrolled under part B.

1 “(3) APPLICATION OF FORMULARY RESTRIC-
2 TIONS.—A drug prescribed for an individual that
3 would otherwise be a covered outpatient drug under
4 this part shall not be so considered under a plan if
5 the plan excludes the drug under a formulary and
6 such exclusion is not successfully appealed under
7 section 1860C(f)(2).

8 “(4) APPLICATION OF GENERAL EXCLUSION
9 PROVISIONS.—A prescription drug plan or
10 Medicare+Choice plan may exclude from qualified
11 prescription drug coverage any covered outpatient
12 drug—

13 “(A) for which payment would not be
14 made if section 1862(a) applied to part D; or

15 “(B) which are not prescribed in accord-
16 ance with the plan or this part.

17 Such exclusions are determinations subject to recon-
18 sideration and appeal pursuant to section 1860C(f).

19 **“SEC. 1860C. BENEFICIARY PROTECTIONS FOR QUALIFIED**
20 **PRESCRIPTION DRUG COVERAGE.**

21 “(a) GUARANTEED ISSUE, COMMUNITY-RELATED
22 PREMIUMS, ACCESS TO NEGOTIATED PRICES, AND NON-
23 DISCRIMINATION.—For provisions requiring guaranteed
24 issue, community-rated premiums, access to negotiated

1 prices, and nondiscrimination, see sections 1860A(c)(1),
2 1860A(c)(2), 1860B(d), and 1860F(b), respectively.

3 “(b) DISSEMINATION OF INFORMATION.—

4 “(1) GENERAL INFORMATION.—A PDP sponsor
5 shall disclose, in a clear, accurate, and standardized
6 form to each enrollee with a prescription drug plan
7 offered by the sponsor under this part at the time
8 of enrollment and at least annually thereafter, the
9 information described in section 1852(c)(1) relating
10 to such plan. Such information includes the fol-
11 lowing:

12 “(A) Access to covered outpatient drugs,
13 including access through pharmacy networks.

14 “(B) How any formulary used by the spon-
15 sor functions.

16 “(C) Co-payments and deductible require-
17 ments, including the identification of the tiered
18 or other co-payment level applicable to each
19 drug (or class of drugs).

20 “(D) Grievance and appeals procedures.

21 “(2) DISCLOSURE UPON REQUEST OF GENERAL
22 COVERAGE, UTILIZATION, AND GRIEVANCE INFORMA-
23 TION.—Upon request of an individual eligible to en-
24 roll under a prescription drug plan, the PDP spon-
25 sor shall provide the information described in section

1 1852(e)(2) (other than subparagraph (D)) to such
2 individual.

3 “(3) RESPONSE TO BENEFICIARY QUESTIONS.—
4 Each PDP sponsor offering a prescription drug plan
5 shall have a mechanism for providing specific infor-
6 mation to enrollees upon request. The sponsor shall
7 make available on a timely basis, through an Inter-
8 net website and in writing upon request, information
9 on specific changes in its formulary.

10 “(4) CLAIMS INFORMATION.—Each PDP spon-
11 sor offering a prescription drug plan must furnish to
12 enrolled individuals in a form easily understandable
13 to such individuals an explanation of benefits (in ac-
14 cordance with section 1806(a) or in a comparable
15 manner) and a notice of the benefits in relation to
16 initial coverage limit and annual out-of-pocket
17 threshold for the current year, whenever prescription
18 drug benefits are provided under this part (except
19 that such notice need not be provided more often
20 than monthly).

21 “(c) ACCESS TO COVERED BENEFITS.—

22 “(1) ASSURING PHARMACY ACCESS.—

23 “(A) IN GENERAL.—The PDP sponsor of
24 the prescription drug plan shall secure the par-
25 ticipation in its network of a sufficient number

1 of pharmacies that dispense (other than by mail
2 order) drugs directly to patients to ensure con-
3 venient access (as determined by the Adminis-
4 trator and including adequate emergency ac-
5 cess) for enrolled beneficiaries, in accordance
6 with standards established under section
7 1860D(e) that ensure such convenient access.

8 “(B) USE OF POINT-OF-SERVICE SYS-
9 TEM.—A PDP sponsor shall establish an op-
10 tional point-of-service method of operation
11 under which—

12 “(i) the plan provides access to any or
13 all pharmacies that are not participating
14 pharmacies in its network; and

15 “(ii) the plan may charge beneficiaries
16 through adjustments in premiums and co-
17 payments any additional costs associated
18 with the point-of-service option.

19 The additional copayments so charged shall not
20 count toward the application of section
21 1860B(b).

22 “(2) USE OF STANDARDIZED TECHNOLOGY.—

23 “(A) IN GENERAL.—The PDP sponsor of
24 a prescription drug plan shall issue (and re-
25 issue, as appropriate) such a card (or other

1 technology) that may be used by an enrolled
2 beneficiary to assure access to negotiated prices
3 under section 1860B(d) for the purchase of
4 prescription drugs for which coverage is not
5 otherwise provided under the prescription drug
6 plan.

7 “(B) STANDARDS.—

8 “(i) DEVELOPMENT.—The Adminis-
9 trator shall provide for the development of
10 national standards relating to a standard-
11 ized format for the card or other tech-
12 nology referred to in subparagraph (A).
13 Such standards shall be compatible with
14 standards established under part C of title
15 XI.

16 “(ii) APPLICATION OF ADVISORY TASK
17 FORCE.—The advisory task force estab-
18 lished under subsection (d)(3)(B)(ii) shall
19 provide recommendations to the Adminis-
20 trator under such subsection regarding the
21 standards developed under clause (i).

22 “(3) REQUIREMENTS ON DEVELOPMENT AND
23 APPLICATION OF FORMULARIES.—If a PDP sponsor
24 of a prescription drug plan uses a formulary, the fol-
25 lowing requirements must be met:

1 “(A) PHARMACY AND THERAPEUTIC (P&T)
2 COMMITTEE.—The sponsor must establish a
3 pharmacy and therapeutic committee that de-
4 velops and reviews the formulary. Such com-
5 mittee shall include at least one physician and
6 at least one pharmacist both with expertise in
7 the care of elderly or disabled persons and a
8 majority of its members shall consist of individ-
9 uals who are a physician or a pharmacist (or
10 both).

11 “(B) FORMULARY DEVELOPMENT.—In de-
12 veloping and reviewing the formulary, the com-
13 mittee shall base clinical decisions on the
14 strength of scientific evidence and standards of
15 practice, including assessing peer-reviewed med-
16 ical literature, such as randomized clinical
17 trials, pharmacoeconomic studies, outcomes re-
18 search data, and such other information as the
19 committee determines to be appropriate.

20 “(C) INCLUSION OF DRUGS IN ALL THERA-
21 PEUTIC CATEGORIES.—The formulary must in-
22 clude drugs within each therapeutic category
23 and class of covered outpatient drugs (although
24 not necessarily for all drugs within such cat-
25 egories and classes).

1 “(D) PROVIDER EDUCATION.—The com-
2 mittee shall establish policies and procedures to
3 educate and inform health care providers con-
4 cerning the formulary.

5 “(E) NOTICE BEFORE REMOVING DRUGS
6 FROM FORMULARY.—Any removal of a drug
7 from a formulary shall take effect only after ap-
8 propriate notice is made available to bene-
9 ficiaries and physicians.

10 “(F) GRIEVANCES AND APPEALS RELAT-
11 ING TO APPLICATION OF FORMULARIES.—For
12 provisions relating to grievances and appeals of
13 coverage, see subsections (e) and (f).

14 “(d) COST AND UTILIZATION MANAGEMENT; QUAL-
15 ITY ASSURANCE; MEDICATION THERAPY MANAGEMENT
16 PROGRAM.—

17 “(1) IN GENERAL.—The PDP sponsor shall
18 have in place with respect to covered outpatient
19 drugs—

20 “(A) an effective cost and drug utilization
21 management program, including medically ap-
22 propriate incentives to use generic drugs and
23 therapeutic interchange, when appropriate;

24 “(B) quality assurance measures and sys-
25 tems to reduce medical errors and adverse drug

1 interactions, including a medication therapy
2 management program described in paragraph
3 (2) and for years beginning with 2006, an elec-
4 tronic prescription program described in para-
5 graph (3); and

6 “(C) a program to control fraud, abuse,
7 and waste.

8 Nothing in this section shall be construed as impair-
9 ing a PDP sponsor from applying cost management
10 tools (including differential payments) under all
11 methods of operation.

12 “(2) MEDICATION THERAPY MANAGEMENT PRO-
13 GRAM.—

14 “(A) IN GENERAL.—A medication therapy
15 management program described in this para-
16 graph is a program of drug therapy manage-
17 ment and medication administration that is de-
18 signed to assure, with respect to beneficiaries
19 with chronic diseases (such as diabetes, asthma,
20 hypertension, and congestive heart failure) or
21 multiple prescriptions, that covered outpatient
22 drugs under the prescription drug plan are ap-
23 propriately used to achieve therapeutic goals
24 and reduce the risk of adverse events, including
25 adverse drug interactions.

1 “(B) ELEMENTS.—Such program may
2 include—

3 “(i) enhanced beneficiary under-
4 standing of such appropriate use through
5 beneficiary education, counseling, and
6 other appropriate means;

7 “(ii) increased beneficiary adherence
8 with prescription medication regimens
9 through medication refill reminders, special
10 packaging, and other appropriate means;
11 and

12 “(iii) detection of patterns of overuse
13 and underuse of prescription drugs.

14 “(C) DEVELOPMENT OF PROGRAM IN CO-
15 OPERATION WITH LICENSED PHARMACISTS.—
16 The program shall be developed in cooperation
17 with licensed pharmacists and physicians.

18 “(D) CONSIDERATIONS IN PHARMACY
19 FEES.—The PDP sponsor of a prescription
20 drug program shall take into account, in estab-
21 lishing fees for pharmacists and others pro-
22 viding services under the medication therapy
23 management program, the resources and time
24 used in implementing the program.

25 “(3) ELECTRONIC PRESCRIPTION PROGRAM.—

1 “(A) IN GENERAL.—An electronic prescrip-
2 tion drug program described in this paragraph
3 is a program that includes at least the following
4 components, consistent with national standards
5 established under subparagraph (B):

6 “(i) ELECTRONIC TRANSMITTAL OF
7 PRESCRIPTIONS.—Prescriptions are only
8 received electronically, except in emergency
9 cases and other exceptional circumstances
10 recognized by the Administrator.

