

108TH CONGRESS
1ST SESSION

H. R. 38

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

IN THE HOUSE OF REPRESENTATIVES

JANUARY 7, 2003

Mrs. CAPITO introduced the following bill; which was referred to the Committee on the 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 voluntary outpatient prescription drug benefit 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 “More Savings, More Choice Prescription Drug Act of
6 2003”.

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

Sec. 1. Short title; table of contents.

Sec. 2. Establishment of a medicare prescription drug benefit.

“PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

- “Sec. 1860A. Benefits; eligibility; enrollment; and coverage period.
 “Sec. 1860B. Requirements for qualified prescription drug coverage.
 “Sec. 1860C. Beneficiary protections for qualified prescription drug coverage.
 “Sec. 1860D. Requirements for prescription drug plan (PDP) sponsors; contracts; establishment of standards.
 “Sec. 1860E. Process for beneficiaries to select qualified prescription drug coverage.
 “Sec. 1860F. Premiums.
 “Sec. 1860G. Premium and cost-sharing subsidies for low-income individuals.
 “Sec. 1860H. Subsidies for all medicare beneficiaries through reinsurance for qualified prescription drug coverage.
 “Sec. 1860I. Medicare Prescription Drug Account in federal Supplementary Medical Insurance Trust Fund.
 “Sec. 1860J. Definitions; treatment of references to provisions in part C.
 “Sec. 1860K. Medicare Prescription Drug Advisory Committee.
 Sec. 3. Offering of qualified prescription drug coverage under the Medicare+Choice program.
 Sec. 4. Medicaid amendments.
 Sec. 5. Medigap transition provisions.

1 **SEC. 2. ESTABLISHMENT OF A MEDICARE PRESCRIPTION**
 2 **DRUG BENEFIT.**

3 (a) IN GENERAL.—Title XVIII of the Social Security
 4 Act is amended—

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

6 (2) by inserting after part C the following new
 7 part:

8 “PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT
 9 PROGRAM

10 **“SEC. 1860A. BENEFITS; ELIGIBILITY; ENROLLMENT; AND**
 11 **COVERAGE PERIOD.**

12 “(a) PROVISION OF QUALIFIED PRESCRIPTION DRUG
 13 COVERAGE THROUGH ENROLLMENT IN PLANS.—Subject
 14 to the succeeding provisions of this part, each individual
 15 who is entitled to benefits under part A or is enrolled

1 under part B is entitled to obtain qualified prescription
2 drug coverage (described in section 1860B(a)) as follows:

3 “(1) MEDICARE+CHOICE PLAN.—If the indi-
4 vidual is eligible to enroll in a Medicare+Choice plan
5 that provides qualified prescription drug coverage
6 under section 1851(j), the individual may enroll in
7 the plan and obtain coverage through such plan.

8 “(2) PRESCRIPTION DRUG PLAN.—If the indi-
9 vidual is not enrolled in a Medicare+Choice plan
10 that provides qualified prescription drug coverage,
11 the individual may enroll under this part in a pre-
12 scription drug plan (as defined in section 1860C(a)).

13 Such individuals shall have a choice of such plans under
14 section 1860E(d).

15 “(b) GENERAL ELECTION PROCEDURES.—

16 “(1) IN GENERAL.—An individual may elect to
17 enroll in a prescription drug plan under this part, or
18 elect the option of qualified prescription drug cov-
19 erage under a Medicare+Choice plan under part C,
20 and change such election only in such manner and
21 form as may be prescribed by regulations of the Sec-
22 retary and only during an election period prescribed
23 in or under this subsection.

24 “(2) ELECTION PERIODS.—

1 “(A) IN GENERAL.—Except as provided in
2 this paragraph, the election periods under this
3 subsection shall be the same as the coverage
4 election periods under the Medicare+Choice
5 program under section 1851(e), including—

6 “(i) annual coordinated election peri-
7 ods; and

8 “(ii) special election periods.

9 In applying the last sentence of section
10 1851(e)(4) (relating to discontinuance of a
11 Medicare+Choice election during the first year
12 of eligibility) under this subparagraph, in the
13 case of an election described in such section in
14 which the individual had elected or is provided
15 qualified prescription drug coverage at the time
16 of such first enrollment, the individual shall be
17 permitted to enroll in a prescription drug plan
18 under this part at the time of the election of
19 coverage under the original fee-for-service plan.

20 “(B) INITIAL ELECTION PERIODS.—

21 “(i) INDIVIDUALS CURRENTLY COV-
22 ERED.—In the case of an individual who is
23 entitled to benefits under part A or en-
24 rolled under part B as of November 1,

1 2005, there shall be an initial election pe-
2 riod of 6 months beginning on that date.

3 “(ii) INDIVIDUAL COVERED IN FU-
4 TURE.—In the case of an individual who is
5 first entitled to benefits under part A or
6 enrolled under part B after November 1,
7 2005, there shall be an initial election pe-
8 riod which is the same as the initial enroll-
9 ment period under section 1837(d).

10 “(C) ADDITIONAL SPECIAL ELECTION PE-
11 RIODS.—The Secretary shall establish special
12 election periods—

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

16 “(ii) in cases described in section
17 1837(h) (relating to errors in enrollment),
18 in the same manner as such section applies
19 to part B; and

20 “(iii) in the case of an individual who
21 meets such exceptional conditions (includ-
22 ing conditions recognized under section
23 1851(d)(4)(D)) as the Secretary may pro-
24 vide.

1 “(c) GUARANTEED ISSUE; COMMUNITY RATING; AND
2 NONDISCRIMINATION.—

3 “(1) GUARANTEED ISSUE.—

4 “(A) IN GENERAL.—An eligible individual
5 who is eligible to elect qualified prescription
6 drug coverage under a prescription drug plan or
7 Medicare+Choice plan at a time during which
8 elections are accepted under this part with re-
9 spect to the plan shall not be denied enrollment
10 based on any health status-related factor (de-
11 scribed in section 2702(a)(1) of the Public
12 Health Service Act) or any other factor.

13 “(B) MEDICARE+CHOICE LIMITATIONS
14 PERMITTED.—The provisions of paragraphs (2)
15 and (3) (other than subparagraph (C)(i), relat-
16 ing to default enrollment) of section 1851(g)
17 (relating to priority and limitation on termi-
18 nation of election) shall apply to PDP sponsors
19 under this subsection.

20 “(2) COMMUNITY-RATED PREMIUM.—

21 “(A) IN GENERAL.—In the case of an indi-
22 vidual who maintains (as determined under sub-
23 paragraph (C)) continuous prescription drug
24 coverage since first qualifying to elect prescrip-
25 tion drug coverage under this part, a PDP

1 sponsor or Medicare+Choice organization offer-
2 ing a prescription drug plan or
3 Medicare+Choice plan that provides qualified
4 prescription drug coverage and in which the in-
5 dividual is enrolled may not deny, limit, or con-
6 dition the coverage or provision of covered pre-
7 scription drug benefits or increase the premium
8 under the plan based on any health status-re-
9 lated factor described in section 2702(a)(1) of
10 the Public Health Service Act or any other fac-
11 tor.

12 “(B) LATE ENROLLMENT PENALTY.—In
13 the case of an individual who does not maintain
14 such continuous prescription drug coverage, a
15 PDP sponsor or Medicare+Choice organization
16 may (notwithstanding any provision in this
17 title) increase the premium otherwise applicable
18 or impose a pre-existing condition exclusion
19 with respect to qualified prescription drug cov-
20 erage in a manner that reflects additional actu-
21 arial risk involved. Such a risk shall be estab-
22 lished through an appropriate actuarial opinion
23 of the type described in subparagraphs (A)
24 through (C) of section 2103(c)(4).

1 “(C) CONTINUOUS PRESCRIPTION DRUG
2 COVERAGE.—An individual is considered for
3 purposes of this part to be maintaining contin-
4 uous prescription drug coverage on and after a
5 date if the individual establishes that there is
6 no period of 63 days or longer on and after
7 such date (beginning not earlier than January
8 1, 2006) during all of which the individual did
9 not have any of the following prescription drug
10 coverage:

11 “(i) COVERAGE UNDER PRESCRIPTION
12 DRUG PLAN OR MEDICARE+CHOICE
13 PLAN.—Qualified prescription drug cov-
14 erage under a prescription drug plan or
15 under a Medicare+Choice plan.

16 “(ii) MEDICAID PRESCRIPTION DRUG
17 COVERAGE.—Prescription drug coverage
18 under a medicaid plan under title XIX, in-
19 cluding through the Program of All-inclu-
20 sive Care for the Elderly (PACE) under
21 section 1934, through a social health main-
22 tenance organization (referred to in section
23 4104(c) of the Balanced Budget Act of
24 1997), or through a Medicare+Choice
25 project that demonstrates the application

1 of capitation payment rates for frail elderly
2 medicare beneficiaries through the use of a
3 interdisciplinary team and through the
4 provision of primary care services to such
5 beneficiaries by means of such a team at
6 the nursing facility involved.

7 “(iii) PRESCRIPTION DRUG COVERAGE
8 UNDER GROUP HEALTH PLAN.—Any out-
9 patient prescription drug coverage under a
10 group health plan, including a health bene-
11 fits plan under the Federal Employees
12 Health Benefit Plan under chapter 89 of
13 title 5, United States Code, and a qualified
14 retiree prescription drug plan as defined in
15 section 1860H(e)(1).

