

108TH CONGRESS  
1ST SESSION

# H. R. 2578

To amend title XVIII of the Social Security Act to establish a voluntary Medicare outpatient prescription drug discount and security program.

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## IN THE HOUSE OF REPRESENTATIVES

JUNE 24, 2003

Mr. BURR (for himself, Mr. BARTON of Texas, Mr. BUYER, Mr. NORWOOD, Mr. SHADEGG, Mr. AKIN, Mr. BARTLETT of Maryland, Mr. BURGESS, Mrs. CUBIN, Mr. HOEKSTRA, Mr. KING of Iowa, Mr. KLINE, Mr. OTTER, Mr. PITTS, Mr. TOOMEY, Mr. WELDON of Florida, Mr. GARRETT of New Jersey, and Mr. JONES of North Carolina) 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

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## A BILL

To amend title XVIII of the Social Security Act to establish a voluntary Medicare outpatient prescription drug discount and security program.

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

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Medicare for the 21st Century Act”.

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

Sec. 1. Short title; table of contents.

Sec. 2. Voluntary medicare outpatient prescription drug discount and security program.

“PART D—VOLUNTARY MEDICARE OUTPATIENT PRESCRIPTION DRUG  
 DISCOUNT AND SECURITY PROGRAM

“Sec. 1860D–1. Establishment of program.

“Sec. 1860D–2. Enrollment.

“Sec. 1860D–3. Enrollee protections.

“Sec. 1860D–4. Benefits under the program.

“Sec. 1860D–5. Prescription drug accounts.

“Sec. 1860D–6. Definitions.

Sec. 3. Exclusion of part D costs from determination of part B monthly premium.

Sec. 4. Medicaid amendments.

3 **SEC. 2. VOLUNTARY MEDICARE OUTPATIENT PRESCRIP-**  
 4 **TION DRUG DISCOUNT AND SECURITY PRO-**  
 5 **GRAM.**

6 (a) ESTABLISHMENT OF PROGRAM.—Title XVIII of  
 7 the Social Security Act (42 U.S.C. 1395 et seq.) is amend-  
 8 ed by redesignating part D as part E and by inserting  
 9 after part C the following new part:

10 “PART D—VOLUNTARY MEDICARE OUTPATIENT PRE-  
 11 SCRIPTON DRUG DISCOUNT AND SECURITY PRO-  
 12 GRAM

13 “ESTABLISHMENT OF PROGRAM

14 “SEC. 1860D–1. (a) PROVISION OF BENEFIT.—The  
 15 Secretary shall establish a Medicare Outpatient Prescrip-  
 16 tion Drug Discount and Security Program under this part  
 17 under which an eligible beneficiary who voluntarily enrolls  
 18 under this part is provided—

1           “(1) access to negotiated prices through an eli-  
2           gible entity with a contract under this part that has  
3           been selected by the beneficiary;

4           “(2) catastrophic coverage under this part; and

5           “(3) a prescription drug account and a public  
6           contribution into such an account.

7           “(b) ELIGIBLE BENEFICIARY; ELIGIBLE ENTITY;  
8           PRESCRIPTION DRUG ACCOUNT.—For purposes of this  
9           part:

10           “(1) ELIGIBLE BENEFICIARY.—The term ‘eligi-  
11           ble beneficiary’ means an individual who is eligible  
12           for benefits under part A or enrolled under part B,  
13           regardless of whether or not the individual is en-  
14           rolled with a plan under part C.

15           “(2) ELIGIBLE ENTITY.—The term ‘eligible en-  
16           tity’ means any entity that the Secretary determines  
17           to be appropriate to provide the benefits under this  
18           part, including—

19                   “(A) pharmaceutical benefit management  
20                   companies and pharmacists;

21                   “(B) wholesale and retail pharmacy deliv-  
22                   ery systems;

23                   “(C) insurers;

24                   “(D) Medicare+Choice organizations;

25                   “(E) other entities; or

1           “(F) any combination of the entities de-  
2           scribed in subparagraphs (A) through (E).

3           “(3) PRESCRIPTION DRUG ACCOUNT.—The  
4           term ‘prescription drug account’ means, with respect  
5           to an eligible beneficiary, an account established for  
6           the benefit of that beneficiary under section 1860D-  
7           5.

8           “(c) IMPLEMENTATION OF PROGRAM.—The Sec-  
9           retary shall establish the program under this part in a  
10          manner so that—

11           “(1) eligible beneficiaries may first enroll with  
12           eligible entities and obtain prescription drug dis-  
13           counts not later than 90 days after the date of the  
14           enactment of this part; and

15           “(2) benefits with respect to contributions to a  
16           prescription drug account and catastrophic coverage  
17           shall begin with the month of September 2004, but  
18           there shall be no catastrophic coverage provided for  
19           any period before January 1, 2005.

20           “(d) VOLUNTARY NATURE OF PROGRAM.—Nothing  
21           in this part shall be construed as requiring an eligible ben-  
22           eficiary to enroll in the program under this part.

23           “(e) FINANCING.—The costs of providing benefits  
24           under this part shall be payable from the Federal Supple-

1 mentary Medical Insurance Trust Fund established under  
2 section 1841.

3 “ENROLLMENT; SELECTION OF ELIGIBLE ENTITY

4 “SEC. 1860D–2. (a) ENROLLMENT UNDER PART  
5 D.—

6 “(1) ESTABLISHMENT OF PROCESS.—

7 “(A) IN GENERAL.—The Secretary shall  
8 establish a process through which an eligible  
9 beneficiary may make an election to enroll  
10 under this part.

11 “(B) REQUIREMENT OF ENROLLMENT.—  
12 An eligible beneficiary must enroll under this  
13 part for a year in order to be eligible to receive  
14 the benefits under this part for that year.

15 “(C) LIMITATION ON ENROLLMENT.—

16 “(i) IN GENERAL.—Except as pro-  
17 vided under this subparagraph and under  
18 such exceptional circumstances as the Sec-  
19 retary may provide, an eligible individual  
20 shall only have 1 opportunity to enroll  
21 under this part. The Secretary shall speci-  
22 fy the form, manner, and timing of such  
23 election but shall permit the exercise of  
24 such election at the time the individual is  
25 eligible to so enroll.

1           “(ii) LATE ENROLLMENT.—The Sec-  
2           retary shall permit individuals to elect to  
3           enroll under this part at times other than  
4           as permitted under the previous provisions  
5           of this paragraph, except that in the case  
6           of such a late enrollment the amount of  
7           the premiums for catastrophic coverage  
8           otherwise established under section  
9           1860D–4(b)(3) shall be increased by such  
10          percentage as the Secretary shall specify in  
11          order to deter adverse selection.

12          “(C) TERMINATION OF ENROLLMENT.—An  
13          enrollee under this part shall be disenrolled—

14                 “(i) upon failure to pay the applicable  
15                 enrollment fee under subsection (e) or the  
16                 premium for catastrophic coverage under  
17                 section 1860D–4(b);

18                 “(ii) upon termination of coverage  
19                 under part A or part B; or

20                 “(iii) upon notice submitted to the  
21                 Secretary in such form, manner, and time  
22                 as the Secretary shall provide.

23          Terminations of enrollment under this subpara-  
24          graph shall be effective as specified by the Sec-  
25          retary in regulations.

1           “(2) ENROLLMENT PERIODS.—

2                   “(A) IN GENERAL.—Except as provided  
3 under this paragraph, an eligible beneficiary  
4 may not enroll in the program under this part  
5 during any period after the beneficiary’s initial  
6 enrollment period under part B (as determined  
7 under section 1837).

8                   “(B) OPEN ENROLLMENT PERIOD FOR  
9 CURRENT BENEFICIARIES.—The Secretary shall  
10 establish a period, which shall begin on the date  
11 on which the Secretary first begins to accept  
12 elections for enrollment under this part and  
13 shall end on November 30, 2003, during which  
14 any eligible beneficiary may enroll under this  
15 part.

16                   “(C) SPECIAL ENROLLMENT PERIOD IN  
17 CASE OF TERMINATION OF COVERAGE UNDER A  
18 GROUP HEALTH PLAN.—The Secretary shall  
19 provide for a special enrollment period under  
20 this part in the same manner as is provided  
21 under section 1837(i) with respect to part B,  
22 except that for purposes of this subparagraph  
23 any reference to ‘by reason of the individual’s  
24 (or the individual’s spouse’s) current employ-  
25 ment status’ shall be treated as being deleted.

1 “(3) PERIOD OF COVERAGE.—

2 “(A) IN GENERAL.—Except as provided in  
3 subparagraph (B) and subject to subparagraph  
4 (C), an eligible beneficiary’s coverage under the  
5 program under this part shall be effective for  
6 the period provided under section 1838, as if  
7 that section applied to the program under this  
8 part.

9 “(B) ENROLLMENT DURING OPEN AND  
10 SPECIAL ENROLLMENT.—Subject to subpara-  
11 graph (C), an eligible beneficiary who enrolls  
12 under the program under this part under sub-  
13 paragraph (B) or (C) of paragraph (2) shall be  
14 entitled to the benefits under this part begin-  
15 ning on the first day of the month following the  
16 month in which such enrollment occurs.