11 “(ii) PROVISION OF INFORMATION TO
12 PRESCRIBING HEALTH CARE PROFES-
13 SIONAL.—The program provides, upon
14 transmittal of a prescription by a pre-
15 scribing health care professional, for trans-
16 mittal by the pharmacist to the profes-
17 sional of information that includes—

18 “(I) information (to the extent
19 available and feasible) on the drugs
20 being prescribed for that patient and
21 other information relating to the med-
22 ical history or condition of the patient
23 that may be relevant to the appro-
24 priate prescription for that patient;

1 “(II) cost-effective alternatives (if
2 any) for the use of the drug pre-
3 scribed; and

4 “(III) information on the drugs
5 included in the applicable formulary.

6 To the extent feasible, such program shall
7 permit the prescribing health care profes-
8 sional to provide (and be provided) related
9 information on an interactive, real-time
10 basis.

11 “(B) STANDARDS.—

12 “(i) DEVELOPMENT.—The Adminis-
13 trator shall provide for the development of
14 national standards relating to the elec-
15 tronic prescription drug program described
16 in subparagraph (A). Such standards shall
17 be compatible with standards established
18 under part C of title XI.

19 “(ii) ADVISORY TASK FORCE.—In de-
20 veloping such standards and the standards
21 described in subsection (c)(2)(B)(i) the Ad-
22 ministrators shall establish a task force that
23 includes representatives of physicians, hos-
24 pitals, pharmacists, and technology experts
25 and representatives of the Departments of

1 Veterans Affairs and Defense and other
2 appropriate Federal agencies to provide
3 recommendations to the Administrator on
4 such standards, including recommenda-
5 tions relating to the following:

6 “(I) The range of available com-
7 puterized prescribing software and
8 hardware and their costs to develop
9 and implement.

10 “(II) The extent to which such
11 systems reduce medication errors and
12 can be readily implemented by physi-
13 cians and hospitals.

14 “(III) Efforts to develop a com-
15 mon software platform for computer-
16 ized prescribing.

17 “(IV) The cost of implementing
18 such systems in the range of hospital
19 and physician office settings, includ-
20 ing hardware, software, and training
21 costs.

22 “(V) Implementation issues as
23 they relate to part C of title XI, and
24 current Federal and State prescribing
25 laws and regulations and their impact

1 on implementation of computerized
2 prescribing.

3 “(iii) DEADLINES.—

4 “(I) The Administrator shall con-
5 stitute the task force under clause (ii)
6 by not later than April 1, 2003.

7 “(II) Such task force shall sub-
8 mit recommendations to Adminis-
9 trator by not later than January 1,
10 2004.

11 “(III) The Administrator shall
12 develop and promulgate the national
13 standards referred to in clause (ii) by
14 not later than July 1, 2004.

15 “(C) REFERENCE TO AVAILABILITY OF
16 GRANT FUNDS.—Grant funds are authorized
17 under section 3990 of the Public Health Serv-
18 ice Act to provide assistance to health care pro-
19 viders in implementing electronic prescription
20 drug programs.

21 “(4) TREATMENT OF ACCREDITATION.—Section
22 1852(e)(4) (relating to treatment of accreditation)
23 shall apply to prescription drug plans under this
24 part with respect to the following requirements, in
25 the same manner as they apply to Medicare+Choice

1 plans under part C with respect to the requirements
2 described in a clause of section 1852(e)(4)(B):

3 “(A) Paragraph (1) (including quality as-
4 surance), including medication therapy manage-
5 ment program under paragraph (2).

6 “(B) Subsection (c)(1) (relating to access
7 to covered benefits).

8 “(C) Subsection (g) (relating to confiden-
9 tiality and accuracy of enrollee records).

10 “(5) PUBLIC DISCLOSURE OF PHARMACEUTICAL
11 PRICES FOR EQUIVALENT DRUGS.—Each PDP spon-
12 sor shall provide that each pharmacy or other dis-
13 penser that arranges for the dispensing of a covered
14 outpatient drug shall inform the beneficiary at the
15 time of purchase of the drug of any differential be-
16 tween the price of the prescribed drug to the enrollee
17 and the price of the lowest cost generic drug covered
18 under the plan that is therapeutically equivalent and
19 bioequivalent.

20 “(e) GRIEVANCE MECHANISM, COVERAGE DETER-
21 MINATIONS, AND RECONSIDERATIONS.—

22 “(1) IN GENERAL.—Each PDP sponsor shall
23 provide meaningful procedures for hearing and re-
24 solving grievances between the organization (includ-
25 ing any entity or individual through which the spon-

1 sor provides covered benefits) and enrollees with pre-
2 scription drug plans of the sponsor under this part
3 in accordance with section 1852(f).

4 “(2) APPLICATION OF COVERAGE DETERMINA-
5 TION AND RECONSIDERATION PROVISIONS.—A PDP
6 sponsor shall meet the requirements of paragraphs
7 (1) through (3) of section 1852(g) with respect to
8 covered benefits under the prescription drug plan it
9 offers under this part in the same manner as such
10 requirements apply to a Medicare+Choice organiza-
11 tion with respect to benefits it offers under a
12 Medicare+Choice plan under part C.

13 “(3) REQUEST FOR REVIEW OF TIERED FOR-
14 MULARY DETERMINATIONS.—In the case of a pre-
15 scription drug plan offered by a PDP sponsor that
16 provides for tiered cost-sharing for drugs included
17 within a formulary and provides lower cost-sharing
18 for preferred drugs included within the formulary,
19 an individual who is enrolled in the plan may re-
20 quest coverage of a nonpreferred drug under the
21 terms applicable for preferred drugs if the pre-
22 scribing physician determines that the preferred
23 drug for treatment of the same condition is not as
24 effective for the individual or has adverse effects for
25 the individual.

1 “(f) APPEALS.—

2 “(1) IN GENERAL.—Subject to paragraph (2), a
3 PDP sponsor shall meet the requirements of para-
4 graphs (4) and (5) of section 1852(g) with respect
5 to drugs not included on any formulary in the same
6 manner as such requirements apply to a
7 Medicare+Choice organization with respect to bene-
8 fits it offers under a Medicare+Choice plan under
9 part C.

10 “(2) FORMULARY DETERMINATIONS.—An indi-
11 vidual who is enrolled in a prescription drug plan of-
12 fered by a PDP sponsor may appeal to obtain cov-
13 erage for a covered outpatient drug that is not on
14 a formulary of the sponsor if the prescribing physi-
15 cian determines that the formulary drug for treat-
16 ment of the same condition is not as effective for the
17 individual or has adverse effects for the individual.

18 “(g) CONFIDENTIALITY AND ACCURACY OF EN-
19 ROLLEE RECORDS.—A PDP sponsor shall meet the re-
20 quirements of section 1852(h) with respect to enrollees
21 under this part in the same manner as such requirements
22 apply to a Medicare+Choice organization with respect to
23 enrollees under part C.

1 **“SEC. 1860D. REQUIREMENTS FOR PRESCRIPTION DRUG**
2 **PLAN (PDP) SPONSORS; CONTRACTS; ESTAB-**
3 **LISHMENT OF STANDARDS.**

4 “(a) GENERAL REQUIREMENTS.—Each PDP sponsor
5 of a prescription drug plan shall meet the following re-
6 quirements:

7 “(1) LICENSURE.—Subject to subsection (c),
8 the sponsor is organized and licensed under State
9 law as a risk-bearing entity eligible to offer health
10 insurance or health benefits coverage in each State
11 in which it offers a prescription drug plan.

12 “(2) ASSUMPTION OF FINANCIAL RISK.—

13 “(A) IN GENERAL.—Subject to subpara-
14 graph (B) and section 1860E(d)(2), the entity
15 assumes full financial risk on a prospective
16 basis for qualified prescription drug coverage
17 that it offers under a prescription drug plan
18 and that is not covered under section 1860H.

19 “(B) REINSURANCE PERMITTED.—The en-
20 tity may obtain insurance or make other ar-
21 rangements for the cost of coverage provided to
22 any enrolled member under this part.

23 “(3) SOLVENCY FOR UNLICENSED SPONSORS.—

24 In the case of a sponsor that is not described in
25 paragraph (1), the sponsor shall meet solvency

1 standards established by the Administrator under
2 subsection (d).

3 “(b) CONTRACT REQUIREMENTS.—

4 “(1) IN GENERAL.—The Administrator shall
5 not permit the election under section 1860A of a
6 prescription drug plan offered by a PDP sponsor
7 under this part, and the sponsor shall not be eligible
8 for payments under section 1860G or 1860H, unless
9 the Administrator has entered into a contract under
10 this subsection with the sponsor with respect to the
11 offering of such plan. Such a contract with a spon-
12 sor may cover more than one prescription drug plan.
13 Such contract shall provide that the sponsor agrees
14 to comply with the applicable requirements and
15 standards of this part and the terms and conditions
16 of payment as provided for in this part.

17 “(2) NEGOTIATION REGARDING TERMS AND
18 CONDITIONS.—The Administrator shall have the
19 same authority to negotiate the terms and conditions
20 of prescription drug plans under this part as the Di-
21 rector of the Office of Personnel Management has
22 with respect to health benefits plans under chapter
23 89 of title 5, United States Code. In negotiating the
24 terms and conditions regarding premiums for which
25 information is submitted under section 1860F(a)(2),

1 the Administrator shall take into account the sub-
2 sidy payments under section 1860H and the ad-
3 justed community rate (as defined in section
4 1854(f)(3)) for the benefits covered.

5 “(3) INCORPORATION OF CERTAIN
6 MEDICARE+CHOICE CONTRACT REQUIREMENTS.—
7 The following provisions of section 1857 shall apply,
8 subject to subsection (c)(5), to contracts under this
9 section in the same manner as they apply to con-
10 tracts under section 1857(a):

11 “(A) MINIMUM ENROLLMENT.—Para-
12 graphs (1) and (3) of section 1857(b).

13 “(B) CONTRACT PERIOD AND EFFECTIVE-
14 NESS.—Paragraphs (1) through (3) and (5) of
15 section 1857(c).

16 “(C) PROTECTIONS AGAINST FRAUD AND
17 BENEFICIARY PROTECTIONS.—Section 1857(d).

18 “(D) ADDITIONAL CONTRACT TERMS.—
19 Section 1857(e); except that in applying section
20 1857(e)(2) under this part—

21 “(i) such section shall be applied sepa-
22 rately to costs relating to this part (from
23 costs under part C);

24 “(ii) in no case shall the amount of
25 the fee established under this subpara-

1 graph for a plan exceed 20 percent of the
2 maximum amount of the fee that may be
3 established under subparagraph (B) of
4 such section; and

5 “(iii) no fees shall be applied under
6 this subparagraph with respect to
7 Medicare+Choice plans.