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, 2006, and only until
25 the date such coverage is terminated.

1 “(v) STATE PHARMACEUTICAL ASSIST-
2 ANCE PROGRAM.—Coverage of prescription
3 drugs under a State pharmaceutical assist-
4 ance program.

5 “(vi) VETERANS’ COVERAGE OF PRE-
6 SCRIPTION DRUGS.—Coverage of prescrip-
7 tion drugs for veterans under chapter 17
8 of title 38, United States Code.

9 “(D) CERTIFICATION.—For purposes of
10 carrying out this paragraph, the certifications
11 of the type described in sections 2701(e) of the
12 Public Health Service Act and in section
13 9801(e) of the Internal Revenue Code shall also
14 include a statement for the period of coverage
15 of whether the individual involved had prescrip-
16 tion drug coverage described in subparagraph
17 (C).

18 “(E) CONSTRUCTION.—Nothing in this
19 section shall be construed as preventing the
20 disenrollment of an individual from a prescrip-
21 tion drug plan or a Medicare+Choice plan
22 based on the termination of an election de-
23 scribed in section 1851(g)(3), including for non-
24 payment of premiums or for other reasons spec-
25 ified in subsection (d)(3), which takes into ac-

1 count a grace period described in section
2 1851(g)(3)(B)(i).

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

8 “(d) EFFECTIVE DATE OF ELECTIONS.—

9 “(1) IN GENERAL.—Except as provided in this
10 section, the Secretary shall provide that elections
11 under subsection (b) take effect at the same time as
12 the Secretary provides that similar elections under
13 section 1851(e) take effect under section 1851(f).

14 “(2) NO ELECTION EFFECTIVE BEFORE 2006.—
15 In no case shall any election take effect before Janu-
16 ary 1, 2006.

17 “(3) TERMINATION.—The Secretary shall pro-
18 vide for the termination of an election in the case
19 of—

20 “(A) termination of coverage under part B
21 (in the case of an individual not entitled to ben-
22 efits under part A); and

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

1 **“SEC. 1860B. REQUIREMENTS FOR QUALIFIED PRESCRIP-**
2 **TION DRUG COVERAGE.**

3 “(a) REQUIREMENTS.—

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

7 “(A) STANDARD COVERAGE WITH ACCESS
8 TO NEGOTIATED PRICES.—Standard coverage
9 (as defined in subsection (b)) and access to ne-
10 gotiated prices under subsection (d).

11 “(B) ACTUARIALLY EQUIVALENT COV-
12 ERAGE WITH ACCESS TO NEGOTIATED
13 PRICES.—Coverage of covered outpatient drugs
14 which meets the alternative coverage require-
15 ments of subsection (c) and access to negotiated
16 prices under subsection (d).

17 “(2) PERMITTING ADDITIONAL OUTPATIENT
18 PRESCRIPTION DRUG COVERAGE.—

19 “(A) IN GENERAL.—Subject to subpara-
20 graph (B), nothing in this part shall be con-
21 strued as preventing qualified prescription drug
22 coverage from including coverage of covered
23 outpatient drugs that exceeds the coverage re-
24 quired under paragraph (1), but any such addi-
25 tional coverage shall be limited to coverage of
26 covered outpatient drugs.

1 “(B) DISAPPROVAL AUTHORITY.—The
2 Secretary shall review the offering of qualified
3 prescription drug coverage under this part or
4 part C. If the Secretary finds that, in the case
5 of a qualified prescription drug coverage under
6 a prescription drug plan or a Medicare+Choice
7 plan, that the organization or sponsor offering
8 the coverage is purposefully engaged in activi-
9 ties intended to result in favorable selection of
10 those eligible medicare beneficiaries obtaining
11 coverage through the plan, the Secretary may
12 terminate the contract with the sponsor or or-
13 ganization under this part or part C.

14 “(3) APPLICATION OF SECONDARY PAYOR PRO-
15 VISIONS.—The provisions of section 1852(a)(4) shall
16 apply under this part in the same manner as they
17 apply under part C.

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

22 “(1) DEDUCTIBLE.—The coverage has an an-
23 nual deductible that is equal to \$100.

1 “(2) LIMITS ON COST-SHARING.—The coverage
2 has cost-sharing (for incurred costs above the annual
3 deductible specified in paragraph (1))—

4 “(A) of 25 percent to the extent that the
5 incurred expenses (including incurred out-of-
6 pocket expenses) for covered outpatient drugs
7 under this part in the year do not exceed
8 \$2,000;

9 “(B) of 50 percent to the extent such in-
10 curred expenses exceed \$2,000 but the true out-
11 of-pocket expenses do not exceed \$5,000; and

12 “(C) of 0 percent to the extent such true
13 out-of-pocket expenses exceed \$5,000.

14 “(3) OUT-OF-POCKET EXPENSES DEFINED.—
15 For purposes of paragraph (2), the term ‘out-of-
16 pocket expenses’ means expenses incurred as a re-
17 sult of the application of the deductible under para-
18 graph (1) and the coinsurance required under this
19 subsection.

20 “(4) TRUE OUT-OF-POCKET EXPENSES DE-
21 FINED.—For purposes of paragraph (2), the term
22 ‘true out-of-pocket expenses’ means out-of-pocket ex-
23 penses insofar as there is no third party reimburse-
24 ment made.

25 “(5) INFLATION ADJUSTMENT.—

1 “(A) IN GENERAL.—In the case of any cal-
 2 endar year beginning after 2006, each of the
 3 dollar amounts in paragraphs (1) and (2) shall
 4 be increased by an amount equal to—

5 “(i) such dollar amount, multiplied by

6 “(ii) the percentage (if any) by which
 7 the amount of average per capita expendi-
 8 tures under this part in the preceding cal-
 9 endar year exceeds the amount of such ex-
 10 penditures in 2006.

11 “(B) ROUNDING.—Any amount determined
 12 under paragraph (1) or (2) that is not a mul-
 13 tiple of \$5 or \$25, respectively, shall be round-
 14 ed to the nearest multiple of \$5 or \$25, respec-
 15 tively.

16 “(c) ALTERNATIVE COVERAGE REQUIREMENTS.—A
 17 prescription drug plan or Medicare+Choice plan may pro-
 18 vide a different prescription drug benefit design from the
 19 standard coverage described in subsection (b) so long as
 20 the following requirements are met:

21 “(1) ASSURING AT LEAST ACTUARIALLY EQUIV-
 22 ALENT COVERAGE.—

23 “(A) ASSURING EQUIVALENT VALUE OF
 24 TOTAL COVERAGE.—The actuarial value of the
 25 total coverage (as determined under subsection

1 (e)) is at least equal to the actuarial value (as
2 so determined) of standard coverage.

3 “(B) ASSURING EQUIVALENT UNSUB-
4 SIDIZED VALUE OF COVERAGE.—The unsub-
5 sidized value of the coverage is at least equal to
6 the unsubsidized value of standard coverage.
7 For purposes of this subparagraph, the unsub-
8 sidized value of coverage is the amount by
9 which the actuarial value of the coverage (as
10 determined under subsection (e)) exceeds the
11 actuarial value of the reinsurance subsidy pay-
12 ments under section 1860H with respect to
13 such coverage.

14 “(C) ASSURING STANDARD PAYMENT FOR
15 COSTS IN INITIAL BENEFIT RANGE.—The cov-
16 erage is designed, based upon an actuarially
17 representative pattern of utilization (as deter-
18 mined under subsection (e)), to provide for the
19 payment, with respect to costs incurred in the
20 range described in subsection (b)(2)(A), of an
21 amount equal to at least 75 percent of the ap-
22 plicable dollar amount under such subsection
23 (as adjusted under subsection (b)(5)).

24 “(2) LIMITATION ON TRUE OUT-OF-POCKET EX-
25 PENDITURES BY BENEFICIARIES.—The coverage

1 provides the limitation on true out-of-pocket expend-
2 itures by beneficiaries described in subsection
3 (b)(2)(C).

4 “(d) ACCESS TO NEGOTIATED PRICES.—Under
5 qualified prescription drug coverage offered by a PDP
6 sponsor or a Medicare+Choice organization, the sponsor
7 or organization shall provide beneficiaries with access to
8 negotiated prices (including applicable discounts) used for
9 payment for covered outpatient drugs, regardless of the
10 fact that no benefits may be payable under the coverage
11 with respect to such drugs because of the application of
12 cost-sharing or an initial coverage limit (described in sub-
13 section (b)(3)). Insofar as a State elects to provide medical
14 assistance under title XIX for a drug based on the prices
15 negotiated by a prescription drug plan under this part,
16 the requirements of section 1927 shall not apply to such
17 drugs.

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

20 “(1) PROCESSES.—For purposes of this section,
21 the Secretary shall establish processes and meth-
22 ods—

23 “(A) for determining the actuarial valu-
24 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.

18 “(f) COVERED OUTPATIENT DRUGS DEFINED.—

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

22 “(A) a drug that may be dispensed only
23 upon a prescription and that is described in
24 subparagraph (A)(i) or (A)(ii) of section
25 1927(k)(2); or

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

5 and such term includes any use of a covered out-
6 patient drug for a medically accepted indication (as
7 defined in section 1927(k)(6)).