17 “(b) SELECTION OF AN ELIGIBLE ENTITY FOR AC-  
18 CESS TO NEGOTIATED PRICES.—

19 “(1) PROCESS.—

20 “(A) IN GENERAL.—The Secretary shall  
21 establish a process through which an eligible  
22 beneficiary who is enrolled under this part shall  
23 select any eligible entity, that has been awarded  
24 a contract under this part and serves the State  
25 in which the beneficiary resides, to provide ac-

1           cess to negotiated prices under section 1860D–  
2           4(a).

3           “(B) RULES.—In establishing the process  
4           under subparagraph (A), the Secretary shall  
5           use rules similar to the rules for enrollment and  
6           disenrollment with a Medicare+Choice plan  
7           under section 1851 (including the special elec-  
8           tion periods under subsection (e)(4) of such sec-  
9           tion), including that—

10                   “(i) an individual may not select more  
11                   than one eligible entity at any time; and

12                   “(ii) an individual shall only be per-  
13                   mitted (except for unusual circumstances)  
14                   to change the selection of the entity once  
15                   a year.

16           In carrying out clause (ii), the Secretary may  
17           consider a change in residential setting (such as  
18           placement in a nursing facility) to be an un-  
19           usual circumstance.

20           “(C) DEFAULT SELECTION.—In estab-  
21           lishing such process, the Secretary shall provide  
22           an equitable method for the selection of an eli-  
23           gible entity for individuals who enroll under this  
24           part and fail to make such a selection.

1           “(2) COMPETITION.—Eligible entities with a  
2           contract under this part shall compete for bene-  
3           ficiaries on the basis of discounts, formularies, phar-  
4           macy networks, and other services provided for  
5           under the contract.

6           “(c) ENROLLMENT PERIOD FOR BENEFITS.—The  
7           processes developed under subsections (a) and (b) shall en-  
8           sure that eligible beneficiaries are permitted to enroll  
9           under this part and to select an eligible entity prior to  
10          90 days after the date of the enactment of this part, in  
11          order to ensure that prescription drug discount benefits  
12          are available under this part as of such date.

13          “(d) PROVIDING ENROLLMENT, SELECTION, AND  
14          COVERAGE INFORMATION TO BENEFICIARIES.—

15                 “(1) ACTIVITIES.—The Secretary shall provide  
16                 for activities under this part to broadly disseminate  
17                 information to eligible beneficiaries (and prospective  
18                 eligible beneficiaries) regarding enrollment under  
19                 this part, the selection of eligible entities, and the  
20                 prescription drug coverage made available by eligible  
21                 entities with a contract under this part.

22                 “(2) SPECIAL RULE FOR FIRST ENROLLMENT  
23                 UNDER THE PROGRAM.—To the extent practicable,  
24                 the activities described in paragraph (1) shall ensure  
25                 that eligible beneficiaries are provided with such in-

1 formation at least 60 days prior to the first enroll-  
2 ment period described in section 1860D–2(c).

3 “(e) ENROLLMENT FEE.—

4 “(1) AMOUNT.—

5 “(A) IN GENERAL.—Except as provided in  
6 paragraph (3), enrollment under the program  
7 under this part is conditioned upon payment of  
8 an annual enrollment fee of \$30 for 2004 (in-  
9 cluding any portion of 2003 in which the pro-  
10 gram is implemented under this section), plus  
11 the premium for catastrophic coverage provided  
12 under section 1860D–4(b)(3).

13 “(B) ANNUAL PERCENTAGE INCREASE IN  
14 ENROLLMENT FEE.—

15 “(i) IN GENERAL.—In the case of any  
16 calendar year beginning after 2004, the  
17 dollar amount of the enrollment fee in sub-  
18 paragraph (A) shall be increased by an  
19 amount equal to—

20 “(I) such dollar amount; multi-  
21 plied by

22 “(II) the annual percentage in-  
23 crease in the consumer price index for  
24 all urban consumers (all items; U.S.

1 city average) for the year ending in  
2 September of the previous year.

3 “(ii) ROUNDING.—If any increase de-  
4 termined under clause (i)(II) is not a mul-  
5 tiple of \$1, such increase shall be rounded  
6 to the nearest multiple of \$1.

7 “(2) COLLECTION OF ENROLLMENT FEE.—The  
8 annual enrollment fee shall be collected and credited  
9 to the Federal Supplementary Medical Insurance  
10 Trust Fund in the same manner as the monthly pre-  
11 mium determined under section 1839 is collected  
12 and credited to such Trust Fund under section  
13 1840, except that it shall be collected only 1 time  
14 per year.

15 “(3) PAYMENT OF ENROLLMENT FEE BY STATE  
16 FOR CERTAIN BENEFICIARIES.—

17 “(A) IN GENERAL.—The Secretary shall  
18 establish an arrangement under which a State  
19 may provide for payment of some or all of the  
20 enrollment fee for some or all qualifying low in-  
21 come enrollees in the State, as specified by the  
22 State under the arrangement. Insofar as such a  
23 payment arrangement is made with respect to  
24 an enrollee, the amount of the enrollment fee  
25 shall be paid directly by the State and shall not

1 be collected under paragraph (2). In carrying  
2 out this paragraph, the Secretary may apply  
3 procedures similar to that applied under state  
4 agreements under section 1843.

5 “(B) NO FEDERAL MATCHING AVAILABLE  
6 UNDER MEDICAID OR SCHIP.—Expenditures  
7 made by a State described in subparagraph (A)  
8 shall not be treated as State expenditures for  
9 purposes of Federal matching payments under  
10 titles XIX and XXI insofar as such expendi-  
11 tures are for an enrollment fee under this sub-  
12 section.

13 “(4) DISTRIBUTION OF PORTION OF ENROLL-  
14 MENT FEE.—Of the enrollment fee collected by the  
15 Secretary under this paragraph with respect to a  
16 beneficiary,  $\frac{2}{3}$  of that fee shall be made available to  
17 the eligible entity selected by the eligible beneficiary.

18 “(f) ISSUANCE OF CARD AND COORDINATION.—Each  
19 eligible entity shall—

20 “(1) issue, in a uniform standard format speci-  
21 fied by the Secretary, to each enrolled beneficiary a  
22 card and an enrollment number that establishes  
23 proof of enrollment and that can be used in a coordi-  
24 nated manner—

1           “(A) to identify the eligible entity selected  
2           to provide access to negotiated prices under sec-  
3           tion 1860D–4(a);

4           “(B) to identify the beneficiary for pur-  
5           poses of the catastrophic coverage under section  
6           1860D–4(b) and, including tracking expendi-  
7           tures that count against the catastrophic cov-  
8           erage threshold; and

9           “(C) to make deposits to and withdrawals  
10          from a prescription drug account under section  
11          1860D–5; and

12          “(2) provide for electronic methods to coordi-  
13          nate with such prescription drug accounts.

14                           “ENROLLEE PROTECTIONS

15          “SEC. 1860D–3. (a) GUARANTEED ISSUE AND NON-  
16          DISCRIMINATION.—

17                           “(1) GUARANTEED ISSUE.—

18                           “(A) IN GENERAL.—An eligible beneficiary  
19                           who is eligible to select an eligible entity under  
20                           section 1860D–2(b) for prescription drug cov-  
21                           erage under this part at a time during which  
22                           selections are accepted under this part with re-  
23                           spect to the coverage shall not be denied selec-  
24                           tion based on any health status-related factor  
25                           (described in section 2702(a)(1) of the Public  
26                           Health Service Act) or any other factor and

1           may not be charged any selection or other fee  
2           as a condition of such acceptance.

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

10          “(2) NONDISCRIMINATION.—An eligible entity  
11          offering prescription drug coverage under this part  
12          shall not establish a service area in a manner that  
13          would discriminate based on health or economic sta-  
14          tus of potential enrollees.

15          “(3) COVERAGE OF ALL PORTIONS OF A  
16          STATE.—If an eligible entity with a contract under  
17          this part serves any part of a State it shall serve the  
18          entire State.

19          “(b) DISSEMINATION OF INFORMATION.—

20          “(1) GENERAL INFORMATION.—An eligible enti-  
21          ty with a contract under this part shall disclose, in  
22          a clear, accurate, and standardized form to each eli-  
23          gible beneficiary who has selected the entity to pro-  
24          vide access to negotiated prices under this part at  
25          the time of selection and at least annually there-

1 after, the information described in section  
2 1852(e)(1) relating to such prescription drug cov-  
3 erage. Such information includes the following (in a  
4 manner designed to permit and promote competition  
5 among eligible entities and to be understood by eligi-  
6 ble beneficiaries with mental impairments):

7 “(A) Summary information regarding ne-  
8 gotiated prices (including discounts) for covered  
9 outpatient drugs.

10 “(B) Access to such prices through phar-  
11 macy networks.

12 “(C) How any formulary used by the eligi-  
13 ble entity functions.

14 “(D) Any use of tiered copayments.

15 The eligible entity also shall notify enrolled bene-  
16 ficiaries when there is a change in the formulary  
17 during the year.

18 “(2) DISCLOSURE UPON REQUEST OF GENERAL  
19 COVERAGE, UTILIZATION, AND GRIEVANCE INFORMA-  
20 TION.—Upon request of an eligible beneficiary, the  
21 eligible entity shall provide the information described  
22 in section 1852(e)(2) (other than subparagraph (D))  
23 to such beneficiary.