8 “(E) INTERMEDIATE SANCTIONS.—Section
9 1857(g).

10 “(F) PROCEDURES FOR TERMINATION.—
11 Section 1857(h).

12 “(4) RULES OF APPLICATION FOR INTER-
13 MEDIATE SANCTIONS.—In applying paragraph
14 (3)(E)—

15 “(A) the reference in section
16 1857(g)(1)(B) to section 1854 is deemed a ref-
17 erence to this part; and

18 “(B) the reference in section
19 1857(g)(1)(F) to section 1852(k)(2)(A)(ii) shall
20 not be applied.

21 “(c) WAIVER OF CERTAIN REQUIREMENTS TO EX-
22 PAND CHOICE.—

23 “(1) IN GENERAL.—In the case of an entity
24 that seeks to offer a prescription drug plan in a
25 State, the Administrator shall waive the requirement

1 of subsection (a)(1) that the entity be licensed in
2 that State if the Administrator determines, based on
3 the application and other evidence presented to the
4 Administrator, that any of the grounds for approval
5 of the application described in paragraph (2) has
6 been met.

7 “(2) GROUNDS FOR APPROVAL.—The grounds
8 for approval under this paragraph are the grounds
9 for approval described in subparagraph (B), (C),
10 and (D) of section 1855(a)(2), and also include the
11 application by a State of any grounds other than
12 those required under Federal law.

13 “(3) APPLICATION OF WAIVER PROCEDURES.—
14 With respect to an application for a waiver (or a
15 waiver granted) under this subsection, the provisions
16 of subparagraphs (E), (F), and (G) of section
17 1855(a)(2) shall apply.

18 “(4) LICENSURE DOES NOT SUBSTITUTE FOR
19 OR CONSTITUTE CERTIFICATION.—The fact that an
20 entity is licensed in accordance with subsection
21 (a)(1) does not deem the entity to meet other re-
22 quirements imposed under this part for a PDP spon-
23 sor.

24 “(5) REFERENCES TO CERTAIN PROVISIONS.—
25 For purposes of this subsection, in applying provi-

1 sions of section 1855(a)(2) under this subsection to
2 prescription drug plans and PDP sponsors—

3 “(A) any reference to a waiver application
4 under section 1855 shall be treated as a ref-
5 erence to a waiver application under paragraph
6 (1); and

7 “(B) any reference to solvency standards
8 shall be treated as a reference to solvency
9 standards established under subsection (d).

10 “(d) SOLVENCY STANDARDS FOR NON-LICENSED
11 SPONSORS.—

12 “(1) ESTABLISHMENT.—The Administrator
13 shall establish, by not later than October 1, 2003,
14 financial solvency and capital adequacy standards
15 that an entity that does not meet the requirements
16 of subsection (a)(1) must meet to qualify as a PDP
17 sponsor under this part.

18 “(2) COMPLIANCE WITH STANDARDS.—Each
19 PDP sponsor that is not licensed by a State under
20 subsection (a)(1) and for which a waiver application
21 has been approved under subsection (c) shall meet
22 solvency and capital adequacy standards established
23 under paragraph (1). The Administrator shall estab-
24 lish certification procedures for such PDP sponsors

1 with respect to such solvency standards in the man-
2 ner described in section 1855(c)(2).

3 “(e) OTHER STANDARDS.—The Administrator shall
4 establish by regulation other standards (not described in
5 subsection (d)) for PDP sponsors and plans consistent
6 with, and to carry out, this part. The Administrator shall
7 publish such regulations by October 1, 2003.

8 “(f) RELATION TO STATE LAWS.—

9 “(1) IN GENERAL.—The standards established
10 under this part shall supersede any State law or reg-
11 ulation (other than State licensing laws or State
12 laws relating to plan solvency, except as provided in
13 subsection (d)) with respect to prescription drug
14 plans which are offered by PDP sponsors under this
15 part.

16 “(2) PROHIBITION OF STATE IMPOSITION OF
17 PREMIUM TAXES.—No State may impose a premium
18 tax or similar tax with respect to premiums paid to
19 PDP sponsors for prescription drug plans under this
20 part, or with respect to any payments made to such
21 a sponsor by the Administrator under this part.

22 **“SEC. 1860E. PROCESS FOR BENEFICIARIES TO SELECT**
23 **QUALIFIED PRESCRIPTION DRUG COVERAGE.**

24 “(a) IN GENERAL.—The Administrator shall estab-
25 lish a process for the selection of the prescription drug

1 plan or Medicare+Choice plan which offer qualified pre-
2 scription drug coverage through which eligible individuals
3 elect qualified prescription drug coverage under this part.

4 “(b) ELEMENTS.—Such process shall include the fol-
5 lowing:

6 “(1) Annual, coordinated election periods, in
7 which such individuals can change the qualifying
8 plans through which they obtain coverage, in accord-
9 ance with section 1860A(b)(2).

10 “(2) Active dissemination of information to pro-
11 mote an informed selection among qualifying plans
12 based upon price, quality, and other features, in the
13 manner described in (and in coordination with) sec-
14 tion 1851(d), including the provision of annual com-
15 parative information, maintenance of a toll-free hot-
16 line, and the use of non-Federal entities.

17 “(3) Coordination of elections through filing
18 with a Medicare+Choice organization or a PDP
19 sponsor, in the manner described in (and in coordi-
20 nation with) section 1851(c)(2).

21 “(c) MEDICARE+CHOICE ENROLLEE IN PLAN OF-
22 FERING PRESCRIPTION DRUG COVERAGE MAY ONLY OB-
23 TAIN BENEFITS THROUGH THE PLAN.—An individual
24 who is enrolled under a Medicare+Choice plan that offers
25 qualified prescription drug coverage may only elect to re-

1 ceive qualified prescription drug coverage under this part
2 through such plan.

3 “(d) ASSURING ACCESS TO A CHOICE OF QUALIFIED
4 PRESCRIPTION DRUG COVERAGE.—

5 “(1) CHOICE OF AT LEAST TWO PLANS IN EACH
6 AREA.—

7 “(A) IN GENERAL.—The Administrator
8 shall assure that each individual who is entitled
9 to benefits under part A or enrolled under part
10 B and who is residing in an area in the United
11 States has available, consistent with subpara-
12 graph (B), a choice of enrollment in at least
13 two qualifying plans (as defined in paragraph
14 (5)) in the area in which the individual resides,
15 at least one of which is a prescription drug
16 plan.

17 “(B) REQUIREMENT FOR DIFFERENT
18 PLAN SPONSORS.—The requirement in subpara-
19 graph (A) is not satisfied with respect to an
20 area if only one PDP sponsor or
21 Medicare+Choice organization offers all the
22 qualifying plans in the area.

23 “(2) GUARANTEEING ACCESS TO COVERAGE.—

24 In order to assure access under paragraph (1) and
25 consistent with paragraph (3), the Administrator

1 may provide financial incentives (including partial
2 underwriting of risk) for a PDP sponsor to expand
3 the service area under an existing prescription drug
4 plan to adjoining or additional areas or to establish
5 such a plan (including offering such a plan on a re-
6 gional or nationwide basis), but only so long as (and
7 to the extent) necessary to assure the access guaran-
8 teed under paragraph (1).

9 “(3) LIMITATION ON AUTHORITY.—In exer-
10 cising authority under this subsection, the
11 Administrator—

12 “(A) shall not provide for the full under-
13 writing of financial risk for any PDP sponsor;

14 “(B) shall not provide for any under-
15 writing of financial risk for a public PDP spon-
16 sor with respect to the offering of a nationwide
17 prescription drug plan; and

18 “(C) shall seek to maximize the assump-
19 tion of financial risk by PDP sponsors or
20 Medicare+Choice organizations.

21 “(4) REPORTS.—The Administrator shall, in
22 each annual report to Congress under section
23 1808(f), include information on the exercise of au-
24 thority under this subsection. The Administrator
25 also shall include such recommendations as may be

1 appropriate to minimize the exercise of such author-
2 ity, including minimizing the assumption of financial
3 risk.

4 “(5) QUALIFYING PLAN DEFINED.—For pur-
5 poses of this subsection, the term ‘qualifying plan’
6 means a prescription drug plan or a
7 Medicare+Choice plan that includes qualified pre-
8 scription drug coverage.

9 **“SEC. 1860F. SUBMISSION OF BIDS.**

10 “(a) SUBMISSION OF BIDS AND RELATED INFORMA-
11 TION.—

12 “(1) IN GENERAL.—Each PDP sponsor shall
13 submit to the Administrator information of the type
14 described in paragraph (2) in the same manner as
15 information is submitted by a Medicare+Choice or-
16 ganization under section 1854(a)(1).

17 “(2) TYPE OF INFORMATION.—The information
18 described in this paragraph is the following:

19 “(A) Information on the qualified prescrip-
20 tion drug coverage to be provided.

21 “(B) Information on the actuarial value of
22 the coverage.

23 “(C) Information on the bid for the cov-
24 erage, including an actuarial certification of—

25 “(i) the actuarial basis for such bid;

1 “(ii) the portion of such bid attrib-
2 utable to benefits in excess of standard
3 coverage; and

4 “(iii) the reduction in such bid result-
5 ing from the subsidy payments provided
6 under section 1860H.

7 “(D) Such other information as the Ad-
8 ministrator may require to carry out this part.

9 “(3) REVIEW.—The Administrator shall review
10 the information filed under paragraph (2) for the
11 purpose of conducting negotiations under section
12 1860D(b)(2).

13 “(b) UNIFORM BID.—

14 “(1) IN GENERAL.—The bid for a prescription
15 drug plan under this section may not vary among in-
16 dividuals enrolled in the plan in the same service
17 area.

18 “(2) CONSTRUCTION.—Nothing in paragraph
19 (1) shall be construed as preventing the imposition
20 of a late enrollment penalty under section
21 1860A(c)(2)(B).

22 “(c) COLLECTION.—

23 “(1) USE OF ELECTRONIC FUNDS TRANSFER
24 MECHANISM OR, AT BENEFICIARY’S OPTION, WITH-
25 HOLDING FROM SOCIAL SECURITY PAYMENT.—In ac-

1 cordance with regulations, a PDP sponsor may en-
2 courage that enrollees under a plan make payment
3 of the premium established by the plan under this
4 part through an electronic funds transfer mecha-
5 nism, such as automatic charges of an account at a
6 financial institution or a credit or debit card ac-
7 count, or, at the option of an enrollee, through with-
8 holding from benefit payments in the manner pro-
9 vided under section 1840 with respect to monthly
10 premiums under section 1839. All such amounts
11 shall be credited to the Medicare Prescription Drug
12 Trust Fund.