8 “(2) EXCLUSIONS.—

9 “(A) IN GENERAL.—Such term does not
10 include drugs or classes of drugs, or their med-
11 ical uses, which may be excluded from coverage
12 or otherwise restricted under section
13 1927(d)(2), other than subparagraph (E) there-
14 of (relating to smoking cessation agents) and
15 except to the extent otherwise specifically pro-
16 vided by the Secretary with respect to a drug
17 in any of such classes.

18 “(B) AVOIDANCE OF DUPLICATE COV-
19 ERAGE.—A drug prescribed for an individual
20 that would otherwise be a covered outpatient
21 drug under this part shall not be so considered
22 if payment for such drug is available under part
23 A or B (but shall be so considered if such pay-
24 ment is not available because benefits under
25 part A or B have been exhausted), without re-

1 gard to whether the individual is entitled to
2 benefits under part A or enrolled under part B.

3 “(3) APPLICATION OF FORMULARY RESTRIC-
4 TIONS.—A drug prescribed for an individual that
5 would otherwise be a covered outpatient drug under
6 this part shall not be so considered under a plan if
7 the plan excludes the drug under a formulary that
8 meets the requirements of section 1860C(f)(2) (in-
9 cluding providing an appeal process).

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

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

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

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

21 **“SEC. 1860C. BENEFICIARY PROTECTIONS FOR QUALIFIED**
22 **PRESCRIPTION DRUG COVERAGE.**

23 “(a) GUARANTEED ISSUE COMMUNITY-RELATED
24 PREMIUMS AND NONDISCRIMINATION.—For provisions re-
25 quiring guaranteed issue, community-rated premiums, and

1 nondiscrimination, see sections 1860A(c)(1), 1860A(c)(2),
2 and 1860F(b).

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.

18 “(D) Grievance and appeals procedures.

19 “(2) DISCLOSURE UPON REQUEST OF GENERAL
20 COVERAGE, UTILIZATION, AND GRIEVANCE INFORMA-
21 TION.—Upon request of an individual eligible to en-
22 roll under a prescription drug plan, the PDP spon-
23 sor shall provide the information described in section
24 1852(c)(2) (other than subparagraph (D)) to such
25 individual.

1 “(3) RESPONSE TO BENEFICIARY QUESTIONS.—

2 Each PDP sponsor offering a prescription drug plan
3 shall have a mechanism for providing specific infor-
4 mation to enrollees upon request. The sponsor shall
5 make available, through an Internet website and in
6 writing upon request, information on specific
7 changes in its formulary.

8 “(4) CLAIMS INFORMATION.—Each PDP spon-

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

19 “(c) ACCESS TO COVERED BENEFITS.—

20 “(1) ASSURING PHARMACY ACCESS.—The PDP

21 sponsor of the prescription drug plan shall secure
22 the participation of sufficient numbers of pharmacies
23 (which may include mail order pharmacies) to en-
24 sure convenient access (including adequate emer-
25 gency access) for enrolled beneficiaries, in accord-

1 ance with standards established under section
2 1860D(e) that ensure such convenient access. Noth-
3 ing in this paragraph shall be construed as requiring
4 the participation of (or permitting the exclusion of)
5 all pharmacies in any area under a plan.

6 “(2) PREFERRED PHARMACY NETWORKS.—

7 “(A) IN GENERAL.—If a PDP sponsor
8 uses a preferred pharmacy network to deliver
9 benefits under this part, such network shall
10 meet minimum access standards established by
11 the Secretary.

12 “(B) STANDARDS.—In establishing stand-
13 ards under subparagraph (A), the Secretary
14 shall take into account reasonable distances to
15 pharmacy services in both urban and rural
16 areas.

17 “(C) ASSURING PHARMACY ACCESS.—Such
18 standards shall require that each PDP sponsor
19 include in any preferred pharmacy network any
20 pharmacy that agrees to the terms and condi-
21 tions established by the sponsor for such par-
22 ticipation in such network.

23 “(3) ACCESS TO NEGOTIATED PRICES FOR PRE-
24 SCRIPTION DRUGS.—The PDP sponsor of a prescrip-
25 tion drug plan shall issue such a card that may be

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

6 “(4) REQUIREMENTS ON DEVELOPMENT AND
7 APPLICATION OF FORMULARIES.—Insofar as a PDP
8 sponsor of a prescription drug plan uses a for-
9 mulary, the following requirements must be met:

10 “(A) FORMULARY COMMITTEE.—The spon-
11 sor must establish a pharmaceutical and thera-
12 peutic committee that develops the formulary.
13 Such committee shall include at least one physi-
14 cian and at least one pharmacist.

15 “(B) INCLUSION OF DRUGS IN ALL THERA-
16 PEUTIC CATEGORIES.—The formulary must in-
17 clude drugs within all therapeutic categories
18 and classes of covered outpatient drugs (al-
19 though not necessarily for all drugs within such
20 categories and classes).

21 “(C) APPEALS AND EXCEPTIONS TO APPLI-
22 CATION.—The PDP sponsor must have, as part
23 of the appeals process under subsection (f)(2),
24 a process for appeals for denials of coverage
25 based on such application of the formulary.

1 “(d) COST AND UTILIZATION MANAGEMENT; QUAL-
2 ITY ASSURANCE; MEDICATION THERAPY MANAGEMENT
3 PROGRAM.—

4 “(1) IN GENERAL.—The PDP sponsor shall
5 have in place—

6 “(A) an effective cost and drug utilization
7 management program, including appropriate in-
8 centives to use generic drugs, when appropriate;

9 “(B) quality assurance measures and sys-
10 tems to reduce medical errors and adverse drug
11 interactions, including a medication therapy
12 management program described in paragraph
13 (2); and

14 “(C) a program to control fraud, abuse,
15 and waste.

16 “(2) MEDICATION THERAPY MANAGEMENT PRO-
17 GRAM.—

18 “(A) IN GENERAL.—A medication therapy
19 management program described in this para-
20 graph is a program of drug therapy manage-
21 ment and medication administration that is de-
22 signed to assure that covered outpatient drugs
23 under the prescription drug plan are appro-
24 priately used to achieve therapeutic goals and

1 reduce the risk of adverse events, including ad-
2 verse drug interactions.

3 “(B) ELEMENTS.—Such program may in-
4 clude—

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

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

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

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

24 “(3) TREATMENT OF ACCREDITATION.—Section
25 1852(e)(4) (relating to treatment of accreditation)

1 shall apply to prescription drug plans under this
2 part with respect to the following requirements, in
3 the same manner as they apply to Medicare+Choice
4 plans under part C with respect to the requirements
5 described in a clause of section 1852(e)(4)(B):

6 “(A) Paragraph (1) (including quality as-
7 surance), including medication therapy manage-
8 ment program under paragraph (2).

9 “(B) Subsection (c)(1) (relating to access
10 to covered benefits).

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

13 “(4) PUBLIC DISCLOSURE OF PHARMACEUTICAL
14 PRICES FOR GENERIC EQUIVALENT DRUGS.—Each
15 PDP sponsor shall provide that each pharmacy or
16 other dispenser that arranges for the dispensing of
17 a covered outpatient drug shall inform the bene-
18 ficiary at the time of purchase of the drug of any
19 differential between the price of the prescribed drug
20 to the enrollee and the price of the lowest cost ge-
21 neric drug that is therapeutically and pharmaceuti-
22 cally equivalent and bioequivalent.

23 “(e) GRIEVANCE MECHANISM.—Each PDP sponsor
24 shall provide meaningful procedures for hearing and re-
25 solving grievances between the organization (including any

1 entity or individual through which the sponsor provides
2 covered benefits) and enrollees with prescription drug
3 plans of the sponsor under this part in accordance with
4 section 1852(f).

5 “(f) COVERAGE DETERMINATIONS, RECONSIDER-
6 ATIONS, AND APPEALS.—

7 “(1) IN GENERAL.—A PDP sponsor shall meet
8 the requirements of section 1852(g) with respect to
9 covered benefits under the prescription drug plan it
10 offers under this part in the same manner as such
11 requirements apply to a Medicare+Choice organiza-
12 tion with respect to benefits it offers under a
13 Medicare+Choice plan under part C.

14 “(2) APPEALS OF FORMULARY DETERMINA-
15 TIONS.—Under the appeals process under paragraph
16 (1) an individual who is enrolled in a prescription
17 drug plan offered by a PDP sponsor may appeal to
18 obtain coverage for a covered outpatient drug that
19 is not on the formulary of the sponsor (established
20 under subsection (c)) if the prescribing physician de-
21 termines that the therapeutically similar drug that is
22 on the formulary is not as effective for the enrollee
23 or has significant adverse effects for the enrollee.

24 “(g) CONFIDENTIALITY AND ACCURACY OF EN-
25 ROLLEE RECORDS.—A PDP sponsor shall meet the re-

1 requirements of section 1852(h) with respect to enrollees
2 under this part in the same manner as such requirements
3 apply to a Medicare+Choice organization with respect to
4 enrollees under part C.

5 **“SEC. 1860D. REQUIREMENTS FOR PRESCRIPTION DRUG**
6 **PLAN (PDP) SPONSORS; CONTRACTS; ESTAB-**
7 **LISHMENT OF STANDARDS.**

8 “(a) GENERAL REQUIREMENTS.—Each PDP sponsor
9 of a prescription drug plan shall meet the following re-
10 quirements:

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

16 “(2) ASSUMPTION OF FULL FINANCIAL RISK.—

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

24 “(B) REINSURANCE PERMITTED.—The en-
25 tity may obtain insurance or make other ar-

1 rangements for the cost of coverage provided to
2 any enrolled member under this part.