24 “(3) RESPONSE TO BENEFICIARY QUESTIONS.—

25 Each eligible entity offering prescription drug cov-

1 erage under this part shall have a mechanism (in-  
2 cluding a toll-free telephone number) for providing  
3 upon request specific information (such as nego-  
4 tiated prices, including discounts) to individuals who  
5 have selected the entity. The entity shall make avail-  
6 able, through an Internet website and in writing  
7 upon request, information on specific changes in its  
8 formulary.

9 “(4) COORDINATION WITH CATASTROPHIC COV-  
10 ERAGE AND PRESCRIPTION DRUG ACCOUNT BENE-  
11 FITS.—Each such eligible entity shall provide for co-  
12 ordination of such information as the Secretary may  
13 specify to carry out sections 1860D–4(b) and  
14 1860D–5.

15 “(5) DISCLOSURE.—Each such eligible entity  
16 shall disclose to the Secretary (in a manner specified  
17 by the Secretary) the extent to which discounts or  
18 rebates or other remuneration or price concessions  
19 made available to the entity by a manufacturer are  
20 passed through to enrollees through pharmacies and  
21 other dispensers or otherwise. The provisions of sec-  
22 tion 1927(b)(3)(D) shall apply to information dis-  
23 closed to the Secretary under this paragraph in the  
24 same manner as such provisions apply to informa-  
25 tion disclosed under such section.

1 “(c) ACCESS TO COVERED BENEFITS.—

2 “(1) ENSURING PHARMACY ACCESS.—

3 “(A) PARTICIPATION OF ANY WILLING  
4 PHARMACY.—The eligible entity shall permit  
5 the participation of any pharmacy that meets  
6 terms and conditions that the entity has estab-  
7 lished.

8 “(B) DISCOUNTS ALLOWED FOR NETWORK  
9 PHARMACIES.—An eligible entity may, notwith-  
10 standing subparagraph (A), reduce coinsurance  
11 or copayments for its enrolled beneficiaries  
12 below the level otherwise provided for covered  
13 outpatient drugs dispensed through in-network  
14 pharmacies, but in no case shall such a reduc-  
15 tion result in an increase in payments made by  
16 the Secretary under this part.

17 “(C) CONVENIENT ACCESS FOR NETWORK  
18 PHARMACIES.—The eligible entity shall secure  
19 the participation in its network of a sufficient  
20 number of pharmacies that dispense (other than  
21 by mail order) drugs directly to patients to en-  
22 sure convenient access, consistent with rules of  
23 the Secretary. The Secretary shall establish  
24 convenient access rules under this subpara-  
25 graph that are no less favorable to enrollees

1 than the rules for convenient access to phar-  
2 macies of the Secretary of Defense established  
3 as of June 1, 2003, for purposes of the  
4 TRICARE Retail Pharmacy (TRRx) program.  
5 Such rules shall include adequate emergency ac-  
6 cess for enrolled beneficiaries.

7 “(D) LEVEL PLAYING FIELD.—An eligible  
8 entity shall permit enrollees to receive benefits  
9 (which may include a 90-day supply of drugs or  
10 biologicals) through a community pharmacy,  
11 rather than through mail order, with any dif-  
12 ferential in cost paid by such enrollees.

13 “(E) NOT REQUIRED TO ACCEPT INSUR-  
14 ANCE RISK.—The terms and conditions under  
15 subparagraph (A) may not require participating  
16 pharmacies to accept insurance risk as a condi-  
17 tion of participation.

18 “(2) ACCESS TO NEGOTIATED PRICES FOR PRE-  
19 SCRIPTON DRUGS.—For requirements relating to  
20 the access of an eligible beneficiary to negotiated  
21 prices (including applicable discounts), see section  
22 1860D–4(a).

23 “(3) REQUIREMENTS ON DEVELOPMENT AND  
24 APPLICATION OF FORMULARIES.—Insofar as an eli-

1 gible entity with a contract under this part uses a  
2 formulary, the following requirements must be met:

3 “(A) PHARMACY AND THERAPEUTIC (P&T)  
4 COMMITTEE.—The entity must establish a  
5 pharmacy and therapeutic committee that de-  
6 velops and reviews the formulary. Such com-  
7 mittee shall include at least one practicing phy-  
8 sician and at least one practicing pharmacist  
9 both with expertise in the care of elderly or dis-  
10 abled persons and a majority of its members  
11 shall consist of individuals who are practicing  
12 physicians or practicing pharmacists (or both).

13 “(B) FORMULARY DEVELOPMENT.—In de-  
14 veloping and reviewing the formulary, the com-  
15 mittee shall—

16 “(i) base clinical decisions on the  
17 strength of scientific evidence and stand-  
18 ards of practice, including assessing peer-  
19 reviewed medical literature, such as ran-  
20 domized clinical trials, pharmacoeconomic  
21 studies, outcomes research data, and such  
22 other information as the committee deter-  
23 mines to be appropriate; and

24 “(ii) shall take into account whether  
25 including in the formulary particular cov-

1           ered outpatient drugs has therapeutic ad-  
2           vantages in terms of safety and efficacy.

3           “(C) INCLUSION OF DRUGS IN ALL THERA-  
4           PEUTIC CATEGORIES.—The formulary must in-  
5           clude drugs within each therapeutic category  
6           and class of covered outpatient drugs (although  
7           not necessarily for all drugs within such cat-  
8           egories and classes). In establishing such class-  
9           es, the committee shall take into account the  
10          standards published in the United States Phar-  
11          macopeia-Drug Information. The committee  
12          shall make available to the enrollees under the  
13          plan through the Internet or otherwise the clin-  
14          ical bases for the coverage of any drug on the  
15          formulary.

16          “(D) PROVIDER AND PATIENT EDU-  
17          CATION.—The committee shall establish policies  
18          and procedures to educate and inform health  
19          care providers and enrollees concerning the for-  
20          mulary.

21          “(E) NOTICE BEFORE REMOVING DRUG  
22          FROM FORMULARY OR CHANGING PREFERRED  
23          OR TIER STATUS OF DRUG.—Any removal of a  
24          covered outpatient drug from a formulary and  
25          any change in the preferred or tier cost-sharing

1 status of such a drug shall take effect only  
2 after appropriate notice is made available to  
3 beneficiaries and physicians.

4 “(F) PERIODIC EVALUATION OF PROTO-  
5 COLS.—In connection with the formulary, an el-  
6 igible entity shall provide for the periodic eval-  
7 uation and analysis of treatment protocols and  
8 procedures.

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

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

16 “(1) IN GENERAL.—For purposes of providing  
17 access to negotiated benefits under section 1860D-  
18 4(a) and the catastrophic benefit described in sec-  
19 tion 1860D-4(b), the eligible entity shall have in  
20 place—

21 “(A) an effective cost and drug utilization  
22 management program, including appropriate in-  
23 centives to use generic drugs, 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

4 “(C) a program to control fraud, abuse,  
5 and waste.

6 “(2) MEDICATION THERAPY MANAGEMENT PRO-  
7 GRAM.—

8 “(A) IN GENERAL.—A medication therapy  
9 management program described in this para-  
10 graph is a program of drug therapy manage-  
11 ment and medication administration that may  
12 be furnished by a pharmacy provider and that  
13 is designed to assure, with respect to bene-  
14 ficiaries at risk for potential medication prob-  
15 lems, such as beneficiaries with complex or  
16 chronic diseases (such as diabetes, asthma, hy-  
17 pertension, and congestive heart failure) or  
18 multiple prescriptions, that covered outpatient  
19 drugs under the plans under this part are ap-  
20 propriately used to optimize therapeutic out-  
21 comes through improved medication use and re-  
22 duce the risk of adverse events, including ad-  
23 verse drug interactions. Such programs may  
24 distinguish between services in ambulatory and  
25 institutional settings.

1           “(B) ELEMENTS.—Such program may in-  
2           clude—

3                   “(i) enhanced beneficiary under-  
4                   standing to promote the appropriate use of  
5                   medications by beneficiaries and to reduce  
6                   the risk of potential adverse events associ-  
7                   ated with medications, through beneficiary  
8                   education, counseling, case management,  
9                   disease state management programs, and  
10                  other appropriate means;

11                  “(ii) increased beneficiary adherence  
12                  with prescription medication regimens  
13                  through medication refill reminders, special  
14                  packaging, and other compliance programs  
15                  and other appropriate means; and

16                  “(iii) detection of patterns of overuse  
17                  and underuse of prescription drugs.

18           “(C) DEVELOPMENT OF PROGRAM IN CO-  
19           OPERATION WITH LICENSED PHARMACISTS.—  
20           The program shall be developed in cooperation  
21           with licensed and practicing pharmacists and  
22           physicians.

23           “(D) CONSIDERATIONS IN PHARMACY  
24           FEES.—Each eligible entity shall take into ac-  
25           count, in establishing fees for pharmacists and

1 others providing services under the medication  
2 therapy management program, the resources  
3 and time used in implementing the program.  
4 Each such entity shall disclose to the Secretary  
5 upon request the amount of any such manage-  
6 ment or dispensing fees.