13 “(2) OFFSETTING.—Reductions in premiums
14 for coverage under parts A and B as a result of a
15 selection of a Medicare+Choice plan may be used to
16 reduce the premium otherwise imposed under para-
17 graph (1).

18 “(3) PAYMENT OF PLANS.—PDP plans shall re-
19 ceive payment based on bid amounts in the same
20 manner as Medicare+Choice organizations receive
21 payment based on bid amounts under section
22 1853(a)(1)(A)(ii) except that such payment shall be
23 made from the Medicare Prescription Drug Trust
24 Fund.

1 “(d) ACCEPTANCE OF BENCHMARK AMOUNT AS
2 FULL PREMIUM FOR SUBSIDIZED LOW-INCOME INDIVID-
3 UALS IF NO STANDARD (OR EQUIVALENT) COVERAGE IN
4 AN AREA.—

5 “(1) IN GENERAL.—If there is no standard pre-
6 scription drug coverage (as defined in paragraph
7 (2)) offered in an area, in the case of an individual
8 who is eligible for a premium subsidy under section
9 1860G and resides in the area, the PDP sponsor of
10 any prescription drug plan offered in the area (and
11 any Medicare+Choice organization that offers quali-
12 fied prescription drug coverage in the area) shall ac-
13 cept the benchmark bid amount (under section
14 1860G(b)(2)) as payment in full for the premium
15 charge for qualified prescription drug coverage.

16 “(2) STANDARD PRESCRIPTION DRUG COV-
17 ERAGE DEFINED.—For purposes of this subsection,
18 the term ‘standard prescription drug coverage’
19 means qualified prescription drug coverage that is
20 standard coverage or that has an actuarial value
21 equivalent to the actuarial value for standard cov-
22 erage.

1 **“SEC. 1860G. PREMIUM AND COST-SHARING SUBSIDIES FOR**
2 **LOW-INCOME INDIVIDUALS.**

3 “(a) INCOME-RELATED SUBSIDIES FOR INDIVIDUALS
4 WITH INCOME BELOW 150 PERCENT OF FEDERAL POV-
5 ERTY LEVEL.—

6 “(1) FULL PREMIUM SUBSIDY AND REDUCTION
7 OF COST-SHARING FOR INDIVIDUALS WITH INCOME
8 BELOW 150 PERCENT OF FEDERAL POVERTY
9 LEVEL.—In the case of a subsidy eligible individual
10 (as defined in paragraph (4)) who is determined to
11 have income that does not exceed 150 percent of the
12 Federal poverty level, the individual is entitled under
13 this section—

14 “(A) to an income-related premium subsidy
15 equal to 100 percent of the amount described in
16 subsection (b)(1); and

17 “(B) subject to subsection (c), to the sub-
18 stitution for the beneficiary cost-sharing de-
19 scribed in paragraphs (1) and (2) of section
20 1860B(b) (up to the initial coverage limit speci-
21 fied in paragraph (3) of such section) of
22 amounts that do not exceed \$2 for a multiple
23 source or generic drug (as described in section
24 1927(k)(7)(A)) and \$5 for a non-preferred
25 drug.

1 “(2) SLIDING SCALE PREMIUM SUBSIDY AND
2 REDUCTION OF COST-SHARING FOR INDIVIDUALS
3 WITH INCOME ABOVE 150, BUT BELOW 175 PERCENT,
4 OF FEDERAL POVERTY LEVEL.—In the case of a
5 subsidy eligible individual who is determined to have
6 income that exceeds 150 percent, but does not ex-
7 ceed 175 percent, of the Federal poverty level, the
8 individual is entitled under this section to—

9 “(A) an income-related premium subsidy
10 determined on a linear sliding scale ranging
11 from 100 percent of the amount described in
12 subsection (b)(1) for individuals with incomes
13 at 150 percent of such level to 0 percent of
14 such amount for individuals with incomes at
15 175 percent of such level; and

16 “(B) subject to subsection (c), to the sub-
17 stitution for the beneficiary cost-sharing de-
18 scribed in paragraphs (1) and (2) of section
19 1860B(b) (up to the initial coverage limit speci-
20 fied in paragraph (3) of such section) of
21 amounts that do not exceed \$2 for a multiple
22 source or generic drug (as described in section
23 1927(k)(7)(A)) and \$5 for a non-preferred
24 drug.

1 “(3) CONSTRUCTION.—Nothing in this section
2 shall be construed as preventing a PDP sponsor
3 from reducing to 0 the cost-sharing otherwise appli-
4 cable to generic drugs.

5 “(4) DETERMINATION OF ELIGIBILITY.—

6 “(A) SUBSIDY ELIGIBLE INDIVIDUAL DE-
7 FINED.—For purposes of this section, subject
8 to subparagraph (D), the term ‘subsidy eligible
9 individual’ means an individual who—

10 “(i) is eligible to elect, and has elect-
11 ed, to obtain qualified prescription drug
12 coverage under this part;

13 “(ii) has income below 175 percent of
14 the Federal poverty line; and

15 “(iii) meets the resources requirement
16 described in section 1905(p)(1)(C).

17 “(B) DETERMINATIONS.—The determina-
18 tion of whether an individual residing in a State
19 is a subsidy eligible individual and the amount
20 of such individual’s income shall be determined
21 under the State medicaid plan for the State
22 under section 1935(a). In the case of a State
23 that does not operate such a medicaid plan (ei-
24 ther under title XIX or under a statewide waiv-
25 er granted under section 1115), such deter-

1 mination shall be made under arrangements
2 made by the Administrator.

3 “(C) INCOME DETERMINATIONS.—For pur-
4 poses of applying this section—

5 “(i) income shall be determined in the
6 manner described in section
7 1905(p)(1)(B); and

8 “(ii) the term ‘Federal poverty line’
9 means the official poverty line (as defined
10 by the Office of Management and Budget,
11 and revised annually in accordance with
12 section 673(2) of the Omnibus Budget
13 Reconciliation Act of 1981) applicable to a
14 family of the size involved.

15 “(D) TREATMENT OF TERRITORIAL RESI-
16 DENTS.—In the case of an individual who is not
17 a resident of the 50 States or the District of
18 Columbia, the individual is not eligible to be a
19 subsidy eligible individual but may be eligible
20 for financial assistance with prescription drug
21 expenses under section 1935(e).

22 “(E) TREATMENT OF CONFORMING
23 MEDIGAP POLICIES.—For purposes of this sec-
24 tion, the term ‘qualified prescription drug cov-

1 erage' includes a medicare supplemental policy
2 described in section 1860H(b)(4).

3 “(5) INDEXING DOLLAR AMOUNTS.—

4 “(A) FOR 2006.—The dollar amounts ap-
5 plied under paragraphs (1)(B) and (2)(B) for
6 2006 shall be the dollar amounts specified in
7 such paragraph increased by the annual per-
8 centage increase described in section
9 1860B(b)(5) for 2006.

10 “(B) FOR SUBSEQUENT YEARS.—The dol-
11 lar amounts applied under paragraphs (1)(B)
12 and (2)(B) for a year after 2006 shall be the
13 amounts (under this paragraph) applied under
14 paragraph (1)(B) or (2)(B) for the preceding
15 year increased by the annual percentage in-
16 crease described in section 1860B(b)(5) (relat-
17 ing to growth in medicare prescription drug
18 costs per beneficiary) for the year involved.

19 “(b) PREMIUM SUBSIDY AMOUNT.—

20 “(1) IN GENERAL.—The premium subsidy
21 amount described in this subsection for an individual
22 residing in an area is the benchmark bid amount (as
23 defined in paragraph (2)) for qualified prescription
24 drug coverage offered by the prescription drug plan

1 or the Medicare+Choice plan in which the individual
2 is enrolled.

3 “(2) BENCHMARK BID AMOUNT DEFINED.—For
4 purposes of this subsection, the term ‘benchmark bid
5 amount’ means, with respect to qualified prescrip-
6 tion drug coverage offered under—

7 “(A) a prescription drug plan that—

8 “(i) provides standard coverage (or al-
9 ternative prescription drug coverage the
10 actuarial value is equivalent to that of
11 standard coverage), the bid amount for en-
12 rollment under the plan under this part
13 (determined without regard to any subsidy
14 under this section or any late enrollment
15 penalty under section 1860A(c)(2)(B)); or

16 “(ii) provides alternative prescription
17 drug coverage the actuarial value of which
18 is greater than that of standard coverage,
19 the bid amount described in clause (i) mul-
20 tiplied by the ratio of (I) the actuarial
21 value of standard coverage, to (II) the ac-
22 tuarial value of the alternative coverage; or

23 “(B) a Medicare+Choice plan, the portion
24 of the bid amount that is attributable to statu-

1 tory drug benefits (described in section
2 1853(a)(1)(A)(ii)(II)).

3 “(c) RULES IN APPLYING COST-SHARING SUB-
4 SIDIES.—

5 “(1) IN GENERAL.—In applying subsections
6 (a)(1)(B) and (a)(2)(B), nothing in this part shall
7 be construed as preventing a plan or provider from
8 waiving or reducing the amount of cost-sharing oth-
9 erwise applicable.

10 “(2) LIMITATION ON CHARGES.—In the case of
11 an individual receiving cost-sharing subsidies under
12 subsection (a)(1)(B) or (a)(2)(B), the PDP sponsor
13 may not charge more than \$5 per prescription.

14 “(3) APPLICATION OF INDEXING RULES.—The
15 provisions of subsection (a)(4) shall apply to the dol-
16 lar amount specified in paragraph (2) in the same
17 manner as they apply to the dollar amounts specified
18 in subsections (a)(1)(B) and (a)(2)(B).

19 “(d) ADMINISTRATION OF SUBSIDY PROGRAM.—The
20 Administrator shall provide a process whereby, in the case
21 of an individual who is determined to be a subsidy eligible
22 individual and who is enrolled in prescription drug plan
23 or is enrolled in a Medicare+Choice plan under which
24 qualified prescription drug coverage is provided—

1 “(1) the Administrator provides for a notifica-
2 tion of the PDP sponsor or Medicare+Choice orga-
3 nization involved that the individual is eligible for a
4 subsidy and the amount of the subsidy under sub-
5 section (a);

6 “(2) the sponsor or organization involved re-
7 duces the premiums or cost-sharing otherwise im-
8 posed by the amount of the applicable subsidy and
9 submits to the Administrator information on the
10 amount of such reduction; and

11 “(3) the Administrator periodically and on a
12 timely basis reimburses the sponsor or organization
13 for the amount of such reductions.