3 “(3) SOLVENCY FOR UNLICENSED SPONSORS.—

4 In the case of a sponsor that is not described in
5 paragraph (1), the sponsor shall meet solvency
6 standards established by the Secretary under sub-
7 section (d).

8 “(b) CONTRACT REQUIREMENTS.—

9 “(1) IN GENERAL.—The Secretary shall not
10 permit the election under section 1860A of a pre-
11 scription drug plan offered by a PDP sponsor under
12 this part, and the sponsor shall not be eligible for
13 payments under section 1860G or 1860H, unless the
14 Secretary has entered into a contract under this sub-
15 section with the sponsor with respect to the offering
16 of such plan. Such a contract with a sponsor may
17 cover more than one prescription drug plan. Such
18 contract shall provide that the sponsor agrees to
19 comply with the applicable requirements and stand-
20 ards of this part and the terms and conditions of
21 payment as provided for in this part.

22 “(2) NEGOTIATION REGARDING TERMS AND
23 CONDITIONS.—The Secretary shall have the same
24 authority to negotiate the terms and conditions of
25 prescription drug plans under this part as the Direc-

1 tor of the Office of Personnel Management has with
2 respect to health benefits plans under chapter 89 of
3 title 5, United States Code. In negotiating the terms
4 and conditions regarding premiums for which infor-
5 mation is submitted under section 1860F(a)(2), the
6 Secretary shall take into account the reinsurance
7 subsidy payments under section 1860H and the ad-
8 justed community rate (as defined in section
9 1854(f)(3)) for the benefits covered.

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

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

18 “(B) CONTRACT PERIOD AND EFFECTIVE-
19 NESS.—Paragraphs (1) through (3) and (5) of
20 section 1857(e).

21 “(C) PROTECTIONS AGAINST FRAUD AND
22 BENEFICIARY PROTECTIONS.—Section 1857(d).

23 “(D) ADDITIONAL CONTRACT TERMS.—
24 Section 1857(e); except that in applying section
25 1857(e)(2) under this part—

1 “(i) such section shall be applied sepa-
2 rately to costs relating to this part (from
3 costs under part C);

4 “(ii) in no case shall the amount of
5 the fee established under this subpara-
6 graph for a plan exceed 20 percent of the
7 maximum amount of the fee that may be
8 established under subparagraph (B) of
9 such section; and

10 “(iii) no fees shall be applied under
11 this subparagraph with respect to
12 Medicare+Choice plans.

13 “(E) INTERMEDIATE SANCTIONS.—Section
14 1857(g).

15 “(F) PROCEDURES FOR TERMINATION.—
16 Section 1857(h).

17 “(4) RULES OF APPLICATION FOR INTER-
18 MEDIATE SANCTIONS.—In applying paragraph
19 (3)(E)—

20 “(A) the reference in section
21 1857(g)(1)(B) to section 1854 is deemed a ref-
22 erence to this part; and

23 “(B) the reference in section
24 1857(g)(1)(F) to section 1852(k)(2)(A)(ii) shall
25 not be applied.

1 “(c) WAIVER OF CERTAIN REQUIREMENTS TO EX-
2 PAND CHOICE.—

3 “(1) IN GENERAL.—In the case of an entity
4 that seeks to offer a prescription drug plan in a
5 State, the Secretary shall waive the requirement of
6 subsection (a)(1) that the entity be licensed in that
7 State if the Secretary determines, based on the ap-
8 plication and other evidence presented to the Sec-
9 retary, that any of the grounds for approval of the
10 application described in paragraph (2) has been met.

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

17 “(3) APPLICATION OF WAIVER PROCEDURES.—
18 With respect to an application for a waiver (or a
19 waiver granted) under this subsection, the provisions
20 of subparagraphs (E), (F), and (G) of section
21 1855(a)(2) shall apply.

22 “(4) LICENSURE DOES NOT SUBSTITUTE FOR
23 OR CONSTITUTE CERTIFICATION.—The fact that an
24 entity is licensed in accordance with subsection
25 (a)(1) does not deem the entity to meet other re-

1 requirements imposed under this part for a PDP spon-
2 sor.

3 “(5) REFERENCES TO CERTAIN PROVISIONS.—

4 For purposes of this subsection, in applying provi-
5 sions of section 1855(a)(2) under this subsection to
6 prescription drug plans and PDP sponsors—

7 “(A) any reference to a waiver application
8 under section 1855 shall be treated as a ref-
9 erence to a waiver application under paragraph
10 (1); and

11 “(B) any reference to solvency standards
12 shall be treated as a reference to solvency
13 standards established under subsection (d).

14 “(d) SOLVENCY STANDARDS FOR NON-LICENSED
15 SPONSORS.—

16 “(1) ESTABLISHMENT.—The Secretary shall es-
17 tablish, by not later than October 1, 2004, financial
18 solvency and capital adequacy standards that an en-
19 tity that does not meet the requirements of sub-
20 section (a)(1) must meet to qualify as a PDP spon-
21 sor under this part.

22 “(2) COMPLIANCE WITH STANDARDS.—Each
23 PDP sponsor that is not licensed by a State under
24 subsection (a)(1) and for which a waiver application
25 has been approved under subsection (c) shall meet

1 solvency and capital adequacy standards established
2 under paragraph (1). The Secretary shall establish
3 certification procedures for such PDP sponsors with
4 respect to such solvency standards in the manner de-
5 scribed in section 1855(e)(2).

6 “(e) OTHER STANDARDS.—The Secretary shall es-
7 tablish by regulation other standards (not described in
8 subsection (d)) for PDP sponsors and plans consistent
9 with, and to carry out, this part. The Secretary shall pub-
10 lish such regulations by October 1, 2004. In order to carry
11 out this requirement in a timely manner, the Secretary
12 may promulgate regulations that take effect on an interim
13 basis, after notice and pending opportunity for public com-
14 ment.

15 “(f) RELATION TO STATE LAWS.—

16 “(1) IN GENERAL.—The standards established
17 under this section shall supersede any State law or
18 regulation (including standards described in para-
19 graph (2)) with respect to prescription drug plans
20 which are offered by PDP sponsors under this part
21 to the extent such law or regulation is inconsistent
22 with such standards.

23 “(2) STANDARDS SPECIFICALLY SUPER-
24 SEDED.—State standards relating to the following
25 are superseded under this subsection:

1 “(A) Benefit requirements.

2 “(B) Requirements relating to inclusion or
3 treatment of providers.

4 “(C) Coverage determinations (including
5 related appeals and grievance processes).

6 “(D) Establishment and regulation of pre-
7 miums.

8 “(3) PROHIBITION OF STATE IMPOSITION OF
9 PREMIUM TAXES.—No State may impose a premium
10 tax or similar tax with respect to premiums paid to
11 PDP sponsors for prescription drug plans under this
12 part, or with respect to any payments made to such
13 a sponsor by the Secretary under this part.

14 **“SEC. 1860E. PROCESS FOR BENEFICIARIES TO SELECT**
15 **QUALIFIED PRESCRIPTION DRUG COVERAGE.**

16 “(a) IN GENERAL.—The Secretary shall establish,
17 based upon and consistent with the procedures used under
18 part C (including section 1851), a process for the selection
19 of the prescription drug plan or Medicare+Choice plan
20 which offer qualified prescription drug coverage through
21 which eligible individuals elect qualified prescription drug
22 coverage under this part.

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

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

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

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

16 “(c) MEDICARE+CHOICE ENROLLEE IN PLAN OF-
17 FERING PRESCRIPTION DRUG COVERAGE MAY ONLY OB-
18 TAIN BENEFITS THROUGH THE PLAN.—An individual
19 who is enrolled under a Medicare+Choice plan that offers
20 qualified prescription drug coverage may only elect to re-
21 ceive qualified prescription drug coverage under this part
22 through such plan.

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

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

3 “(A) IN GENERAL.—The Secretary shall
4 assure that each individual who is entitled to
5 benefits under part A or is enrolled under part
6 B and who is residing in an area has available,
7 consistent with subparagraph (B), a choice of
8 enrollment in at least two qualifying plans (as
9 defined in paragraph (5)) in the area in which
10 the individual resides, at least one of which is
11 a prescription drug plan.

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

18 “(2) GUARANTEEING ACCESS TO COVERAGE.—
19 In order to assure access under paragraph (1) and
20 consistent with paragraph (3), the Secretary may
21 provide financial incentives (including partial under-
22 writing of risk) for a PDP sponsor to expand the
23 service area under an existing prescription drug plan
24 to adjoining or additional areas or to establish such
25 a plan (including offering such a plan on a regional

1 or nationwide basis), but only so long as (and to the
2 extent) necessary to assure the access guaranteed
3 under paragraph (1).

4 “(3) LIMITATION ON AUTHORITY.—In exer-
5 cising authority under this subsection, the Sec-
6 retary—

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

9 “(B) shall not provide for any under-
10 writing of financial risk for a public PDP spon-
11 sor with respect to the offering of a nationwide
12 prescription drug plan; and

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

16 “(4) REPORTS.—The Secretary shall, in each
17 annual report to Congress under section 1807(f), in-
18 clude information on the exercise of authority under
19 this subsection. The Secretary also shall include
20 such recommendations as may be appropriate to
21 minimize the exercise of such authority, including
22 minimizing the assumption of financial risk.