7 “(3) TREATMENT OF ACCREDITATION.—Section  
8 1852(e)(4) (relating to treatment of accreditation)  
9 shall apply to prescription drug coverage provided  
10 under this part with respect to the following require-  
11 ments, in the same manner as they apply to  
12 Medicare+Choice plans under part C with respect to  
13 the requirements described in a clause of section  
14 1852(e)(4)(B):

15 “(A) Subsection (c)(1) (relating to access  
16 to covered benefits).

17 “(B) Subsection (g) (relating to confiden-  
18 tiality and accuracy of enrollee records).

19 “(4) PUBLIC DISCLOSURE OF PHARMACEUTICAL  
20 PRICES FOR EQUIVALENT DRUGS.—Each eligible en-  
21 tity shall provide that each pharmacy or other dis-  
22 penser that arranges for the dispensing of a covered  
23 outpatient drug shall inform the beneficiary at the  
24 time of purchase of the drug of any differential be-  
25 tween the price of the prescribed drug to the enrollee

1 and the price of the lowest cost available generic  
2 drug covered under the plan that is therapeutically  
3 equivalent and bioequivalent.

4 “(e) GRIEVANCE MECHANISM, COVERAGE DETER-  
5 MINATIONS, AND RECONSIDERATIONS.—

6 “(1) IN GENERAL.—Each eligible entity shall  
7 provide meaningful procedures for hearing and re-  
8 solving grievances between the entity (including any  
9 entity or individual through which the entity pro-  
10 vides covered benefits) and enrollees in accordance  
11 with section 1852(f).

12 “(2) APPLICATION OF COVERAGE DETERMINA-  
13 TION AND RECONSIDERATION PROVISIONS.—An eli-  
14 gible entity shall meet the requirements of para-  
15 graphs (1) through (3) of section 1852(g) with re-  
16 spect to covered benefits under the plan it offers  
17 under this part in the same manner as such require-  
18 ments apply to an organization with respect to bene-  
19 fits it offers under a plan under part C.

20 “(3) REQUEST FOR REVIEW OF TIERED FOR-  
21 MULARY DETERMINATIONS.—In the case of a plan  
22 offered by an eligible entity that provides for tiered  
23 cost-sharing for drugs included within a formulary  
24 and provides lower cost-sharing for preferred drugs  
25 included within the formulary, an individual who is

1 enrolled in the plan may request coverage of a non-  
2 preferred drug under the terms applicable for pre-  
3 ferred drugs if the prescribing physician determines  
4 that the preferred drug for treatment of the same  
5 condition either would not be as effective for the in-  
6 dividual or would have adverse effects for the indi-  
7 vidual or both.

8 “(f) APPEALS.—

9 “(1) IN GENERAL.—Subject to paragraph (2),  
10 an eligible entity shall meet the requirements of  
11 paragraphs (4) and (5) of section 1852(g) with re-  
12 spect to drugs (including a determination related to  
13 the application of tiered cost-sharing described in  
14 subsection (e)(3)) in the same manner as such re-  
15 quirements apply to an organization with respect to  
16 benefits it offers under a plan under part C.

17 “(2) FORMULARY DETERMINATIONS.—An indi-  
18 vidual who is enrolled in a plan offered by an eligible  
19 entity may appeal to obtain coverage for a covered  
20 outpatient drug that is not on a formulary of the en-  
21 tity offering the plan if the prescribing physician de-  
22 termines that the formulary drug for treatment of  
23 the same condition either would not be as effective  
24 for the individual or would have adverse effects for  
25 the individual or both.

1           “(g) CONFIDENTIALITY AND ACCURACY OF EN-  
2 ROLLEE RECORDS.—An eligible entity shall meet the re-  
3 quirements of section 1852(h) with respect to enrollees  
4 under this section in the same manner as such require-  
5 ments apply to a Medicare Advantage organization with  
6 respect to enrollees under part C. The eligible entity shall  
7 implement policies and procedures to safeguard the use  
8 and disclosure of enrollees’ individually identifiable health  
9 information in a manner consistent with the Federal regu-  
10 lations (concerning the privacy of individually identifiable  
11 health information) promulgated under section 264(e) of  
12 the Health Insurance Portability and Accountability Act  
13 of 1996. The eligible entity shall be treated as a covered  
14 entity for purposes of the provisions of subpart E of part  
15 164 of title 45, Code of Federal Regulations, adopted pur-  
16 suant to the authority of the Secretary under section  
17 264(e) of the Health Insurance Portability and Account-  
18 ability Act of 1996 (42 U.S. C. 1320d–2 note).

19           “(h) OVERSIGHT.—The Secretary shall provide ap-  
20 propriate oversight to ensure compliance of eligible entities  
21 with the requirements of this section, including  
22 verification of the discounts and services provided.

23                           “BENEFITS UNDER THE PROGRAM

24           “SEC. 1860D–4. (a) SAVINGS TO ENROLLEES  
25 THROUGH NEGOTIATED PRICES.—

1           “(1) IN GENERAL.—Subject to paragraph (2),  
2           each eligible entity with a contract under this part  
3           shall provide each eligible beneficiary enrolled with  
4           the entity with access to negotiated prices (including  
5           applicable discounts). For purposes of this para-  
6           graph, the term ‘prescription drugs’ is not limited to  
7           covered outpatient drugs, but does not include any  
8           over-the-counter drug that is not a covered out-  
9           patient drug. The prices negotiated by an eligible en-  
10          tity under this paragraph shall (notwithstanding any  
11          other provision of law) not be taken into account for  
12          the purposes of establishing the best price under sec-  
13          tion 1927(c)(1)(C).

14          “(2) FORMULARY RESTRICTIONS.—Insofar as  
15          an eligible entity with a contract under this part  
16          uses a formulary, the negotiated prices (including  
17          applicable discounts) for prescription drugs shall  
18          only be available for drugs included in such for-  
19          mulary.

20          “(3) PROHIBITION ON APPLICATION ONLY TO  
21          MAIL ORDER.—The negotiated prices under this sub-  
22          section shall apply to prescription drugs that are  
23          available other than solely through mail order.

24          “(4) PROHIBITION ON CHARGES FOR REQUIRED  
25          SERVICES.—An eligible entity (and any pharmacy

1 contracting with such entity for the provision of a  
2 discount under this part) may not charge a bene-  
3 ficiary any amount for any services required to be  
4 provided by the entity under this part.

5 “(b) CATASTROPHIC COVERAGE.—

6 “(1) THROUGH COMPETITION AMONG PRIVATE  
7 PLANS.—

8 “(A) IN GENERAL.—Each enrollee under  
9 this part shall be entitled to catastrophic cov-  
10 erage through a contract with a qualified pri-  
11 vate entity under this subsection.

12 “(B) CONTRACT REQUIREMENTS TO PRO-  
13 MOTE COMPETITION.—The Secretary shall  
14 enter into contracts with qualified private enti-  
15 ties to offer the catastrophic coverage under  
16 this subsection. To the maximum extent prac-  
17 ticable, the Secretary shall enter into such con-  
18 tracts in a manner so that enrollees in all areas  
19 have a choice among at least 3 such entities to  
20 obtain the catastrophic coverage. Such an entity  
21 may be an eligible entity with a contract under  
22 subsection (a). Each such entity shall meet  
23 such financial solvency and other requirements  
24 as the Secretary determines to be necessary to  
25 carry out the program under this subsection.

1           Such a contract shall provide for the prospec-  
2           tive assumption of the maximum amount of risk  
3           under the contract as the Secretary may nego-  
4           tiate. In providing catastrophic coverage under  
5           this subsection, the qualified private entities  
6           (and not the Secretary) shall establish the pay-  
7           ment rates for drugs so covered.

8           “(C) CONTINGENCY.—If the Secretary is  
9           otherwise unable to enter into a contract with  
10          any qualified private entity under this para-  
11          graph for the offering of catastrophic coverage  
12          for enrollees in an area, the Secretary shall oth-  
13          erwise provide directly for the offering of the  
14          catastrophic coverage under this subsection to  
15          such enrollees. In such contingency, the pay-  
16          ment rates for drugs so covered shall be the  
17          rates established by entities offering price dis-  
18          counts under this part.

19          “(2) SCOPE OF COVERAGE.—

20                  “(A) SCOPE.—

21                          “(i) IN GENERAL.—Subject to para-  
22                          graph (4), the catastrophic coverage under  
23                          this section shall consist of payment under  
24                          this part for incurred expenses for covered  
25                          outpatient drugs for an enrollee, less the

1 applicable copayment amount under para-  
2 graph (4), after the enrollee has incurred  
3 in a year expenses that equal the cata-  
4 strophic coverage threshold specified in  
5 subparagraph (C) or (D) for the enrollee  
6 and year involved.

7 “(ii) PAYMENT RATE.—The rate of  
8 payment negotiated (or agreed to) by the  
9 eligible entity with the manufacturer for a  
10 covered outpatient drug shall be the  
11 amount paid under this part on behalf of  
12 the individual for the drug except as may  
13 otherwise be provided under the contract  
14 under paragraph (1).