14 The reimbursement under paragraph (3) with respect to
15 cost-sharing subsidies may be computed on a capitated
16 basis, taking into account the actuarial value of the sub-
17 sidies and with appropriate adjustments to reflect dif-
18 ferences in the risks actually involved.

19 “(e) RELATION TO MEDICAID PROGRAM.—

20 “(1) IN GENERAL.—For provisions providing
21 for eligibility determinations, and additional financ-
22 ing, under the medicaid program, see section 1935.

23 “(2) MEDICAID PROVIDING WRAP AROUND BEN-
24 EFITS.—The coverage provided under this part is

1 primary payor to benefits for prescribed drugs pro-
2 vided under the medicaid program under title XIX.

3 “(3) COORDINATION.—The Administrator shall
4 develop and implement a plan for the coordination
5 of prescription drug benefits under this part with
6 the benefits provided under the medicaid program
7 under title XIX, with particular attention to insur-
8 ing coordination of payments and prevention of
9 fraud and abuse. In developing and implementing
10 such plan, the Administrator shall involve the Sec-
11 retary, the States, the data processing industry,
12 pharmacists, and pharmaceutical manufacturers,
13 and other experts.

14 **“SEC. 1860H. SUBSIDIES FOR ALL MEDICARE BENE-**
15 **FICIARIES FOR QUALIFIED PRESCRIPTION**
16 **DRUG COVERAGE.**

17 “(a) SUBSIDY PAYMENT.—In order to reduce pre-
18 mium levels applicable to qualified prescription drug cov-
19 erage for all medicare beneficiaries consistent with an
20 overall subsidy level of 66 percent, to reduce adverse selec-
21 tion among prescription drug plans and Medicare+Choice
22 plans that provide qualified prescription drug coverage,
23 and to promote the participation of PDP sponsors under
24 this part, the Administrator shall provide in accordance

1 with this section for payment to a qualifying entity (as
2 defined in subsection (b)) of the following subsidies:

3 “(1) DIRECT SUBSIDY.—In the case of an indi-
4 vidual enrolled in a prescription drug plan,
5 Medicare+Choice plan that provides qualified pre-
6 scription drug coverage, or qualified retiree prescrip-
7 tion drug plan, a direct subsidy equal to 36 percent
8 of the total payments made by a qualifying entity
9 for standard drug coverage provided under the re-
10 spective plan.

11 “(2) SUBSIDY THROUGH REINSURANCE.—The
12 reinsurance payment amount (as defined in sub-
13 section (c)), which in the aggregate is 30 percent of
14 such total payments, for excess costs incurred in
15 providing qualified prescription drug coverage—

16 “(A) for individuals enrolled with a pre-
17 scription drug plan under this part;

18 “(B) for individuals enrolled with a
19 Medicare+Choice plan that provides qualified
20 prescription drug coverage under part C; and

21 “(C) for individuals who are enrolled in a
22 qualified retiree prescription drug plan.

23 This section constitutes budget authority in advance of ap-
24 propriations Acts and represents the obligation of the Ad-

1 administrator to provide for the payment of amounts pro-
2 vided under this section.

3 “(b) QUALIFYING ENTITY DEFINED.—For purposes
4 of this section, the term ‘qualifying entity’ means any of
5 the following that has entered into an agreement with the
6 Administrator to provide the Administrator with such in-
7 formation as may be required to carry out this section:

8 “(1) A PDP sponsor offering a prescription
9 drug plan under this part.

10 “(2) A Medicare+Choice organization that pro-
11 vides qualified prescription drug coverage under a
12 Medicare+Choice plan under part C.

13 “(3) The sponsor of a qualified retiree prescrip-
14 tion drug plan (as defined in subsection (f)).

15 “(c) REINSURANCE PAYMENT AMOUNT.—

16 “(1) IN GENERAL.—Subject to subsection
17 (d)(2) and paragraph (4), the reinsurance payment
18 amount under this subsection for a qualifying cov-
19 ered individual (as defined in subsection (g)(1)) for
20 a coverage year (as defined in subsection (g)(2)) is
21 equal to the sum of the following:

22 “(A) For the portion of the individual’s
23 gross covered prescription drug costs (as de-
24 fined in paragraph (3)) for the year that ex-
25 ceeds the initial copayment threshold specified

1 in section 1860B(b)(2)(C), but does not exceed
2 the initial coverage limit specified in section
3 1860B(b)(3), an amount equal to 30 percent of
4 the allowable costs (as defined in paragraph
5 (2)) attributable to such gross covered prescrip-
6 tion drug costs.

7 “(B) For the portion of the individual’s
8 gross covered prescription drug costs for the
9 year that exceeds the annual out-of-pocket
10 threshold specified in 1860B(b)(4)(B), an
11 amount equal to 80 percent of the allowable
12 costs attributable to such gross covered pre-
13 scription drug costs.

14 “(2) ALLOWABLE COSTS.—For purposes of this
15 section, the term ‘allowable costs’ means, with re-
16 spect to gross covered prescription drug costs under
17 a plan described in subsection (b) offered by a quali-
18 fying entity, the part of such costs that are actually
19 paid (net of average percentage rebates) under the
20 plan, but in no case more than the part of such
21 costs that would have been paid under the plan if
22 the prescription drug coverage under the plan were
23 standard coverage.

24 “(3) GROSS COVERED PRESCRIPTION DRUG
25 COSTS.—For purposes of this section, the term

1 ‘gross covered prescription drug costs’ means, with
2 respect to an enrollee with a qualifying entity under
3 a plan described in subsection (b) during a coverage
4 year, the costs incurred under the plan (including
5 costs attributable to administrative costs) for cov-
6 ered prescription drugs dispensed during the year,
7 including costs relating to the deductible, whether
8 paid by the enrollee or under the plan, regardless of
9 whether the coverage under the plan exceeds stand-
10 ard coverage and regardless of when the payment
11 for such drugs is made.

12 “(4) INDEXING DOLLAR AMOUNTS.—

13 “(A) AMOUNTS FOR 2005.—The dollar
14 amounts applied under paragraph (1) for 2005
15 shall be the dollar amounts specified in such
16 paragraph.

17 “(B) FOR 2006.—The dollar amounts ap-
18 plied under paragraph (1) for 2006 shall be the
19 dollar amounts specified in such paragraph in-
20 creased by the annual percentage increase de-
21 scribed in section 1860B(b)(5) for 2006.

22 “(C) FOR SUBSEQUENT YEARS.—The dol-
23 lar amounts applied under paragraph (1) for a
24 year after 2006 shall be the amounts (under
25 this paragraph) applied under paragraph (1)

1 for the preceding year increased by the annual
2 percentage increase described in section
3 1860B(b)(5) (relating to growth in medicare
4 prescription drug costs per beneficiary) for the
5 year involved.

6 “(D) ROUNDING.—Any amount, deter-
7 mined under the preceding provisions of this
8 paragraph for a year, which is not a multiple of
9 \$10 shall be rounded to the nearest multiple of
10 \$10.

11 “(d) ADJUSTMENT OF PAYMENTS.—

12 “(1) ADJUSTMENT OF REINSURANCE PAY-
13 MENTS TO ASSURE 30 PERCENT LEVEL OF SUBSIDY
14 THROUGH REINSURANCE.—

15 “(A) ESTIMATION OF PAYMENTS.—The
16 Administrator shall estimate—

17 “(i) the total payments to be made
18 (without regard to this subsection) during
19 a year under subsections (a)(2) and (c);
20 and

21 “(ii) the total payments to be made by
22 qualifying entities for standard coverage
23 under plans described in subsection (b)
24 during the year.

1 “(B) ADJUSTMENT.—The Administrator
2 shall proportionally adjust the payments made
3 under subsections (a)(2) and (c) for a coverage
4 year in such manner so that the total of the
5 payments made under such subsections for the
6 year is equal to 30 percent of the total pay-
7 ments described in subparagraph (A)(ii).

8 “(2) RISK ADJUSTMENT FOR DIRECT SUB-
9 SIDIES.—To the extent the Administrator deter-
10 mines it appropriate to avoid risk selection, the pay-
11 ments made for direct subsidies under subsection
12 (a)(1) are subject to adjustment based upon risk
13 factors specified by the Administrator. Any such risk
14 adjustment shall be designed in a manner as to not
15 result in a change in the aggregate payments made
16 under such subsection.

17 “(e) PAYMENT METHODS.—

18 “(1) IN GENERAL.—Payments under this sec-
19 tion shall be based on such a method as the Admin-
20 istrator determines. The Administrator may estab-
21 lish a payment method by which interim payments
22 of amounts under this section are made during a
23 year based on the Administrator’s best estimate of
24 amounts that will be payable after obtaining all of
25 the information.

1 “(2) SOURCE OF PAYMENTS.—Payments under
2 this section shall be made from the Medicare Pre-
3 scription Drug Trust Fund.

4 “(f) QUALIFIED RETIREE PRESCRIPTION DRUG
5 PLAN DEFINED.—

6 “(1) IN GENERAL.—For purposes of this sec-
7 tion, the term ‘qualified retiree prescription drug
8 plan’ means employment-based retiree health cov-
9 erage (as defined in paragraph (3)(A)) if, with re-
10 spect to an individual enrolled (or eligible to be en-
11 rolled) under this part who is covered under the
12 plan, the following requirements are met:

13 “(A) ASSURANCE.—The sponsor of the
14 plan shall annually attest, and provide such as-
15 surances as the Administrator may require,
16 that the coverage meets or exceeds the require-
17 ments for qualified prescription drug coverage.

18 “(B) AUDITS.—The sponsor (and the plan)
19 shall maintain, and afford the Administrator
20 access to, such records as the Administrator
21 may require for purposes of audits and other
22 oversight activities necessary to ensure the ade-
23 quacy of prescription drug coverage, and the ac-
24 curacy of payments made.

1 “(C) PROVISION OF CERTIFICATION OF
2 PRESCRIPTION DRUG COVERAGE.—The sponsor
3 of the plan shall provide for issuance of certifi-
4 cations of the type described in section
5 1860A(c)(2)(D).