23 “(5) QUALIFYING PLAN DEFINED.—For pur-
24 poses of this subsection, the term ‘qualifying plan’
25 means a prescription drug plan or a

1 Medicare+Choice plan that includes qualified pre-
2 scription drug coverage.

3 **“SEC. 1860F. PREMIUMS.**

4 “(a) SUBMISSION OF PREMIUMS AND RELATED IN-
5 FORMATION.—

6 “(1) IN GENERAL.—Each PDP sponsor shall
7 submit to the Secretary information of the type de-
8 scribed in paragraph (2) in the same manner as in-
9 formation is submitted by a Medicare+Choice orga-
10 nization under section 1854(a)(1).

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

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

15 “(B) Information on the actuarial value of
16 the coverage.

17 “(C) Information on the monthly premium
18 to be charged for the coverage, including an ac-
19 tuarial certification of—

20 “(i) the actuarial basis for such pre-
21 mium;

22 “(ii) the portion of such premium at-
23 tributable to benefits in excess of standard
24 coverage; and

1 “(iii) the reduction in such premium
2 resulting from the reinsurance subsidy
3 payments provided under section 1860H.

4 “(D) Such other information as the Sec-
5 retary may require to carry out this part.

6 “(3) REVIEW.—The Secretary shall review the
7 information filed under paragraph (2) for the pur-
8 pose of conducting negotiations under section
9 1860D(b)(2).

10 “(4) LIMITATIONS ON PREMIUMS.—

11 “(A) \$35 MONTHLY PREMIUM FOR 2006.—
12 In no case may the monthly premium of a PDP
13 plan for months in 2006 exceed \$35.

14 “(B) MONTHLY PREMIUM LIMITATION FOR
15 SUBSEQUENT YEARS.—In no case may the
16 monthly premium of a PDP plan for months in
17 a year after 2006 exceed the dollar limitation
18 specified in this paragraph for the preceding
19 year adjusted by the annual percentage change
20 in the increase in the consumer price index for
21 all urban consumers (U.S. city average) as esti-
22 mated by the Secretary for the 12-month period
23 ending with the midpoint of previous year. If
24 any dollar amount after being adjusted under
25 this subparagraph is not a multiple of \$1, such

1 dollar amount shall be rounded to the nearest
2 multiple of \$1.

3 “(b) UNIFORM PREMIUM.—The premium for a pre-
4 scription drug plan charged under this section may not
5 vary among individuals enrolled in the plan in the same
6 service area, except as is permitted under section
7 1860A(c)(2)(B) (relating to late enrollment penalties).

8 “(c) TERMS AND CONDITIONS FOR IMPOSING PRE-
9 MIUMS.—The provisions of section 1854(d) shall apply
10 under this part in the same manner as they apply under
11 part C, and, for this purpose, the reference in such section
12 to section 1851(g)(3)(B)(i) is deemed a reference to sec-
13 tion 1860A(d)(3)(B) (relating to failure to pay premiums
14 required under this part).

15 “(d) ACCEPTANCE OF REFERENCE PREMIUM AS
16 FULL PREMIUM IF NO STANDARD (OR EQUIVALENT)
17 COVERAGE IN AN AREA.—

18 “(1) IN GENERAL.—If there is no standard pre-
19 scription drug coverage (as defined in paragraph
20 (2)) offered in an area, in the case of an individual
21 who is eligible for a premium subsidy under section
22 1860G and resides in the area, the PDP sponsor of
23 any prescription drug plan offered in the area (and
24 any Medicare+Choice organization that offers quali-
25 fied prescription drug coverage in the area) shall ac-

1 cept the reference premium under section
2 1860G(b)(2) as payment in full for the premium
3 charge for qualified prescription drug coverage.

4 “(2) STANDARD PRESCRIPTION DRUG COV-
5 ERAGE DEFINED.—For purposes of this subsection,
6 the term ‘standard prescription drug coverage’
7 means qualified prescription drug coverage that is
8 standard coverage or that has an actuarial value
9 equivalent to the actuarial value for standard cov-
10 erage.

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

13 “(a) IN GENERAL.—

14 “(1) FULL PREMIUM SUBSIDY AND REDUCTION
15 OF COST-SHARING FOR INDIVIDUALS WITH INCOME
16 BELOW 135 PERCENT OF FEDERAL POVERTY
17 LEVEL.—In the case of a subsidy eligible individual
18 (as defined in paragraph (4)) who is determined to
19 have income that does not exceed 150 percent of the
20 Federal poverty level, the individual is entitled under
21 this section—

22 “(A) to a premium subsidy equal to 100
23 percent of the amount described in subsection
24 (b)(1); and

1 “(B) subject to subsection (c), to the sub-
2 stitution for the beneficiary cost-sharing de-
3 scribed in section 1860B(b)(2)) of amounts
4 that are nominal.

5 “(2) PREMIUM SUBSIDY ONLY FOR INDIVID-
6 UALS WITH INCOME ABOVE 150, BUT BELOW 175
7 PERCENT, OF FEDERAL POVERTY LEVEL.—In the
8 case of a subsidy eligible individual who is deter-
9 mined to have income that exceeds 150 percent, but
10 does not exceed 175 percent, of the Federal poverty
11 level, the individual is entitled under this section to
12 a premium subsidy equal to 100 percent of the
13 amount described in subsection (b)(1).

14 “(3) SLIDING SCALE PREMIUM SUBSIDY FOR
15 INDIVIDUALS WITH INCOME ABOVE 175, BUT BELOW
16 200 PERCENT, OF FEDERAL POVERTY LEVEL.—In
17 the case of a subsidy eligible individual who is deter-
18 mined to have income that exceeds 175 percent, but
19 does not exceed 200 percent, of the Federal poverty
20 level, the individual is entitled under this section to
21 a premium subsidy determined on a linear sliding
22 scale ranging from 100 percent of the amount de-
23 scribed in subsection (b)(1) for individuals with in-
24 comes at 175 percent of such level to 0 percent of

1 such amount for individuals with incomes at 200
2 percent of such level.

3 “(4) DETERMINATION OF ELIGIBILITY.—

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

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

11 “(ii) has income below 200 percent of
12 the Federal poverty line.

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

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

1 “(i) income shall be determined in the
2 manner described in section
3 1905(p)(1)(B); and

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

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

18 “(b) PREMIUM SUBSIDY AMOUNT.—

19 “(1) IN GENERAL.—The premium subsidy
20 amount described in this subsection for an individual
21 residing in an area is the reference premium (as de-
22 fined in paragraph (2)) for qualified prescription
23 drug coverage offered by the prescription drug plan
24 or the Medicare+Choice plan in which the individual
25 is enrolled.

1 “(2) REFERENCE PREMIUM DEFINED.—For
2 purposes of this subsection, the term ‘reference pre-
3 mium’ means, with respect to qualified prescription
4 drug coverage offered under—

5 “(A) a prescription drug plan that—

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

15 “(ii) provides alternative prescription
16 drug coverage the actuarial value of which
17 is greater than that of standard coverage,
18 the premium described in clause (i) multi-
19 plied by the ratio of (I) the actuarial value
20 of standard coverage, to (II) the actuarial
21 value of the alternative coverage; or

22 “(B) a Medicare+Choice plan, the stand-
23 ard premium computed under section
24 1851(j)(5)(A)(iii), determined without regard to

1 any reduction effected under section
2 1851(j)(5)(B).

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

5 “(1) IN GENERAL.—In applying subsection
6 (a)(1)(B)—

7 “(A) the maximum amount of subsidy that
8 may be provided with respect to an enrollee for
9 a year may not exceed 95 percent of the max-
10 imum cost-sharing described in such subsection
11 that may be incurred for standard coverage;

12 “(B) the Secretary shall determine what is
13 ‘nominal’ taking into account the rules applied
14 under section 1916(a)(3); and

15 “(C) nothing in this part shall be con-
16 strued as preventing a plan or provider from
17 waiving or reducing the amount of cost-sharing
18 otherwise applicable.

19 “(2) LIMITATION ON CHARGES.—In the case of
20 an individual receiving cost-sharing subsidies under
21 subsection (a)(1)(B), the PDP sponsor may not
22 charge more than a nominal amount in cases in
23 which the cost-sharing subsidy is provided under
24 such subsection.

1 “(d) ADMINISTRATION OF SUBSIDY PROGRAM.—The
2 Secretary shall provide a process whereby, in the case of
3 an individual who is determined to be a subsidy eligible
4 individual and who is enrolled in prescription drug plan
5 or is enrolled in a Medicare+Choice plan under which
6 qualified prescription drug coverage is provided—

7 “(1) the Secretary provides for a notification of
8 the PDP sponsor or Medicare+Choice organization
9 involved that the individual is eligible for a subsidy
10 and the amount of the subsidy under subsection (a);

11 “(2) the sponsor or organization involved re-
12 duces the premiums or cost-sharing otherwise im-
13 posed by the amount of the applicable subsidy and
14 submits to the Secretary information on the amount
15 of such reduction; and

16 “(3) the Secretary periodically and on a timely
17 basis reimburses the sponsor or organization for the
18 amount of such reductions.