15 “(B) COUNTING ALL INCURRED EX-  
16 PENSES.—

17 “(i) IN GENERAL.—In applying sub-  
18 paragraph (A), expenses shall be treated as  
19 incurred if they are paid directly from the  
20 prescription drug account of the individual  
21 or, subject to clause (ii), if they are paid  
22 by the individual or by any other person,  
23 including a family member, on behalf of  
24 the individual or otherwise, whether or not  
25 such expenses may otherwise be reim-

1 bursed through insurance or otherwise, a  
2 group health plan, or other third-party  
3 payment arrangement, but shall not in-  
4 clude expenses insofar as payment is made  
5 for such expenses under part A or part B  
6 of this title.

7 “(ii) REQUIREMENT FOR ACCOUNT  
8 NUMBER ON ALL COUNTABLE TRANS-  
9 ACTIONS.—Expenses that are not paid di-  
10 rectly from a prescription drug account  
11 shall be counted under clause (i) only if,  
12 under such process as the Secretary shall  
13 recognize, the account number of the indi-  
14 vidual’s prescription drug account is part  
15 of the transaction involved.

16 “(C) CATASTROPHIC COVERAGE THRESH-  
17 OLDS.—

18 “(i) INITIAL CATASTROPHIC COV-  
19 ERAGE THRESHOLD.—Subject to clause  
20 (ii), the catastrophic coverage threshold is  
21 \$10,000.

22 “(ii) INFLATION ADJUSTMENT.—The  
23 provisions of subsection (c)(2)(B) shall  
24 apply with respect to the catastrophic cov-  
25 erage threshold under clause (i) for a year

1 after 2004 in the same manner as it ap-  
2 plied to the annual Federal contribution  
3 amount for that year, except that, for pur-  
4 poses of this subparagraph, any reference  
5 in subsection (c)(2)(B)(ii) to ‘\$1’ is  
6 deemed a reference to ‘\$100’.

7 “(3) PREMIUMS.—

8 “(A) IN GENERAL.—The premium for cat-  
9 astrophic coverage under this subsection  
10 through a qualified private entity shall be the  
11 rate negotiated by the Secretary with the entity  
12 reduced by the premium subsidy under this  
13 paragraph. Such rate shall be consistent with  
14 rules similar to the rules applied under section  
15 1860D–3(a) for eligible entities offering pre-  
16 scription drug coverage (including guaranteed  
17 issue, community-rated premiums, and non-  
18 discrimination). In the case described in para-  
19 graph (1)(C), such premium shall be based on  
20 an actuarial basis specified by the Secretary.

21 “(B) SUBSIDIZED PREMIUMS.—

22 “(i) FULL PREMIUM SUBSIDY FOR  
23 QUALIFYING LOW INCOME ENROLLEES.—  
24 In the case of an enrollee who is a quali-  
25 fying low income enrollee (as defined in

1 section 1860D–6(5)) for a month, there  
2 shall be a premium subsidy equal to the  
3 average of the premiums under subpara-  
4 graph (A) for catastrophic coverage under  
5 this subsection in the area in which the en-  
6 rollee resides.

7 “(ii) SLIDING SCALE PREMIUM SUB-  
8 SIDIES FOR OTHER ENROLLEES.—In the  
9 case of an enrollee who is not a qualifying  
10 low income enrollee (as so defined) but  
11 would be a qualifying low income enrollee  
12 (as defined in section 1860D–6(5)) for a  
13 month if 250 percent were substituted for  
14 175 percent in such section, there shall be  
15 a premium subsidy equal to a percentage  
16 of the average referred to in clause (i),  
17 with such percentage determined on a slid-  
18 ing scale from—

19 “(I) 75 percent for enrollees with  
20 income equal to 175 percent of the  
21 poverty line; to

22 “(II) 0 percent for enrollees with  
23 income equal to 250 percent of such  
24 poverty line.

1           “(C) COLLECTION.—Premiums under this  
2 paragraph shall be collected in the manner  
3 specified in section 1860D–2(e)(2) but shall be  
4 paid over, in a manner specified by the Sec-  
5 retary, to the entity that offers the catastrophic  
6 coverage. Premium subsidies under subpara-  
7 graph (B) shall also be paid over in such a  
8 manner to such an entity.

9           “(4) APPLICABLE COPAYMENT AMOUNTS.—

10           “(A) IN GENERAL.—For purposes of this  
11 subsection, subject to subparagraphs (D) and  
12 (E), the term ‘applicable copayment amount’,  
13 with respect to an enrollee that has selected an  
14 eligible entity under this part and for a covered  
15 outpatient drug that is—

16           “(i) a multiple source or generic drug  
17 (as described in section 1927(k)(7)(A)(i)),  
18 means \$3;

19           “(ii) a single source or brand-name  
20 drug (as described in section  
21 1927(k)(7)(A)(iv))) that is included in for-  
22 mulary of that eligible entity, means \$5; or

23           “(iii) any other drug, means \$10.

24           In the case of a private contract entered into  
25 under paragraph (1), the Secretary may provide

1 for the substitution of the qualifying private en-  
2 tity offering such contract for the eligible entity  
3 under this subparagraph.

4 “(B) COLLECTION.—Nothing in this para-  
5 graph shall be construed as preventing a phar-  
6 macy from requiring, as a condition of sup-  
7 plying covered outpatient drugs to any enrollee,  
8 that payment is made of the applicable copay-  
9 ment amount under subparagraph (A).

10 “(C) NO FEDERAL MATCHING AVAILABLE  
11 UNDER MEDICAID OR SCHIP TO COVER COPAY-  
12 MENT AMOUNTS.—No expenditure of a State  
13 that reimburses for, or otherwise covers, any co-  
14 payment amounts established under this para-  
15 graph may be treated as State expenditures for  
16 purposes of Federal matching payments under  
17 titles XIX and XXI.

18 “(D) ALTERNATIVE TIERS PERMITTED FOR  
19 CATASTROPHIC COVERAGE.—With respect to cata-  
20 strophic coverage, an eligible entity may provide for  
21 tiered copayments that are different from the copay-  
22 ments specified in subparagraph (A) so long as co-  
23 payment amounts resulting from such application  
24 approximate the copayment amounts that would re-

1 sult from the application of the copayments under  
2 such subparagraph.

3 “(E) APPLICATION OF FORMULARY AT CATA-  
4 STROPHIC COVERAGE LIMIT.—Once an eligible bene-  
5 ficiary reaches the catastrophic coverage limit on  
6 prescription drug expenses, such beneficiary is sub-  
7 ject to the formulary of the eligible entity and rules  
8 regarding catastrophic coverage.

9 “(5) ADMINISTRATION.—Insofar as the Sec-  
10 retary does not provide for the catastrophic coverage  
11 under this subsection through a contract with a  
12 qualifying private entity, the Secretary is authorized  
13 to enter into such agreements with entities as may  
14 be required to provide for the benefits under this  
15 subsection. Such entities may be eligible entities,  
16 carriers under part B, fiscal intermediaries under  
17 part A, or other qualified entities.

18 “(6) SECONDARY PAYER PROVISIONS.—The  
19 provisions of section 1862(b) shall apply to the bene-  
20 fits provided under this subsection.

21 “(c) CONTRIBUTION INTO PRESCRIPTION DRUG AC-  
22 COUNT.—

23 “(1) IN GENERAL.—In the case of an individual  
24 enrolled under this part—

1           “(A) the Secretary shall establish a pre-  
2           scription drug account for the individual under  
3           section 1860D–5; and

4           “(B) shall deposit into such account on a  
5           monthly or other periodic basis an amount that,  
6           on an annual basis, is equivalent to the annual  
7           Federal contribution amount specified in para-  
8           graph (2) for the enrollee involved.

9           Amounts so deposited shall not be treated as income  
10          to the accountholder for purposes of the Internal  
11          Revenue Code of 1986.

12          “(2) ANNUAL FEDERAL CONTRIBUTION  
13          AMOUNT.—

14                 “(A) INITIAL AMOUNT.—Subject to sub-  
15                 paragraph (B) and subsection (d), in the case  
16                 of an accountholder whose modified adjusted  
17                 gross income is—

18                         “(i) not more than 100 percent of the  
19                         poverty line, the annual Federal contribu-  
20                         tion amount is \$2,500;

21                         “(ii) more than 100 percent, but less  
22                         than 125 percent, of the poverty line, the  
23                         annual Federal contribution amount is  
24                         \$1,500;

1           “(iii) more than 125 percent, but less  
2 than 175 percent, of the poverty line, the  
3 annual Federal contribution amount is  
4 \$1,100;

5           “(iv) at least 175 percent, but less  
6 than 250 percent, of the poverty line, the  
7 annual Federal contribution amount is  
8 \$600;

9           “(v) at least 250 percent, but less  
10 than 350 percent, of the poverty line the  
11 annual Federal contribution amount is  
12 \$300.

13           “(vi) at least 350 percent of the pov-  
14 erty line (or who has not authorized in-  
15 come verification under subsection (d)) the  
16 annual Federal contribution amount is  
17 \$100.

18           “(B) INFLATION ADJUSTMENT.—

19           “(i) IN GENERAL.—For a year after  
20 2004, the annual Federal contribution  
21 amount shall be the amount specified in  
22 subparagraph (A) increased by the per-  
23 centage (if any) by which—

24           “(I) the average per capita ag-  
25 gregate expenditures for covered out-

1 patient drugs in the United States for  
2 medicare beneficiaries, as determined  
3 by the Secretary for the 12-month pe-  
4 riod ending in July of the previous  
5 year; exceeds

6 “(II) such aggregate expendi-  
7 tures for the 12-month period ending  
8 with July 2004.