6 “(2) LIMITATION ON BENEFIT ELIGIBILITY.—
7 No payment shall be provided under this section
8 with respect to an individual who is enrolled under
9 a qualified retiree prescription drug plan unless the
10 individual is—

11 “(A) enrolled under this part;

12 “(B) is covered under the plan; and

13 “(C) is eligible to obtain qualified prescrip-
14 tion drug coverage under section 1860A but did
15 not elect such coverage under this part (either
16 through a prescription drug plan or through a
17 Medicare+Choice plan).

18 “(3) DEFINITIONS.—As used in this section:

19 “(A) EMPLOYMENT-BASED RETIREE
20 HEALTH COVERAGE.—The term ‘employment-
21 based retiree health coverage’ means health in-
22 surance or other coverage of health care costs
23 for individuals enrolled under this part (or for
24 such individuals and their spouses and depend-

1 ents) based on their status as former employees
2 or labor union members.

3 “(B) SPONSOR.—The term ‘sponsor’
4 means a plan sponsor, as defined in section
5 3(16)(B) of the Employee Retirement Income
6 Security Act of 1974.

7 “(g) GENERAL DEFINITIONS.—For purposes of this
8 section:

9 “(1) QUALIFYING COVERED INDIVIDUAL.—The
10 term ‘qualifying covered individual’ means an indi-
11 vidual who—

12 “(A) is enrolled with a prescription drug
13 plan under this part;

14 “(B) is enrolled with a Medicare+Choice
15 plan that provides qualified prescription drug
16 coverage under part C; or

17 “(C) is enrolled for benefits under this title
18 and is covered under a qualified retiree pre-
19 scription drug plan.

20 “(2) COVERAGE YEAR.—The term ‘coverage
21 year’ means a calendar year in which covered out-
22 patient drugs are dispensed if a claim for payment
23 is made under the plan for such drugs, regardless
24 of when the claim is paid.

1 **“SEC. 1860I. MEDICARE PRESCRIPTION DRUG TRUST FUND.**

2 “(a) IN GENERAL.—There is created on the books
3 of the Treasury of the United States a trust fund to be
4 known as the ‘Medicare Prescription Drug Trust Fund’
5 (in this section referred to as the ‘Trust Fund’). The
6 Trust Fund shall consist of such gifts and bequests as
7 may be made as provided in section 201(i)(1), and such
8 amounts as may be deposited in, or appropriated to, such
9 fund as provided in this part. Except as otherwise pro-
10 vided in this section, the provisions of subsections (b)
11 through (i) of section 1841 shall apply to the Trust Fund
12 in the same manner as they apply to the Federal Supple-
13 mentary Medical Insurance Trust Fund under such sec-
14 tion.

15 “(b) PAYMENTS FROM TRUST FUND.—

16 “(1) IN GENERAL.—The Managing Trustee
17 shall pay from time to time from the Trust Fund
18 such amounts as the Administrator certifies are nec-
19 essary to make—

20 “(A) payments under section 1860G (relat-
21 ing to low-income subsidy payments);

22 “(B) payments under section 1860H (re-
23 lating to subsidy payments); and

24 “(C) payments with respect to administra-
25 tive expenses under this part in accordance with
26 section 201(g).

1 “(2) TRANSFERS TO MEDICAID ACCOUNT FOR
2 INCREASED ADMINISTRATIVE COSTS.—The Man-
3 aging Trustee shall transfer from time to time from
4 the Trust Fund to the Grants to States for Medicaid
5 account amounts the Administrator certifies are at-
6 tributable to increases in payment resulting from the
7 application of a higher Federal matching percentage
8 under section 1935(b).

9 “(c) DEPOSITS INTO TRUST FUND.—

10 “(1) LOW-INCOME TRANSFER.—There is hereby
11 transferred to the Trust Fund, from amounts appro-
12 priated for Grants to States for Medicaid, amounts
13 equivalent to the aggregate amount of the reductions
14 in payments under section 1903(a)(1) attributable to
15 the application of section 1935(c).

16 “(2) APPROPRIATIONS TO COVER GOVERNMENT
17 CONTRIBUTIONS.—There are authorized to be appro-
18 priated from time to time, out of any moneys in the
19 Treasury not otherwise appropriated, to the Trust
20 Fund, an amount equivalent to the amount of pay-
21 ments made from the Trust Fund under subsection
22 (b), reduced by the amount transferred to the Trust
23 Fund under paragraph (1).

24 “(d) RELATION TO SOLVENCY REQUIREMENTS.—
25 Any provision of law that relates to the solvency of the

1 Trust Fund under this part shall take into account the
2 Trust Fund and amounts receivable by, or payable from,
3 the Trust Fund.

4 **“SEC. 1860J. DEFINITIONS; TREATMENT OF REFERENCES**
5 **TO PROVISIONS IN PART C.**

6 “(a) DEFINITIONS.—For purposes of this part:

7 “(1) COVERED OUTPATIENT DRUGS.—The term
8 ‘covered outpatient drugs’ is defined in section
9 1860B(f).

10 “(2) INITIAL COVERAGE LIMIT.—The term ‘ini-
11 tial coverage limit’ means such limit as established
12 under section 1860B(b)(3), or, in the case of cov-
13 erage that is not standard coverage, the comparable
14 limit (if any) established under the coverage.

15 “(3) MEDICARE PRESCRIPTION DRUG TRUST
16 FUND.—The term ‘Medicare Prescription Drug
17 Trust Fund’ means the Trust Fund created under
18 section 1860I(a).

19 “(4) PDP SPONSOR.—The term ‘PDP sponsor’
20 means an entity that is certified under this part as
21 meeting the requirements and standards of this part
22 for such a sponsor.

23 “(5) PRESCRIPTION DRUG PLAN.—The term
24 ‘prescription drug plan’ means health benefits cov-
25 erage that—

1 “(A) is offered under a policy, contract, or
2 plan by a PDP sponsor pursuant to, and in ac-
3 cordance with, a contract between the Adminis-
4 trator and the sponsor under section 1860D(b);

5 “(B) provides qualified prescription drug
6 coverage; and

7 “(C) meets the applicable requirements of
8 the section 1860C for a prescription drug plan.

9 “(6) QUALIFIED PRESCRIPTION DRUG COV-
10 ERAGE.—The term ‘qualified prescription drug cov-
11 erage’ is defined in section 1860B(a).

12 “(7) STANDARD COVERAGE.—The term ‘stand-
13 ard coverage’ is defined in section 1860B(b).

14 “(b) APPLICATION OF MEDICARE+CHOICE PROVI-
15 SIONS UNDER THIS PART.—For purposes of applying pro-
16 visions of part C under this part with respect to a pre-
17 scription drug plan and a PDP sponsor, unless otherwise
18 provided in this part such provisions shall be applied as
19 if—

20 “(1) any reference to a Medicare+Choice plan
21 included a reference to a prescription drug plan;

22 “(2) any reference to a provider-sponsored or-
23 ganization included a reference to a PDP sponsor;

1 “(3) any reference to a contract under section
2 1857 included a reference to a contract under sec-
3 tion 1860D(b); and

4 “(4) any reference to part C included a ref-
5 erence to this part.”.

6 (b) ADDITIONAL CONFORMING CHANGES.—

7 (1) CONFORMING REFERENCES TO PREVIOUS
8 PART D.—Any reference in law (in effect before the
9 date of the enactment of this Act) to part D of title
10 XVIII of the Social Security Act is deemed a ref-
11 erence to part E of such title (as in effect after such
12 date).

13 (2) CONFORMING AMENDMENT PERMITTING
14 WAIVER OF COST-SHARING.—Section 1128B(b)(3)
15 (42 U.S.C. 1320a-7b(b)(3)) is amended—

16 (A) by striking “and” at the end of sub-
17 paragraph (E);

18 (B) by striking the period at the end of
19 subparagraph (F) and inserting “; and”; and

20 (C) by adding at the end the following new
21 subparagraph:

22 “(G) the waiver or reduction of any cost-shar-
23 ing imposed under part D of title XVIII.”.

24 (3) SUBMISSION OF LEGISLATIVE PROPOSAL.—

25 Not later than 6 months after the date of the enact-

1 coverage (other than that required under parts
2 A and B) to an enrollee under a
3 Medicare+Choice plan unless such drug cov-
4 erage is at least qualified prescription drug cov-
5 erage and unless the requirements of this sub-
6 section with respect to such coverage are met.

7 “(B) CONSTRUCTION.—Nothing in this
8 subsection shall be construed as—

9 “(i) requiring a Medicare+Choice
10 plan to include coverage of qualified pre-
11 scription drug coverage; or

12 “(ii) permitting a Medicare+Choice
13 organization from providing such coverage
14 to an individual who has not elected such
15 coverage under section 1860A(b).

16 For purposes of this part, an individual who
17 has not elected qualified prescription drug cov-
18 erage under section 1860A(b) shall be treated
19 as being ineligible to enroll in a
20 Medicare+Choice plan under this part that of-
21 fers such coverage.

22 “(2) COMPLIANCE WITH ADDITIONAL BENE-
23 FICIARY PROTECTIONS.—With respect to the offer-
24 ing of qualified prescription drug coverage by a
25 Medicare+Choice organization under a

1 Medicare+Choice plan, the organization and plan
2 shall meet the requirements of section 1860C, in-
3 cluding requirements relating to information dis-
4 semination and grievance and appeals, in the same
5 manner as they apply to a PDP sponsor and a pre-
6 scription drug plan under part D and shall submit
7 to the Administrator the information described in
8 section 1860F(a)(2). The Administrator shall waive
9 such requirements to the extent the Administrator
10 determines that such requirements duplicate require-
11 ments otherwise applicable to the organization or
12 plan under this part.

13 “(3) AVAILABILITY OF PREMIUM AND COST-
14 SHARING SUBSIDIES FOR LOW-INCOME ENROLLEES
15 AND DIRECT AND REINSURANCE SUBSIDY PAYMENTS
16 FOR ORGANIZATIONS.—For provisions—

17 “(A) providing premium and cost-sharing
18 subsidies to low-income individuals receiving
19 qualified prescription drug coverage through a
20 Medicare+Choice plan, see section 1860G; and

21 “(B) providing a Medicare+Choice organi-
22 zation with direct and insurance subsidy pay-
23 ments for providing qualified prescription drug
24 coverage under this part, see section 1860H.

1 “(4) TRANSITION IN INITIAL ENROLLMENT PE-
2 RIOD.—Notwithstanding any other provision of this
3 part, the annual, coordinated election period under
4 subsection (e)(3)(B) for 2005 shall be the 6-month
5 period beginning with November 2004.

6 “(5) QUALIFIED PRESCRIPTION DRUG COV-
7 ERAGE; STANDARD COVERAGE.—For purposes of
8 this part, the terms ‘qualified prescription drug cov-
9 erage’ and ‘standard coverage’ have the meanings
10 given such terms in section 1860B.”.