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

24 “(e) RELATION TO MEDICAID PROGRAM.—

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

4 “(2) MEDICAID PROVIDING WRAP AROUND BEN-
5 EFITS.—The coverage provided under this part is
6 primary payor to benefits for prescribed drugs pro-
7 vided under the medicaid program under title XIX.

8 **“SEC. 1860H. SUBSIDIES FOR ALL MEDICARE BENE-**
9 **FICIARIES THROUGH REINSURANCE FOR**
10 **QUALIFIED PRESCRIPTION DRUG COVERAGE.**

11 “(a) REINSURANCE SUBSIDY PAYMENT.—In order to
12 reduce premium levels applicable to qualified prescription
13 drug coverage for all medicare beneficiaries, to reduce ad-
14 verse selection among prescription drug plans and
15 Medicare+Choice plans that provide qualified prescription
16 drug coverage, and to promote the participation of PDP
17 sponsors under this part, the Secretary shall provide in
18 accordance with this section for payment to a qualifying
19 entity (as defined in subsection (b)) of the reinsurance
20 payment amount (as defined in subsection (c)) for excess
21 costs incurred in providing qualified prescription drug cov-
22 erage—

23 “(1) for individuals enrolled with a prescription
24 drug plan under this part;

1 “(2) for individuals enrolled with a
2 Medicare+Choice plan that provides qualified pre-
3 scription drug coverage under part C; and

4 “(3) for medicare primary individuals (de-
5 scribed in subsection (e)(3)(D)) who are enrolled in
6 a qualified retiree prescription drug plan.

7 This section constitutes budget authority in advance of ap-
8 propriations Acts and represents the obligation of the Sec-
9 retary to provide for the payment of amounts provided
10 under this section.

11 “(b) QUALIFYING ENTITY DEFINED.—For purposes
12 of this section, the term ‘qualifying entity’ means any of
13 the following that has entered into an agreement with the
14 Secretary to provide the Secretary with such information
15 as may be required to carry out this section:

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

18 “(2) A Medicare+Choice organization that pro-
19 vides qualified prescription drug coverage under a
20 Medicare+Choice plan under part C.

21 “(3) The sponsor of a qualified retiree prescrip-
22 tion drug plan (as defined in subsection (e)).

23 “(c) REINSURANCE PAYMENT AMOUNT.—

24 “(1) IN GENERAL.—Subject to paragraph (3),
25 the reinsurance payment amount under this sub-

1 section for a qualifying covered individual (as de-
2 fined in subsection (f)(1)) for a coverage year (as
3 defined in subsection (f)(2)) is equal to such per-
4 centages, at such attachment points, as the Sec-
5 retary may specify in order to provide that the total
6 of the payments made for the year under this sec-
7 tion is equal to 65 percent of the total payments de-
8 scribed in paragraph (2)(B) during the year. The
9 Secretary shall adjust such percentages and attach-
10 ment points each year.

11 “(2) PAYMENT COMPUTATIONS.—The Secretary
12 shall estimate—

13 “(A) the total payments to be made (with-
14 out regard to this subsection) during a year
15 under this section; and

16 “(B) the total payments to be made by
17 qualifying entities for standard coverage under
18 plans described in subsection (b) during the
19 year.

20 “(3) ADJUSTMENT OF PAYMENTS.—In lieu of,
21 or in addition to, the adjustment made under para-
22 graph (1), the Secretary may provide for such pay-
23 ment adjustments (or direct subsidy payments) to
24 PDP sponsors as the Secretary may specify in order
25 to assure participation of PDP sponsors under this

1 part consistent with the limitations on premiums
2 under section 1860F(a)(4).

3 “(d) PAYMENT METHODS.—

4 “(1) IN GENERAL.—Payments under this sec-
5 tion shall be based on such a method as the Sec-
6 retary determines. The Secretary may establish a
7 payment method by which interim payments of
8 amounts under this section are made during a year
9 based on the Secretary’s best estimate of amounts
10 that will be payable after obtaining all of the infor-
11 mation.

12 “(2) SOURCE OF PAYMENTS.—Payments under
13 this section shall be made from the Medicare Pre-
14 scription Drug Account.

15 “(e) QUALIFIED RETIREE PRESCRIPTION DRUG
16 PLAN DEFINED.—

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

24 “(A) ASSURANCE.—The sponsor of the
25 plan shall annually attest, and provide such as-

1 surances as the Secretary may require, that the
2 coverage meets the requirements for qualified
3 prescription drug coverage.

4 “(B) AUDITS.—The sponsor (and the plan)
5 shall maintain, and afford the Secretary access
6 to, such records as the Secretary may require
7 for purposes of audits and other oversight ac-
8 tivities necessary to ensure the adequacy of pre-
9 scription drug coverage, the accuracy of pay-
10 ments made, and such other matters as may be
11 appropriate.

12 “(C) PROVISION OF CERTIFICATION OF
13 PRESCRIPTION DRUG COVERAGE.—The sponsor
14 of the plan shall provide for issuance of certifi-
15 cations of the type described in section
16 1860A(c)(2)(D).

17 “(D) OTHER REQUIREMENTS.—The spon-
18 sor of the plan shall comply with such other re-
19 quirements as the Secretary finds necessary to
20 administer the program under this section.

21 “(2) LIMITATION ON BENEFIT ELIGIBILITY.—
22 No payment shall be provided under this section
23 with respect to an individual who is enrolled under
24 a qualified retiree prescription drug plan unless the
25 individual is a medicare primary individual who—

1 “(A) is covered under the plan; and

2 “(B) is eligible to obtain qualified prescrip-
3 tion drug coverage under section 1860A but did
4 not elect such coverage under this part (either
5 through a prescription drug plan or through a
6 Medicare+Choice plan).

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

8 “(A) EMPLOYMENT-BASED RETIREE
9 HEALTH COVERAGE.—The term ‘employment-
10 based retiree health coverage’ means health in-
11 surance or other coverage of health care costs
12 for medicare primary individuals (or for such
13 individuals and their spouses and dependents)
14 based on their status as former employees or
15 labor union members.

16 “(B) EMPLOYER.—The term ‘employer’
17 has the meaning given such term by section
18 3(5) of the Employee Retirement Income Secu-
19 rity Act of 1974 (except that such term shall
20 include only employers of two or more employ-
21 ees).

22 “(C) SPONSOR.—The term ‘sponsor’
23 means a plan sponsor, as defined in section
24 3(16)(B) of the Employee Retirement Income
25 Security Act of 1974.

1 “(D) MEDICARE PRIMARY INDIVIDUAL.—
2 The term ‘medicare primary individual’ means,
3 with respect to a plan, an individual who is cov-
4 ered under the plan and with respect to whom
5 the plan is not a primary plan (as defined in
6 section 1862(b)(2)(A)).

7 “(f) 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 covered as a medicare primary in-
18 dividual under a qualified retiree prescription
19 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 of
24 when the claim is paid.

1 **“SEC. 1860I. MEDICARE PRESCRIPTION DRUG ACCOUNT IN**
2 **FEDERAL SUPPLEMENTARY MEDICAL INSUR-**
3 **ANCE TRUST FUND.**

4 “(a) IN GENERAL.—There is created within the Fed-
5 eral Supplementary Medical Insurance Trust Fund estab-
6 lished by section 1841 an account to be known as the
7 ‘Medicare Prescription Drug Account’ (in this section re-
8 ferred to as the ‘Account’). The Account shall consist of
9 such gifts and bequests as may be made as provided in
10 section 201(i)(1), and such amounts as may be deposited
11 in, or appropriated to, such fund as provided in this part.
12 Funds provided under this part to the Account shall be
13 kept separate from all other funds within the Federal Sup-
14 plementary Medical Insurance Trust Fund.

15 “(b) PAYMENTS FROM ACCOUNT.—

16 “(1) IN GENERAL.—The Managing Trustee
17 shall pay from time to time from the Account such
18 amounts as the Secretary certifies are necessary to
19 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 reinsurance 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 Account to the Grants to States for Medicaid ac-
5 count amounts the Secretary certifies are attrib-
6 utable to increases in payment resulting from the
7 application of a higher Federal matching percentage
8 under section 1935(b).

9 “(3) TREATMENT IN RELATION TO PART B PRE-
10 MIUM.—Amounts payable from the Account shall not
11 be taken into account in computing actuarial rates
12 or premium amounts under section 1839.

13 “(c) DEPOSITS INTO ACCOUNT.—

14 “(1) MEDICAID TRANSFER.—There is hereby
15 transferred to the Account, from amounts appro-
16 priated for Grants to States for Medicaid, amounts
17 equivalent to the aggregate amount of the reductions
18 in payments under section 1903(a)(1) attributable to
19 the application of section 1935(c).

20 “(2) APPROPRIATIONS TO COVER GOVERNMENT
21 CONTRIBUTIONS.—There are authorized to be appro-
22 priated from time to time, out of any moneys in the
23 Treasury not otherwise appropriated, to the Ac-
24 count, an amount equivalent to the amount of pay-
25 ments made from the Account under subsection (b),

1 reduced by the amount transferred to the Account
2 under paragraph (1).