9 “(ii) ROUNDING.—If an annual Fed-  
10 eral contribution amount determined under  
11 clause (i) is not a multiple of \$1, such in-  
12 crease shall be rounded to the nearest mul-  
13 tiple of \$1.

14 “(C) AVAILABILITY OF ADDITIONAL  
15 AMOUNTS FOR VERY LOW INCOME INDIVID-  
16 UALS.—

17 “(i) IN GENERAL.—The Secretary  
18 shall make available an additional amount  
19 for accounts of individuals in subparagraph  
20 (A)(i) up to \$7,500 in any year insofar as  
21 the accountholder incurs expenses in the  
22 year for which the balance in the account  
23 may be applied.

24 “(ii) CONDITION.—In the case of an  
25 individual described in clause (i) who is re-

1           siding in a State, upon the request of the  
2           State, the Secretary may condition the  
3           availability of an additional amount under  
4           such clause upon the individual’s enroll-  
5           ment under this part with an eligible entity  
6           that is recognized or approved by that  
7           State.

8           “(iii) TREATMENT AS MEDICAL AS-  
9           SISTANCE.—For provisions providing for  
10          State participation with respect to addi-  
11          tional amounts made available under  
12          clause (i), see section 1935(c)(1)(A)(ii).

13          “(d) REQUIREMENT FOR INCOME VERIFICATION TO  
14          OBTAIN INCREASED CONTRIBUTION AMOUNT OR FOR RE-  
15          DUCED PREMIUM.—

16               “(1) IN GENERAL.—The provisions of sub-  
17               sections (b)(2)(C)(iii), (b)(3)(B), and clauses (i)  
18               through (iii) of subsection (c)(2)(A) shall apply to  
19               an individual only if the individual—

20                       “(A) provides such information as the Sec-  
21                       retary may require in order to determine the  
22                       appropriate category of benefits or subsidies  
23                       under the respective provisions; and

24                       “(B) authorizes in a form and manner  
25                       specified by the Secretary the verification of the

1 individual's modified adjusted gross income by  
2 the Secretary through arrangements with  
3 States.

4 An arrangement with a State under subparagraph  
5 (B) shall provide for the payment by the Secretary  
6 under this part of the State's reasonable costs of  
7 conducting income verifications under such arrange-  
8 ment.

9 “(2) PENALTIES FOR UNDERSTATEMENT OF IN-  
10 COME.—The provision of false information under  
11 paragraph (1)(A) is subject to criminal penalties  
12 under section 1128B.

13 “(3) PROCEDURES FOR DETERMINING MODI-  
14 FIED ADJUSTED GROSS INCOME.—

15 “(A) IN GENERAL.—The Secretary shall  
16 establish procedures for determining the modi-  
17 fied adjusted gross income of enrollees. The  
18 Secretary shall consult with the Secretary of  
19 the Treasury in making such determinations.  
20 Income determinations under this subsection  
21 shall be valid for a period (of not less than 1  
22 year) specified by the Secretary.

23 “(B) DISCLOSURE OF INFORMATION.—  
24 Notwithstanding section 6103(a) of the Internal  
25 Revenue Code of 1986, the Secretary of the

1 Treasury may, upon written request from the  
2 Secretary, disclose to the Secretary such return  
3 information as is necessary to make the deter-  
4 minations described in subparagraph (A). Re-  
5 turn information disclosed under the preceding  
6 sentence may be used by the Secretary only for  
7 the purposes of, and to the extent necessary in,  
8 making such determinations.

9 “(e) APPROPRIATION TO COVER NET PROGRAM EX-  
10 PENDITURES.—There are authorized to be appropriated  
11 from time to time, out of any moneys in the Treasury not  
12 otherwise appropriated, to the Federal Supplementary  
13 Medical Insurance Trust Fund established under section  
14 1841, an amount equal to the amount by which the bene-  
15 fits and administrative costs of providing the benefits  
16 under this part exceed the sum of the portion of the enroll-  
17 ment fees retained by the Secretary and premiums col-  
18 lected under subsection (b)(3).

19 “PRESCRIPTION DRUG ACCOUNTS

20 “SEC. 1860D–5. “(a) ESTABLISHMENT OF AC-  
21 COUNTS.—

22 “(1) IN GENERAL.—The Secretary shall estab-  
23 lish and maintain for each eligible beneficiary who is  
24 enrolled under this part at the time of enrollment a  
25 prescription drug account (in this section referred to  
26 as an ‘account’).

1           “(2) RESERVE ACCOUNTS.—In cases described  
2 in subsections (b)(3)(A), (b)(3)(B)(i), and  
3 (b)(3)(B)(ii)(I), the Secretary shall establish and  
4 maintain for each surviving spouse who is not en-  
5 rolled under this part a reserve prescription drug ac-  
6 count (in this section referred to as a ‘reserve ac-  
7 count’).

8           “(3) ACCOUNTHOLDER DEFINED.—In this sec-  
9 tion, the term ‘accountholder’ means an individual  
10 for whom an account or reserve account has been es-  
11 tablished under this section.

12           “(4) EXPENDITURES FROM ACCOUNT.—Noth-  
13 ing in this section shall be construed as requiring  
14 the Federal Government to obligate funds for  
15 amounts in any account until such time as a with-  
16 drawal from such account is authorized under this  
17 section.

18           “(b) USE OF ACCOUNTS.—

19           “(1) IN GENERAL.—Except as provided in this  
20 subsection, amounts credited to an account shall  
21 only be used for the purchase of covered outpatient  
22 drugs for the accountholder. Any amounts remaining  
23 at the end of a year remain available for expendi-  
24 tures in succeeding years.

1           “(2) ACCOUNT RULES FOR PUBLIC AND PRI-  
2           VATE CONTRIBUTIONS.—The Secretary shall estab-  
3           lish an ongoing process for the determination of the  
4           amount in each account that is attributable to public  
5           and private contributions (including spousal rollover  
6           contributions) based on the following rules:

7                   “(A) TREATMENT OF EXPENDITURES.—

8                   Expenditures from the account shall—

9                           “(i) first be counted against any pub-  
10                           lic contribution; and

11                           “(ii) next be counted against private  
12                           contributions.

13                   “(B) TREATMENT OF SPOUSAL ROLLOVER

14                   CONTRIBUTIONS.—With respect to any spousal  
15                   rollover contribution, the portions of such con-  
16                   tribution that were attributable to public and  
17                   private contributions at the time of its distribu-  
18                   tion under subsection (b)(3) shall be treated  
19                   under this paragraph as if it were a direct pub-  
20                   lic or private contribution, respectively, into the  
21                   account of the spouse.

22                   “(3) DEATH OF ACCOUNTHOLDER.—In the case  
23                   of the death of an accountholder, the balance in any  
24                   account (taking into account liabilities accrued be-

1       fore the time of death) shall be distributed as fol-  
2       lows:

3               “(A) TREATMENT OF PUBLIC CONTRIBU-  
4               TIONS.—If the accountholder is married at the  
5               time of death, the amount in the account that  
6               is attributable to public contributions shall be  
7               credited to the account (if any) of the surviving  
8               spouse of the accountholder (or, if the surviving  
9               spouse is not an eligible beneficiary, into a re-  
10              serve account to be held for when that spouse  
11              becomes an eligible beneficiary).

12             “(B) TREATMENT OF PRIVATE CONTRIBU-  
13             TIONS.—The amount in the account that is at-  
14             tributable to private contributions shall be dis-  
15             tributed as follows:

16               “(i) DESIGNATION OF DIS-  
17               TRIBUTE.—If the accountholder has  
18               made a designation, in a form and manner  
19               specified by the Secretary, for the distribu-  
20               tion of some or all of such amount, such  
21               amount shall be distributed in accordance  
22               with the designation. Such designation  
23               may provide for the distribution into an  
24               account (including a reserve account) of a  
25               surviving spouse.

1           “(ii) ABSENCE OF DESIGNATION.—In-  
2           sofar as the accountholder has not made  
3           such a designation—

4           “(I) SURVIVING SPOUSE.—If the  
5           accountholder was married at the time  
6           of death, the remainder shall be cred-  
7           ited to an account (including a reserve  
8           account) of the accountholder’s sur-  
9           viving spouse.

10          “(II) NO SURVIVING SPOUSE.—If  
11          the accountholder was not so married,  
12          the remainder shall be distributed to  
13          the estate of the accountholder and  
14          distributed as provided by law.

15          “(4) USE OF ACCOUNT FOR PREMIUMS.—

16          “(A) FOR ENROLLMENT IN A MEDICARE  
17          PLAN.—During any period in which an  
18          accountholder is enrolled in a plan under part  
19          C, the balance in the account may be used and  
20          applied only to reimburse the amount of the  
21          premium (if any) established for enrollment  
22          under the plan.

23          “(B) FOR CATASTROPHIC COVERAGE.—  
24          Amounts in an account of an accountholder  
25          may be used and applied to reimburse the

1 amount of the premium imposed for cata-  
2 strophic coverage under section 1860D–4(b)(3).