11 (b) CONFORMING AMENDMENTS.—Section 1851 (42
12 U.S.C. 1395w–21) is amended—

13 (1) in subsection (a)(1)—

14 (A) by inserting “(other than qualified pre-
15 scription drug benefits)” after “benefits”;

16 (B) by striking the period at the end of
17 subparagraph (B) and inserting a comma; and

18 (C) by adding after and below subpara-
19 graph (B) the following:

20 “and may elect qualified prescription drug coverage
21 in accordance with section 1860A.”; and

22 (2) in subsection (g)(1), by inserting “and sec-
23 tion 1860A(e)(2)(B)” after “in this subsection”.

1 (c) EFFECTIVE DATE.—The amendments made by
 2 this section apply to coverage provided on or after January
 3 1, 2005.

4 **SEC. 103. MEDICAID AMENDMENTS.**

5 (a) DETERMINATIONS OF ELIGIBILITY FOR LOW-IN-
 6 COME SUBSIDIES.—

7 (1) REQUIREMENT.—Section 1902(a) (42
 8 U.S.C. 1396a(a)) is amended—

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

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

13 (C) by inserting after paragraph (65) the
 14 following new paragraph:

15 “(66) provide for making eligibility determina-
 16 tions under section 1935(a).”.

17 (2) NEW SECTION.—Title XIX is further
 18 amended—

19 (A) by redesignating section 1935 as sec-
 20 tion 1936; and

21 (B) by inserting after section 1934 the fol-
 22 lowing new section:

23 “SPECIAL PROVISIONS RELATING TO MEDICARE
 24 PRESCRIPTION DRUG BENEFIT

25 “SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGI-
 26 BILITY DETERMINATIONS FOR LOW-INCOME SUB-

1 SIDIES.—As a condition of its State plan under this title
2 under section 1902(a)(66) and receipt of any Federal fi-
3 nancial assistance under section 1903(a), a State shall—

4 “(1) make determinations of eligibility for pre-
5 mium and cost-sharing subsidies under (and in ac-
6 cordance with) section 1860G;

7 “(2) inform the Administrator of the Medicare
8 Benefits Administration of such determinations in
9 cases in which such eligibility is established; and

10 “(3) otherwise provide such Administrator with
11 such information as may be required to carry out
12 part D of title XVIII (including section 1860G).

13 “(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE
14 COSTS.—

15 “(1) IN GENERAL.—The amounts expended by
16 a State in carrying out subsection (a) are, subject to
17 paragraph (2), expenditures reimbursable under the
18 appropriate paragraph of section 1903(a); except
19 that, notwithstanding any other provision of such
20 section, the applicable Federal matching rates with
21 respect to such expenditures under such section shall
22 be increased as follows (but in no case shall the rate
23 as so increased exceed 100 percent):

24 “(A) For expenditures attributable to costs
25 incurred during 2005, the otherwise applicable

1 Federal matching rate shall be increased by 10
2 percent of the percentage otherwise payable
3 (but for this subsection) by the State.

4 “(B)(i) For expenditures attributable to
5 costs incurred during 2006 and each subse-
6 quent year through 2013, the otherwise applica-
7 ble Federal matching rate shall be increased by
8 the applicable percent (as defined in clause (ii))
9 of the percentage otherwise payable (but for
10 this subsection) by the State.

11 “(ii) For purposes of clause (i), the ‘appli-
12 cable percent’ for—

13 “(I) 2006 is 20 percent; or

14 “(II) a subsequent year is the applica-
15 ble percent under this clause for the pre-
16 vious year increased by 10 percentage
17 points.

18 “(C) For expenditures attributable to costs
19 incurred after 2013, the otherwise applicable
20 Federal matching rate shall be increased to 100
21 percent.

22 “(2) COORDINATION.—The State shall provide
23 the Administrator with such information as may be
24 necessary to properly allocate administrative expend-

1 itures described in paragraph (1) that may otherwise
2 be made for similar eligibility determinations.”.

3 (b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID
4 RESPONSIBILITY FOR PREMIUM AND COST-SHARING SUB-
5 SIDIES FOR DUALY ELIGIBLE INDIVIDUALS.—

6 (1) IN GENERAL.—Section 1903(a)(1) (42
7 U.S.C. 1396b(a)(1)) is amended by inserting before
8 the semicolon the following: “, reduced by the
9 amount computed under section 1935(c)(1) for the
10 State and the quarter”.

11 (2) AMOUNT DESCRIBED.—Section 1935, as in-
12 serted by subsection (a)(2), is amended by adding at
13 the end the following new subsection:

14 “(c) FEDERAL ASSUMPTION OF MEDICAID PRE-
15 SCRIPTION DRUG COSTS FOR DUALY-ELIGIBLE BENE-
16 FICIARIES.—

17 “(1) IN GENERAL.—For purposes of section
18 1903(a)(1), for a State that is one of the 50 States
19 or the District of Columbia for a calendar quarter
20 in a year (beginning with 2005) the amount com-
21 puted under this subsection is equal to the product
22 of the following:

23 “(A) MEDICARE SUBSIDIES.—The total
24 amount of payments made in the quarter under
25 section 1860G (relating to premium and cost-

1 sharing prescription drug subsidies for low-in-
2 come medicare beneficiaries) that are attrib-
3 utable to individuals who are residents of the
4 State and are entitled to benefits with respect
5 to prescribed drugs under the State plan under
6 this title (including such a plan operating under
7 a waiver under section 1115).

8 “(B) STATE MATCHING RATE.—A propor-
9 tion computed by subtracting from 100 percent
10 the Federal medical assistance percentage (as
11 defined in section 1905(b)) applicable to the
12 State and the quarter.

13 “(C) PHASE-OUT PROPORTION.—The
14 phase-out proportion (as defined in paragraph
15 (2)) for the quarter.

16 “(2) PHASE-OUT PROPORTION.—For purposes
17 of paragraph (1)(C), the ‘phase-out proportion’ for
18 a calendar quarter in—

19 “(A) 2005 is 90 percent;

20 “(B) a subsequent year before 2014, is the
21 phase-out proportion for calendar quarters in
22 the previous year decreased by 10 percentage
23 points; or

24 “(C) a year after 2013 is 0 percent.”.

1 (c) MEDICAID PROVIDING WRAP-AROUND BENE-
2 FITS.—Section 1935, as so inserted and amended, is fur-
3 ther amended by adding at the end the following new sub-
4 section:

5 “(d) ADDITIONAL PROVISIONS.—

6 “(1) MEDICAID AS SECONDARY PAYOR.—In the
7 case of an individual who is entitled to qualified pre-
8 scription drug coverage under a prescription drug
9 plan under part D of title XVIII (or under a
10 Medicare+Choice plan under part C of such title)
11 and medical assistance for prescribed drugs under
12 this title, medical assistance shall continue to be pro-
13 vided under this title for prescribed drugs to the ex-
14 tent payment is not made under the prescription
15 drug plan or the Medicare+Choice plan selected by
16 the individual.

17 “(2) CONDITION.—A State may require, as a
18 condition for the receipt of medical assistance under
19 this title with respect to prescription drug benefits
20 for an individual eligible to obtain qualified prescrip-
21 tion drug coverage described in paragraph (1), that
22 the individual elect qualified prescription drug cov-
23 erage under section 1860A.”.

24 (d) TREATMENT OF TERRITORIES.—

1 (1) IN GENERAL.—Section 1935, as so inserted
2 and amended, is further amended—

3 (A) in subsection (a) in the matter pre-
4 ceding paragraph (1), by inserting “subject to
5 subsection (e)” after “section 1903(a)”;

6 (B) in subsection (c)(1), by inserting “sub-
7 ject to subsection (e)” after “1903(a)(1)”; and

8 (C) by adding at the end the following new
9 subsection:

10 “(e) TREATMENT OF TERRITORIES.—

11 “(1) IN GENERAL.—In the case of a State,
12 other than the 50 States and the District of
13 Columbia—

14 “(A) the previous provisions of this section
15 shall not apply to residents of such State; and

16 “(B) if the State establishes a plan de-
17 scribed in paragraph (2) (for providing medical
18 assistance with respect to the provision of pre-
19 scription drugs to medicare beneficiaries), the
20 amount otherwise determined under section
21 1108(f) (as increased under section 1108(g))
22 for the State shall be increased by the amount
23 specified in paragraph (3).

24 “(2) PLAN.—The plan described in this para-
25 graph is a plan that—

1 “(A) provides medical assistance with re-
2 spect to the provision of covered outpatient
3 drugs (as defined in section 1860B(f)) to low-
4 income medicare beneficiaries; and

5 “(B) assures that additional amounts re-
6 ceived by the State that are attributable to the
7 operation of this subsection are used only for
8 such assistance.

9 “(3) INCREASED AMOUNT.—

10 “(A) IN GENERAL.—The amount specified
11 in this paragraph for a State for a year is equal
12 to the product of—

13 “(i) the aggregate amount specified in
14 subparagraph (B); and

15 “(ii) the amount specified in section
16 1108(g)(1) for that State, divided by the
17 sum of the amounts specified in such sec-
18 tion for all such States.

19 “(B) AGGREGATE AMOUNT.—The aggre-
20 gate amount specified in this subparagraph
21 for—

22 “(i) 2005, is equal to \$20,000,000; or

23 “(ii) a subsequent year, is equal to the
24 aggregate amount specified in this sub-
25 paragraph for the previous year increased

1 by annual percentage increase specified in
2 section 1860B(b)(5) for the year involved.

3 “(4) REPORT.—The Administrator shall submit
4 to Congress a report on the application of this sub-
5 section and may include in the report such rec-
6 ommendations as the Administrator deems appro-
7 priate.”.

8 (2) CONFORMING AMENDMENT.—Section
9 1108(f) (42 U.S.C. 1308(f)) is amended by inserting
10 “and section 1935(e)(1)(B)” after “Subject to sub-
11 section (g)”.

12 (e) AMENDMENT TO BEST PRICE.—Section
13 1927(c)(1)(C)(i) (42 U.S.C. 1396r–8(c)(1)(C)(i)) is
14 amended—

15 (1) by striking “and” at the end of subclause
16 (III);

17 (2) by striking the period at the end of sub-
18 clause (IV) and inserting “; and”; and

19 (3) by adding at the end the following new sub-
20 clause:

21 “(V) any prices charged which
22 are negotiated by a prescription drug
23 plan under part D of title XVIII, by
24 a Medicare+Choice plan under part C
25 of such title with respect to covered

1 outpatient drugs, or by a qualified re-
2 tiree prescription drug plan (as de-
3 fined in section 1860H(f)(1)) with re-
4 spect to such drugs on behalf of indi-
5 viduals entitled to benefits under part
6 A or enrolled under part B of such
7 title.”.