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

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

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

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

14 “(3) MEDICARE PRESCRIPTION DRUG AC-
15 COUNT.—The term ‘Medicare Prescription Drug Ac-
16 count’ means the Account in the Federal Supple-
17 mentary Medical Insurance Trust Fund created
18 under 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 Secretary
4 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 “MEDICARE PRESCRIPTION DRUG ADVISORY COMMITTEE

7 “SEC. 1860K. (a) ESTABLISHMENT OF COM-
8 MITTEE.—There is established a Medicare Prescription
9 Drug Advisory Committee (in this section referred to as
10 the ‘Committee’).

11 “(b) FUNCTIONS OF COMMITTEE.—The Committee
12 shall advise the Secretary on policies related to the devel-
13 opment of standards and guidelines for the implementa-
14 tion and administration of the outpatient prescription
15 drug benefit program under this part.

16 “(c) STRUCTURE AND MEMBERSHIP OF THE COM-
17 MITTEE.—

18 “(1) STRUCTURE.—The Committee shall be
19 composed of 19 members, of whom—

20 “(A) 12 shall be appointed by the Sec-
21 retary;

22 “(B) 3 shall be appointed by the President;

23 “(C) 2 shall be appointed by the Speaker
24 of the House of Representatives; and

25 “(D) 2 shall be appointed by the Majority
26 Leader of the Senate.

1 “(2) MEMBERSHIP.—

2 “(A) IN GENERAL.—The members of the
3 Committee shall be chosen on the basis of their
4 integrity, impartiality, and good judgment, and
5 shall be individuals who are, by reason of their
6 education, experience, and attainments, excep-
7 tionally qualified to perform the duties of mem-
8 bers of the Committee.

9 “(B) SPECIFIC MEMBERS.—Of the mem-
10 bers appointed under paragraph (1)(A)—

11 “(i) 4 shall be chosen to represent
12 physicians;

13 “(ii) 3 shall be chosen to represent
14 pharmacists;

15 “(iii) 1 shall be chosen to represent
16 the Centers for Medicare & Medicaid Serv-
17 ices;

18 “(iv) 3 shall be chosen to represent
19 actuaries, pharmacoeconomists, research-
20 ers, and other appropriate experts; and

21 “(v) 1 shall be chosen to represent
22 emerging drug technologies.

23 “(d) TERMS OF APPOINTMENT.—Each member of
24 the Committee shall serve for a term determined appro-

1 piate by the Secretary. The terms of service of the mem-
2 bers initially appointed shall begin on January 1, 2004.

3 “(e) CHAIRPERSON.—The Secretary shall designate
4 a member of the Committee as Chairperson. The term as
5 Chairperson shall be for a 1-year period.

6 “(f) COMMITTEE PERSONNEL MATTERS.—

7 “(1) MEMBERS.—

8 “(A) COMPENSATION.—Each member of
9 the Committee who is not an officer or em-
10 ployee of the Federal Government shall be com-
11 pensated at a rate equal to the daily equivalent
12 of the annual rate of basic pay prescribed for
13 level IV of the Executive Schedule under section
14 5315 of title 5, United States Code, for each
15 day (including travel time) during which such
16 member is engaged in the performance of the
17 duties of the Committee. All members of the
18 Committee who are officers or employees of the
19 United States shall serve without compensation
20 in addition to that received for their services as
21 officers or employees of the United States.

22 “(B) TRAVEL EXPENSES.—The members
23 of the Committee shall be allowed travel ex-
24 penses, including per diem in lieu of subsist-
25 ence, at rates authorized for employees of agen-

1 cies under subchapter I of chapter 57 of title 5,
2 United States Code, while away from their
3 homes or regular places of business in the per-
4 formance of services for the Committee.

5 “(2) STAFF.—The Committee may appoint
6 such personnel as the Committee considers appro-
7 priate.

8 “(g) OPERATION OF THE COMMITTEE.—

9 “(1) MEETINGS.—The Committee shall meet at
10 the call of the Chairperson (after consultation with
11 the other members of the Committee) not less often
12 than quarterly to consider a specific agenda of
13 issues, as determined by the Chairperson after such
14 consultation.

15 “(2) QUORUM.—Ten members of the Com-
16 mittee shall constitute a quorum for purposes of
17 conducting business.

18 “(h) FEDERAL ADVISORY COMMITTEE ACT.—Section
19 14 of the Federal Advisory Committee Act (5 U.S.C.
20 App.) shall not apply to the Committee.

21 “(i) TRANSFER OF PERSONNEL, RESOURCES, AND
22 ASSETS.—For purposes of carrying out its duties, the Sec-
23 retary and the Committee may provide for the transfer
24 to the Committee of such civil service personnel in the em-
25 ploy of the Department of Health and Human Services

1 (including the Centers for Medicare & Medicaid Services),
2 and such resources and assets of the Department used in
3 carrying out this title, as the Committee requires.

4 “(j) AUTHORIZATION OF APPROPRIATIONS.—There
5 are authorized to be appropriated such sums as may be
6 necessary to carry out the purposes of this section.”.

7 (b) CONFORMING AMENDMENTS TO FEDERAL SUP-
8 PLEMENTARY MEDICAL INSURANCE TRUST FUND.—Sec-
9 tion 1841 of the Social Security Act (42 U.S.C. 1395t)
10 is amended—

11 (1) in the last sentence of subsection (a)—

12 (A) by striking “and” before “such
13 amounts”; and

14 (B) by inserting before the period the fol-
15 lowing: “and such amounts as may be deposited
16 in, or appropriated to, the Medicare Prescrip-
17 tion Drug Account established by section
18 1860I”; and

19 (2) in subsection (g), by inserting after “by this
20 part,” the following: “the payments provided for
21 under part D (in which case the payments shall
22 come from the Medicare Prescription Drug Account
23 in the Trust Fund),”.

24 (c) ADDITIONAL CONFORMING CHANGES.—

1 an enrollee under a Medicare+Choice plan unless
2 such drug coverage is at least qualified prescription
3 drug coverage and unless the requirements of this
4 subsection with respect to such coverage are met.

5 “(2) COMPLIANCE WITH ADDITIONAL BENE-
6 FICIARY PROTECTIONS.—With respect to the offer-
7 ing of qualified prescription drug coverage by a
8 Medicare+Choice organization under a
9 Medicare+Choice plan, the organization and plan
10 shall meet the requirements of section 1860C, in-
11 cluding requirements relating to information dis-
12 semination and grievance and appeals, in the same
13 manner as they apply to a PDP sponsor and a pre-
14 scription drug plan under part D. The Secretary
15 shall waive such requirements to the extent the Sec-
16 retary determines that such requirements duplicate
17 requirements otherwise applicable to the organiza-
18 tion or plan under this part.

19 “(3) TREATMENT OF COVERAGE.—Except as
20 provided in this subsection, qualified prescription
21 drug coverage offered under this subsection shall be
22 treated under this part in the same manner as sup-
23 plemental health care benefits described in section
24 1852(a)(3)(A).

1 “(4) AVAILABILITY OF PREMIUM AND COST-
2 SHARING SUBSIDIES FOR LOW-INCOME ENROLLEES
3 AND REINSURANCE SUBSIDY PAYMENTS FOR ORGA-
4 NIZATIONS.—For provisions—

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

9 “(B) providing a Medicare+Choice organi-
10 zation with reinsurance subsidy payments for
11 providing qualified prescription drug coverage
12 under this part, see section 1860H.

13 “(5) SPECIFICATION OF SEPARATE AND STAND-
14 ARD PREMIUM.—

15 “(A) IN GENERAL.—For purposes of ap-
16 plying section 1854 and section 1860G(b)(2)(B)
17 with respect to qualified prescription drug cov-
18 erage offered under this subsection under a
19 plan, the Medicare+Choice organization shall
20 compute and publish the following:

21 “(i) SEPARATE PRESCRIPTION DRUG
22 PREMIUM.—A premium for prescription
23 drug benefits that constitute qualified pre-
24 scription drug coverage that is separate
25 from other coverage under the plan. Such

1 premium shall be established consistent
2 with the limitations described in section
3 1860F(a)(4).

4 “(ii) PORTION OF COVERAGE ATTRIB-
5 UTABLE TO STANDARD BENEFITS.—The
6 ratio of the actuarial value of standard
7 coverage to the actuarial value of the
8 qualified prescription drug coverage offered
9 under the plan.

10 “(iii) PORTION OF PREMIUM ATTRIB-
11 UTABLE TO STANDARD BENEFITS.—A
12 standard premium equal to the product of
13 the premium described in clause (i) and
14 the ratio under clause (ii).

15 The premium under clause (i) shall be compute
16 without regard to any reduction in the premium
17 permitted under subparagraph (B).

18 “(B) REDUCTION OF PREMIUMS AL-
19 LOWED.—Nothing in this subsection shall be
20 construed as preventing a Medicare+Choice or-
21 ganization from reducing the amount of a pre-
22 mium charged for prescription drug coverage
23 because of the application of section
24 1854(f)(1)(A) to other coverage.

1 “(C) ACCEPTANCE OF REFERENCE PRE-
2 MIUM AS FULL PREMIUM IF NO STANDARD (OR
3 EQUIVALENT) COVERAGE IN AN AREA.—For re-
4 quirement to accept reference premium as full
5 premium if there is no standard (or equivalent)
6 coverage in the area of a Medicare+Choice
7 plan, see section 1860F(d).