3 “(5) APPLICATION TO MEDICAID EXPENSES IN  
4 CERTAIN CASES.—

5 “(A) IN GENERAL.—Except as provided in  
6 this paragraph, an account shall be treated as  
7 an asset for purposes of establishing eligibility  
8 for medical assistance under title XIX.

9 “(B) APPLICATION TOWARDS  
10 SPENDDOWN.—In the case of an accountholder  
11 who is applying for such medical assistance and  
12 who would, but for the application of subpara-  
13 graph (A), be eligible for such assistance—

14 “(i) subparagraph (A) shall not apply;  
15 and

16 “(ii) the account shall be available (in  
17 accordance with a procedure established by  
18 the Secretary) to the State to reimburse  
19 the State for any expenditures made under  
20 the plan for such medical assistance.

21 “(6) TREATMENT OF WITHDRAWALS.—

22 “(A) IN GENERAL.—Except as provided in  
23 subparagraph (B), the withdrawal of any  
24 amounts from an account in accordance with

1           this section shall not be subject to income or  
2           other tax.

3                   “(B) DISTRIBUTION OF PRIVATE CON-  
4           TRIBUTIONS AT TIME OF DEATH.—Amounts in  
5           the account of an accountholder at the time of  
6           death of the accountholder that are not trans-  
7           ferred to an account (including a reserve ac-  
8           count) of a surviving spouse shall be includable  
9           in the estate of the accountholder and may be  
10          subject to taxation as part of such estate.

11          “(c) AMOUNTS CREDITED IN ACCOUNT.—The Sec-  
12       retary shall credit to a prescription drug account of an  
13       eligible beneficiary the following amounts:

14                   “(1) PUBLIC CONTRIBUTIONS.—The following  
15       contributions (each referred to in this section as a  
16       ‘public contribution’):

17                           “(A) FEDERAL CONTRIBUTIONS.—Federal  
18       contributions provided under subsection (d).

19                           “(B) STATE CONTRIBUTIONS.—Contribu-  
20       tions made by a State under subsection (f).

21                   “(2) SPOUSAL ROLLOVER CONTRIBUTION.—A  
22       distribution from a deceased spouse under sub-  
23       section (b)(3) (referred to in this section as a ‘spous-  
24       al rollover contribution’).

1           “(3) PRIVATE CONTRIBUTIONS.—The following  
2           contributions (each referred to in this section as a  
3           ‘private contribution’):

4                   “(A) TAX-FAVORED EMPLOYER AND INDI-  
5           VIDUAL CONTRIBUTIONS.—Contributions made  
6           under subsection (e).

7                   “(B) OTHER INDIVIDUAL CONTRIBU-  
8           TIONS.—Contributions made by accountholder  
9           other than under subsection (e).

10                   “(C) CONTRIBUTIONS BY NONPROFIT OR-  
11           GANIZATIONS.—Contributions made by a chari-  
12           table, not-for-profit organization (that may be a  
13           religious organization).

14           Except as provided in this subsection, no amounts may  
15           be contributed to, or credited to, a prescription drug ac-  
16           count.

17                   “(d) FEDERAL CONTRIBUTION.—For Federal con-  
18           tributions in the case of accountholders, see section  
19           1860D–4(c). Such contributions shall not be treated as  
20           income for purposes of chapter 1 of the Internal Revenue  
21           Code of 1986.

22                   “(e) EMPLOYER AND INDIVIDUAL CONTRIBU-  
23           TIONS.—

24                   “(1) EMPLOYMENT-RELATED CONTRIBUTION.—

1           “(A) IN GENERAL.—In the case of any  
2           accountholder who is a beneficiary or partici-  
3           pant in a group health plan (including a multi-  
4           employer plan), whether as an employee, former  
5           employee or otherwise, including as a dependent  
6           of an employee or former employee, the plan  
7           may make a contribution into the  
8           accountholder’s account (but not into a reserve  
9           account of the accountholder). Amounts so con-  
10          tributed shall be treated under the Internal  
11          Revenue Code of 1986 as employer-provided  
12          coverage under an accident or health plan (de-  
13          scribed in section 106 of such Code).

14          “(B) LIMITATION.—The total amount that  
15          may be contributed under subparagraph (A)  
16          under a plan to an account during any year  
17          may not exceed \$5,000.

18          “(C) CONDITION.—A group health plan  
19          may condition a contribution with respect to an  
20          accountholder under this paragraph on the  
21          accountholder’s enrollment under this part with  
22          an eligible entity that is recognized or approved  
23          by that plan.

24          “(2) OTHER INDIVIDUALS.—

1           “(A) IN GENERAL.—Any individual may  
2           also contribute to the account of that individual  
3           or the account of any other individual under  
4           this subsection. Notwithstanding any other pro-  
5           vision of law, subject to subparagraph (B), the  
6           amount of income of an individual in a taxable  
7           year for purposes of subchapter A of chapter 1  
8           of the Internal Revenue Code of 1986 shall be  
9           treated as being reduced by the amount contrib-  
10          uted in the taxable year under the previous sen-  
11          tence by that individual.

12          “(B) LIMITATION.—The total amount that  
13          may be contributed to an account under sub-  
14          paragraph (A) and treated as a reduction in in-  
15          come under the second sentence of such sub-  
16          paragraph during any year may not exceed  
17          \$5,000, regardless of who makes such contribu-  
18          tion. Nothing in the previous sentence shall be  
19          treated as limiting the amount of non-tax-fa-  
20          vored contributions that may be made to such  
21          an account.

22          “(3) NO CONTRIBUTION PERMITTED TO RE-  
23          SERVE ACCOUNT.—No contribution may be made  
24          under this subsection to a reserve account.

1           “(4) FORM AND MANNER OF CONTRIBUTION.—  
2           The Secretary shall specify the form and manner of  
3           contributions under this subsection.

4           “(5) INDEXING OF DOLLAR AMOUNTS.—The  
5           provisions of section 1860D-4(c)(2)(B) shall apply  
6           with respect to the limitation amounts specified in  
7           paragraphs (1)(B) and (2)(B) for a year after 2004  
8           in the same manner as it applied to the annual Fed-  
9           eral contribution amount for that year, except that,  
10          for purposes of this paragraph, any reference in  
11          clause (ii) of such section to ‘\$1’ is deemed a ref-  
12          erence to ‘\$100’.

13          “(f) STATE CONTRIBUTIONS.—

14                 “(1) IN GENERAL.—A State may enter into ar-  
15                 rangements with the Secretary for the crediting of  
16                 amounts for accountholders.

17                 “(2) FORM AND MANNER OF CONTRIBUTION.—  
18                 The Secretary shall specify the form and manner of  
19                 contributions under this subsection.

20                 “(3) TAX AND MEDICAID TREATMENT.—  
21                 Amounts credited under this subsection—

22                         “(A) shall not be treated as income to the  
23                         accountholder for purposes of the Internal Rev-  
24                         enue Code of 1986; and



1 under subparagraph (E) of such section  
2 (relating to smoking cessation agents).

3 “(ii) AVOIDANCE OF DUPLICATE COV-  
4 ERAGE.—A drug prescribed for an indi-  
5 vidual that would otherwise be a covered  
6 outpatient drug under this part shall not  
7 be considered to be such a drug if payment  
8 for the drug is available under part A or  
9 B (but such drug shall be so considered if  
10 such payment is not available because the  
11 eligible beneficiary has exhausted benefits  
12 under part A or B), without regard to  
13 whether the individual is entitled to bene-  
14 fits under part A or enrolled under part B.

15 “(2) INCOME.—

16 “(A) IN GENERAL.—The term ‘income’  
17 means, with respect to benefits under this part  
18 in a year, the modified adjusted gross income of  
19 the individual for the taxable year ending in the  
20 previous year.

21 “(B) TREATMENT OF JOINT RETURNS.—In  
22 the case of a individual who files a joint return  
23 (as defined for purposes of the Internal Rev-  
24 enue Code of 1986), the income of the modified

1 adjusted gross income of both individuals shall  
2 be treated as the income of each individual.

3 “(C) TREATMENT OF SEPARATE RE-  
4 TURNS.—In the case of an individual who is  
5 married and who does not file a joint return  
6 and who is not living separate and apart from  
7 the individual’s spouse during at least 6 months  
8 of the taxable year shall be treated for purposes  
9 of this title as having income that exceeds 350  
10 percent of the poverty line.

11 “(3) DEFINITION OF MODIFIED ADJUSTED  
12 GROSS INCOME.—The term ‘modified adjusted gross  
13 income’ means adjusted gross income (as defined in  
14 section 62 of the Internal Revenue Code of 1986)—

15 “(A) determined without regard to sections  
16 911, 931, and 933 of such Code; and

17 “(B) increased by—

18 “(i) the amount of interest received or  
19 accrued by the taxpayer during the taxable  
20 year which is exempt from tax under such  
21 Code, and

22 “(ii) the amount of social security  
23 benefits not includible in gross income  
24 under section 86 of such Code.

1           “(4) POVERTY LINE.—The term ‘poverty line’  
2 means the income official poverty line (as defined by  
3 the Office of Management and Budget, and revised  
4 annually in accordance with section 673(2) of the  
5 Omnibus Budget Reconciliation Act of 1981) appli-  
6 cable to a family of the size involved.