8 **SEC. 104. MEDIGAP TRANSITION.**

9 (a) IN GENERAL.—Section 1882 (42 U.S.C. 1395ss)
10 is amended by adding at the end the following new sub-
11 section:

12 “(v) COVERAGE OF PRESCRIPTION DRUGS.—

13 “(1) IN GENERAL.—Notwithstanding any other
14 provision of law, except as provided in paragraph (3)
15 no new medicare supplemental policy that provides
16 coverage of expenses for prescription drugs may be
17 issued under this section on or after January 1,
18 2005, to an individual unless it replaces a medicare
19 supplemental policy that was issued to that indi-
20 vidual and that provided some coverage of expenses
21 for prescription drugs.

22 “(2) ISSUANCE OF SUBSTITUTE POLICIES IF
23 OBTAIN PRESCRIPTION DRUG COVERAGE UNDER
24 PART D.—

1 “(A) IN GENERAL.—The issuer of a medi-
2 care supplemental policy—

3 “(i) may not deny or condition the
4 issuance or effectiveness of a medicare
5 supplemental policy that has a benefit
6 package classified as ‘A’, ‘B’, ‘C’, ‘D’, ‘E’,
7 ‘F’, or ‘G’ (under the standards estab-
8 lished under subsection (p)(2)) and that is
9 offered and is available for issuance to new
10 enrollees by such issuer;

11 “(ii) may not discriminate in the prie-
12 ing of such policy, because of health sta-
13 tus, claims experience, receipt of health
14 care, or medical condition; and

15 “(iii) may not impose an exclusion of
16 benefits based on a pre-existing condition
17 under such policy,

18 in the case of an individual described in sub-
19 paragraph (B) who seeks to enroll under the
20 policy not later than 63 days after the date of
21 the termination of enrollment described in such
22 paragraph and who submits evidence of the
23 date of termination or disenrollment along with
24 the application for such medicare supplemental
25 policy.

1 “(B) INDIVIDUAL COVERED.—An indi-
2 vidual described in this subparagraph is an in-
3 dividual who—

4 “(i) enrolls in a prescription drug plan
5 under part D; and

6 “(ii) at the time of such enrollment
7 was enrolled and terminates enrollment in
8 a medicare supplemental policy which has
9 a benefit package classified as ‘H’, ‘I’, or
10 ‘J’ under the standards referred to in sub-
11 paragraph (A)(i) or terminates enrollment
12 in a policy to which such standards do not
13 apply but which provides benefits for pre-
14 scription drugs.

15 “(C) ENFORCEMENT.—The provisions of
16 paragraph (4) of subsection (s) shall apply with
17 respect to the requirements of this paragraph in
18 the same manner as they apply to the require-
19 ments of such subsection.

20 “(3) NEW STANDARDS.—In applying subsection
21 (p)(1)(E) (including permitting the NAIC to revise
22 its model regulations in response to changes in law)
23 with respect to the change in benefits resulting from
24 title I of the Medicare Modernization and Prescrip-
25 tion Drug Act of 2002, with respect to policies

1 issued to individuals who are enrolled under part D,
2 the changes in standards shall provide only provide
3 for substituting for the benefit packages that in-
4 cluded coverage for prescription drugs two benefit
5 packages that may provide for coverage of cost-shar-
6 ing with respect to qualified prescription drug cov-
7 erage under such part, except that such coverage
8 may not cover the prescription drug deductible
9 under such part. The two benefit packages shall be
10 consistent with the following:

11 “(A) FIRST NEW POLICY.—The policy de-
12 scribed in this subparagraph has the following
13 benefits, notwithstanding any other provision of
14 this section relating to a core benefit package:

15 “(i) Coverage of 50 percent of the
16 cost-sharing otherwise applicable, except
17 coverage of 100 percent of any cost-shar-
18 ing otherwise applicable for preventive ben-
19 efits.

20 “(ii) No coverage of the part B de-
21 ductible.

22 “(iii) Coverage for all hospital coin-
23 surance for long stays (as in the current
24 core benefit package).

1 “(iv) A limitation on annual out-of-
2 pocket expenditures to \$4,000 in 2005 (or,
3 in a subsequent year, to such limitation for
4 the previous year increased by an appro-
5 priate inflation adjustment specified by the
6 Secretary).

7 “(B) SECOND NEW POLICY.—The policy
8 described in this subparagraph has the same
9 benefits as the policy described in subparagraph
10 (A), except as follows:

11 “(i) Substitute ‘75 percent’ for ‘50
12 percent’ in clause (i) of such subpara-
13 graph.

14 “(ii) Substitute ‘\$2,000’ for ‘\$4,000’
15 in clause (iv) of such subparagraph.

16 “(4) CONSTRUCTION.—Any provision in this
17 section or in a medicare supplemental policy relating
18 to guaranteed renewability of coverage shall be
19 deemed to have been met through the offering of
20 other coverage under this subsection.”.

21 **SEC. 105. MEDICARE PRESCRIPTION DRUG DISCOUNT**
22 **CARD ENDORSEMENT PROGRAM.**

23 Title XVIII is amended by inserting after section
24 1806 the following new section:

1 “MEDICARE PRESCRIPTION DRUG DISCOUNT CARD
2 ENDORSEMENT PROGRAM

3 “SEC. 1807. (a) IN GENERAL.—The Secretary (or
4 the Medicare Benefits Administrator pursuant to section
5 1808(c)(3)(C)) shall establish a program—

6 “(1) to endorse prescription drug discount card
7 programs that meet the requirements of this section;
8 and

9 “(2) to make available to medicare beneficiaries
10 information regarding such endorsed programs.

11 “(b) REQUIREMENTS FOR ENDORSEMENT.—The
12 Secretary may not endorse a prescription drug discount
13 card program under this section unless the program meets
14 the following requirements:

15 “(1) SAVINGS TO MEDICARE BENEFICIARIES.—
16 The program passes on to medicare beneficiaries
17 who enroll in the program discounts on prescription
18 drugs, including discounts negotiated with manufac-
19 turers.

20 “(2) PROHIBITION ON APPLICATION ONLY TO
21 MAIL ORDER.—The program applies to drugs that
22 are available other than solely through mail order.

23 “(3) BENEFICIARY SERVICES.—The program
24 provides pharmaceutical support services, such as

1 education and counseling, and services to prevent
2 adverse drug interactions.

3 “(4) INFORMATION.—The program makes
4 available to medicare beneficiaries through the Inter-
5 net and otherwise information, including information
6 on enrollment fees, prices charged to beneficiaries,
7 and services offered under the program, that the
8 Secretary identifies as being necessary to provide for
9 informed choice by beneficiaries among endorsed
10 programs.

11 “(5) DEMONSTRATED EXPERIENCE.—The enti-
12 ty operating the program has demonstrated experi-
13 ence and expertise in operating such a program or
14 a similar program.

15 “(6) QUALITY ASSURANCE.—The entity has in
16 place adequate procedures for assuring quality serv-
17 ice under the program.

18 “(7) ADDITIONAL BENEFICIARY PROTEC-
19 TIONS.—The program meets such additional require-
20 ments as the Secretary identifies to protect and pro-
21 mote the interest of medicare beneficiaries, including
22 requirements that ensure that beneficiaries are not
23 charged more than the lower of the negotiated retail
24 price or the usual and customary price.

1 “(c) PROGRAM OPERATION.—The Secretary shall op-
2 erate the program under this section consistent with the
3 following:

4 “(1) PROMOTION OF INFORMED CHOICE.—In
5 order to promote informed choice among endorsed
6 prescription drug discount card programs, the Sec-
7 retary shall provide for the dissemination of infor-
8 mation which compares the costs and benefits of
9 such programs in a manner coordinated with the
10 dissemination of educational information on
11 Medicare+Choice plans under part C.

12 “(2) OVERSIGHT.—The Secretary shall provide
13 appropriate oversight to ensure compliance of en-
14 dored programs with the requirements of this sec-
15 tion, including verification of the discounts and serv-
16 ices provided.

17 “(3) USE OF MEDICARE TOLL-FREE NUMBER.—
18 The Secretary shall provide through the 1-800-medi-
19 care toll free telephone number for the receipt and
20 response to inquiries and complaints concerning the
21 program and programs endorsed under this section.

22 “(4) DISQUALIFICATION FOR ABUSIVE PRAC-
23 TICES.—The Secretary shall revoke the endorsement
24 of a program that the Secretary determines no
25 longer meets the requirements of this section or that

1 has engaged in false or misleading marketing prac-
2 tices.

3 “(5) ENROLLMENT PRACTICES.—A medicare
4 beneficiary may not be enrolled in more than one en-
5 dored program at any time.

6 “(d) TRANSITION.—The Secretary shall provide for
7 an appropriate transition and discontinuation of the pro-
8 gram under this section at the time prescription drug ben-
9 efits first become available under part D.

10 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
11 are authorized to be appropriated such sums as may be
12 necessary to carry out the program under this section.”.

13 **SEC. 106. GAO STUDY OF THE EFFECTIVENESS OF THE NEW**
14 **PRESCRIPTION DRUG PROGRAM.**

15 (a) STUDY.—The Comptroller General of the United
16 States shall conduct a study on the effectiveness of the
17 prescription drug program provided under part D of title
18 XVIII of the Social Security Act. Such study shall—

19 (1) report—

20 (A) the percentage of eligible individuals
21 who enrolled in the program;

22 (B) the demographic characteristics (in-
23 cluding health status) of such enrollees;

24 (C) the number and type of qualified pre-
25 scription drug coverage available to such indi-

1 viduals (including the percentage of enrollees
2 who had access to single or multiple plans); and

3 (D) the premiums imposed for enrollment
4 in different areas;

5 (2) evaluate the processes and methods devel-
6 oped by the Administrator and the decisions reached
7 by outside actuaries to determine the actuarial valu-
8 ation of prescription drug coverage; and

9 (3) assess whether the subsidy payments under
10 such part accomplished its stated goals of reducing
11 premium levels for all beneficiaries, reducing adverse
12 selection, and promoting participation of PDP spon-
13 sors.

14 (b) REPORT.—Not later January 1, 2006, the Comp-
15 troller General shall submit a report to Congress on the
16 study conducted under subsection (a).

○