7           “(5) QUALIFYING LOW INCOME; VERY LOW IN-  
8 COME.—

9           “(A) The term ‘qualifying low income’  
10 means, with respect to an enrollee or  
11 accountholder, that the income of the enrollee  
12 or accountholder is under 175 percent of the  
13 poverty line, but only if the enrollee or  
14 accountholder has authorized income  
15 verification under section 1860D–4(d).

16           “(B) The term ‘very low income’ means,  
17 with respect to an enrollee or accountholder,  
18 that the income of the enrollee or accountholder  
19 is under 100 percent of the poverty line, but  
20 only if the enrollee or accountholder has author-  
21 ized income verification under section 1860D–  
22 4(d).”.

23           (b) CONFORMING REFERENCES TO PREVIOUS PART  
24 D.—

1           (1) IN GENERAL.—Any reference in law (in ef-  
2           fect before the date of enactment of this Act) to part  
3           D of title XVIII of the Social Security Act is deemed  
4           a reference to part F of such title (as in effect after  
5           such date).

6           (2) SECRETARIAL SUBMISSION OF LEGISLATIVE  
7           PROPOSAL.—Not later than 6 months after the date  
8           of enactment of this section, the Secretary of Health  
9           and Human Services shall submit to the appropriate  
10          committees of Congress a legislative proposal pro-  
11          viding for such technical and conforming amend-  
12          ments in the law as are required by the provisions  
13          of this section.

14 **SEC. 3. EXCLUSION OF PART D COSTS FROM DETERMINA-**  
15 **TION OF PART B MONTHLY PREMIUM.**

16          Section 1839(g) of the Social Security Act (42 U.S.C.  
17 1395r(g)) is amended—

18           (1) by striking “attributable to the application  
19           of section” and inserting “attributable to—

20           “(1) the application of section”;

21           (2) by striking the period and inserting “;  
22           and”; and

23           (3) by adding at the end the following new  
24           paragraph:



1 D BENEFITS.—As a condition of its State plan under this  
2 title under section 1902(a)(66) and receipt of any Federal  
3 financial assistance under section 1903(a), a State shall  
4 provide for verification of income statements in accordance  
5 with arrangements under section 1860D–4(d)(1).

6 “(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE  
7 COSTS.—

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

17 “(A) For expenditures attributable to costs  
18 incurred during 2004, the otherwise applicable  
19 Federal matching rate shall be increased by 10  
20 percent of the percentage otherwise payable  
21 (but for this subsection) by the State.

22 “(B)(i) For expenditures attributable to  
23 costs incurred during 2005 and each subse-  
24 quent year through 2011, the otherwise applica-  
25 ble Federal matching rate shall be increased by

1 the applicable percent (as defined in clause (ii))  
2 of the percentage otherwise payable (but for  
3 this subsection) by the State.

4 “(ii) For purposes of clause (i), the ‘applicable  
5 percent’ for—

6 “(I) 2005 is 20 percent; or

7 “(II) a subsequent year is the applicable  
8 percent under this clause for the previous  
9 year increased by 10 percentage  
10 points.

11 “(C) For expenditures attributable to costs  
12 incurred after 2011, the otherwise applicable  
13 Federal matching rate shall be increased to 100  
14 percent.

15 “(2) COORDINATION.—The State shall provide  
16 the Secretary with such information as may be necessary  
17 to properly allocate administrative expenditures  
18 described in paragraph (1) that may otherwise  
19 be made for eligibility determinations.”.

20 (b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID  
21 RESPONSIBILITY FOR PRESCRIPTION DRUG BENEFITS  
22 FOR DUALY ELIGIBLE INDIVIDUALS.—

23 (1) IN GENERAL.—Section 1903(a)(1) (42  
24 U.S.C. 1396b(a)(1)) is amended by inserting before  
25 the semicolon the following: “, reduced by the

1 amount computed under section 1935(e)(1) for the  
2 State and the quarter”.

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

6 “(c) FEDERAL ASSUMPTION OF MEDICAID PRE-  
7 SCRIPTION DRUG COSTS FOR DUALY-ELIGIBLE BENE-  
8 FICIARIES.—

9 “(1) IN GENERAL.—For purposes of section  
10 1903(a)(1), for a State that is one of the 50 States  
11 or the District of Columbia for a calendar quarter  
12 in a year (beginning with 2004) the amount com-  
13 puted under this subsection is equal to the product  
14 of the following:

15 “(A) IMPROVED MEDICARE BENEFITS.—

16 The sum of—

17 “(i) the total amount of reductions in  
18 catastrophic coverage premiums in the  
19 quarter under part D of title XVIII that  
20 are the result of applying a zero premium  
21 under section 1860D-4(b)(3)(D) for indi-  
22 viduals who are residents of the State and  
23 are entitled to benefits with respect to pre-  
24 scribed drugs under the State plan under  
25 this title (including such a plan operating

1 under a waiver under section 1115), multi-  
2 plied by the phase-out proportion (as de-  
3 fined in paragraph (2)) for the quarter;  
4 and

5 “(ii) the total amount of additional  
6 payments made to prescription drug ac-  
7 counts in the quarter under such part D  
8 that are attributable to the application of  
9 section 1860D-4(c)(2)(C) to individuals  
10 residing in the State.

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

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

19 “(A) 2004 is 90 percent;

20 “(B) a subsequent year before 2012, 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 2011 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 eligible to be enrolled  
8 under part D of title XVIII and is eligible for med-  
9 ical assistance for prescribed drugs under this  
10 title—

11                           “(A) Federal financial participation is not  
12 available—

13                                   “(i) for such medical assistance for  
14 very low income individuals (as defined in  
15 section 1860D–6(5)); or

16                                   “(ii) for other individuals to the ex-  
17 tent payment may be made under such  
18 part for such assistance; and

19                           “(B) subject to paragraph (2), Federal fi-  
20 nancial participation shall continue to be avail-  
21 able for prescribed drugs for such other individ-  
22 uals described in subparagraph (A)(ii) to the  
23 extent payment may not be made under such  
24 part (including under a prescription drug ac-  
25 count under such part).

1           “(2) LIMITATION.—Federal financial participa-  
2           tion shall not be available under paragraph (1)(B)  
3           for the following medical assistance:

4                   “(A) For any applicable copayment  
5                   amount under section 1860D–4(b)(4).

6                   “(B) For the amount of any enrollment fee  
7                   under section 1860D–2(e).

8                   “(C) For any assistance for any individual  
9                   who is not a qualifying low income individual  
10                  (as defined in section 1860D–6(5)).”.

11       (d) TREATMENT OF TERRITORIES.—

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

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

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

19                   (C) by adding at the end the following new  
20                   subsection:

21       “(e) TREATMENT OF TERRITORIES.—

22           “(1) IN GENERAL.—In the case of a State,  
23           other than the 50 States and the District of Colum-  
24           bia—

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

3           “(B) if the State establishes a plan de-  
4 scribed in paragraph (2) (for providing medical  
5 assistance with respect to the provision of pre-  
6 scription drugs to medicare beneficiaries), the  
7 amount otherwise determined under section  
8 1108(f) (as increased under section 1108(g))  
9 for the State shall be increased by the amount  
10 specified in paragraph (3).

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

13           “(A) provides medical assistance with re-  
14 spect to the provision of covered outpatient  
15 drugs to low-income medicare beneficiaries; and

16           “(B) assures that additional amounts re-  
17 ceived by the State that are attributable to the  
18 operation of this subsection are used only for  
19 such assistance.

20           “(3) INCREASED AMOUNT.—

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

24           “(i) the aggregate amount specified in  
25 subparagraph (B); and

1                   “(ii) the amount specified in section  
2                   1108(g)(1) for that State, divided by the  
3                   sum of the amounts specified in such sec-  
4                   tion for all such States.

5                   “(B) AGGREGATE AMOUNT.—The aggre-  
6                   gate amount specified in this subparagraph  
7                   for—

8                   “(i) 2004, is equal to \$20,000,000; or

9                   “(ii) a subsequent year, is equal to the  
10                  amount specified in clause (i) increased by  
11                  applicable percentage increase specified in  
12                  section 1860D–2(e)(1)(B) for the year in-  
13                  volved.

14                  “(4) REPORT.—The Secretary shall submit to  
15                  Congress a report on the application of this sub-  
16                  section and may include in the report such rec-  
17                  ommendations as the Secretary deems appropriate.”.

18                  (2) CONFORMING AMENDMENT.—Section  
19                  1108(g)(2) (42 U.S.C. 1308(g)(2)) is amended by  
20                  inserting “but subject to section 1935(e)(1)(B)”  
21                  after “Notwithstanding subsection (f)”.

22                  (e) AMENDMENT TO BEST PRICE.—Section  
23                  1927(c)(1)(C)(i) (42 U.S.C. 1396r–8(c)(1)(C)(i)) is  
24                  amended—

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

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

5           (3) by adding at the end the following new sub-  
6           clause:

7                                   “(V) any prices charged which  
8                                   are negotiated under an eligible entity  
9                                   under part D of title XVIII on behalf  
10                                  of individuals enrolled under such  
11                                  part.”.

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