8 “(6) TRANSITION IN INITIAL ENROLLMENT PE-
9 RIOD.—Notwithstanding any other provision of this
10 part, the annual, coordinated election period under
11 subsection (e)(3)(B) for 2004 shall be the 6-month
12 period beginning with November 2003.

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

18 (b) CONFORMING AMENDMENTS.—Section 1851 of
19 such Act (42 U.S.C. 1395w–21) is amended—

20 (1) in subsection (a)(1)—

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

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

1 (C) by adding after and below subpara-
2 graph (B) the following:

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

5 (2) in subsection (g)(1), by inserting “and sec-
6 tion 1860A(c)(2)(B)” after “in this subsection”.

7 (c) EFFECTIVE DATE.—The amendments made by
8 this section apply to coverage provided on or after January
9 1, 2006.

10 **SEC. 4. MEDICAID AMENDMENTS.**

11 (a) DETERMINATIONS OF ELIGIBILITY FOR LOW-IN-
12 COME SUBSIDIES.—

13 (1) REQUIREMENT.—Section 1902 of the Social
14 Security Act (42 U.S.C. 1396a) is amended—

15 (A) in subsection (a)—

16 (i) by striking “and” at the end of
17 paragraph (64);

18 (ii) by striking the period at the end
19 of paragraph (65) and inserting “; and”;
20 and

21 (iii) by inserting after paragraph (65)
22 the following new paragraph:

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

1 (2) NEW SECTION.—Title XIX of such Act is
2 further amended—

3 (A) by redesignating section 1935 as sec-
4 tion 1936; and

5 (B) by inserting after section 1934 the fol-
6 lowing new section:

7 “SPECIAL PROVISIONS RELATING TO MEDICARE

8 PRESCRIPTION DRUG BENEFIT

9 “SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGI-
10 BILITY DETERMINATIONS FOR LOW-INCOME SUB-
11 SIDIES.—As a condition of its State plan under this title
12 under section 1902(a)(66) and receipt of any Federal fi-
13 nancial assistance under section 1903(a), a State shall—

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

17 “(2) inform the Secretary of such determina-
18 tions in cases in which such eligibility is established;
19 and

20 “(3) otherwise provide such Secretary with such
21 information as may be required to carry out part D
22 of title XVIII (including section 1860G).

23 “(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE
24 COSTS.—

25 “(1) IN GENERAL.—The amounts expended by
26 a State in carrying out subsection (a) are, subject to

1 paragraph (2), expenditures reimbursable under the
2 appropriate paragraph of section 1903(a); except
3 that, notwithstanding any other provision of such
4 section, the applicable Federal matching rates with
5 respect to such expenditures under such section shall
6 be increased as follows:

7 “(A) For expenditures attributable to costs
8 incurred during 2006, the otherwise applicable
9 Federal matching rate shall be increased by 20
10 percent of the percentage otherwise payable
11 (but for this subsection) by the State.

12 “(B) For expenditures attributable to costs
13 incurred during 2007, the otherwise applicable
14 Federal matching rate shall be increased by 40
15 percent of the percentage otherwise payable
16 (but for this subsection) by the State.

17 “(C) For expenditures attributable to costs
18 incurred during 2008, the otherwise applicable
19 Federal matching rate shall be increased by 60
20 percent of the percentage otherwise payable
21 (but for this subsection) by the State.

22 “(D) For expenditures attributable to costs
23 incurred during 2009, the otherwise applicable
24 Federal matching rate shall be increased by 80

1 percent of the percentage otherwise payable
2 (but for this subsection) by the State.

3 “(E) For expenditures attributable to costs
4 incurred after 2010, the otherwise applicable
5 Federal matching rate shall be increased to 100
6 percent.

7 “(2) COORDINATION.—The State shall provide
8 the Secretary with such information as may be nec-
9 essary to properly allocate administrative expendi-
10 tures described in paragraph (1) that may otherwise
11 be made for similar eligibility determinations.”.

12 (b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID
13 RESPONSIBILITY FOR PREMIUM AND COST-SHARING SUB-
14 SIDIES FOR DUALY ELIGIBLE INDIVIDUALS.—

15 (1) IN GENERAL.—Section 1903(a)(1) of the
16 Social Security Act (42 U.S.C. 1396b(a)(1)) is
17 amended by inserting before the semicolon the fol-
18 lowing: “, reduced by the amount computed under
19 section 1935(c)(1) for the State and the quarter”.

20 (2) AMOUNT DESCRIBED.—Section 1935 of
21 such Act, as inserted by subsection (a)(2), is amend-
22 ed by adding at the end the following new sub-
23 section:

1 “(c) FEDERAL ASSUMPTION OF MEDICAID PRE-
2 SCRIPTION DRUG COSTS FOR DUALY-ELIGIBLE BENE-
3 FIARIIES.—

4 “(1) IN GENERAL.—For purposes of section
5 1903(a)(1), for a State that is one of the 50 States
6 or the District of Columbia for a calendar quarter
7 in a year (beginning with 2006) the amount com-
8 puted under this subsection is equal to the product
9 of the following:

10 “(A) MEDICARE SUBSIDIES.—The total
11 amount of payments made in the quarter under
12 section 1860G (relating to premium and cost-
13 sharing prescription drug subsidies for low-in-
14 come medicare beneficiaries) that are attrib-
15 utable to individuals who are residents of the
16 State and are entitled to benefits with respect
17 to prescribed drugs under the State plan under
18 this title (including such a plan operating under
19 a waiver under section 1115).

20 “(B) STATE MATCHING RATE.—A propor-
21 tion computed by subtracting from 100 percent
22 the Federal medical assistance percentage (as
23 defined in section 1905(b)) applicable to the
24 State and the quarter.

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

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

7 “(A) 2006 is 80 percent;

8 “(B) 2007 is 60 percent;

9 “(C) 2008 is 40 percent;

10 “(D) 2009 is 20 percent; or

11 “(E) a year after 2009 is 0 percent.”.

12 (c) MEDICAID PROVIDING WRAP-AROUND BENE-
13 FITS.—Section 1935 of such Act, as so inserted and
14 amended, is further amended by adding at the end the
15 following new subsection:

16 “(d) ADDITIONAL PROVISIONS.—

17 “(1) MEDICAID AS SECONDARY PAYOR.—In the
18 case of an individual dually entitled to qualified pre-
19 scription drug coverage under a prescription drug
20 plan under part D of title XVIII (or under a
21 Medicare+Choice plan under part C of such title)
22 and medical assistance for prescribed drugs under
23 this title, medical assistance shall continue to be pro-
24 vided under this title for prescribed drugs to the ex-
25 tent payment is not made under the prescription

1 drug plan or the Medicare+Choice plan selected by
2 the individual.

3 “(2) CONDITION.—A State may require, as a
4 condition for the receipt of medical assistance under
5 this title with respect to prescription drug benefits
6 for an individual eligible to obtain qualified prescrip-
7 tion drug coverage described in paragraph (1), that
8 the individual elect qualified prescription drug cov-
9 erage under section 1860A.”.

10 (d) TREATMENT OF TERRITORIES.—

11 (1) IN GENERAL.—Section 1935 of such Act, as
12 so inserted and amended, is further amended—

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

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

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

20 “(e) TREATMENT OF TERRITORIES.—

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

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

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

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

11 “(A) provides medical assistance with re-
12 spect to the provision of covered outpatient
13 drugs (as defined in section 1860B(f)) to low-
14 income medicare beneficiaries; and

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

19 “(3) INCREASED AMOUNT.—

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

23 “(i) the aggregate amount specified in
24 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) 2006, is equal to \$20,000,000; or

9 “(ii) a subsequent year, is equal to the
10 aggregate amount specified in this sub-
11 paragraph for the previous year increased
12 by annual percentage increase specified in
13 section 1860B(b)(5) for the year involved.

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(f) of such Act is amended by inserting “and
20 section 1935(e)(1)(B)” after “Subject to subsection
21 (g)”.

22 **SEC. 5. MEDIGAP TRANSITION PROVISIONS.**

23 (a) IN GENERAL.—Notwithstanding any other provi-
24 sion of law, no new medicare supplemental policy that pro-
25 vides coverage of expenses for prescription drugs may be

1 issued under section 1882 of the Social Security Act on
2 or after January 1, 2006, to an individual unless it re-
3 places a medicare supplemental policy that was issued to
4 that individual and that provided some coverage of ex-
5 penses for prescription drugs.

6 (b) ISSUANCE OF SUBSTITUTE POLICIES IF OBTAIN
7 PRESCRIPTION DRUG COVERAGE THROUGH MEDICARE.—

8 (1) IN GENERAL.—The issuer of a medicare
9 supplemental policy—

10 (A) may not deny or condition the issuance
11 or effectiveness of a medicare supplemental pol-
12 icy that has a benefit package classified as “A”,
13 “B”, “C”, “D”, “E”, “F”, or “G” (under the
14 standards established under subsection (p)(2) of
15 section 1882 of the Social Security Act, 42
16 U.S.C. 1395ss) and that is offered and is avail-
17 able for issuance to new enrollees by such
18 issuer;

19 (B) may not discriminate in the pricing of
20 such policy, because of health status, claims ex-
21 perience, receipt of health care, or medical con-
22 dition; and

23 (C) may not impose an exclusion of bene-
24 fits based on a pre-existing condition under
25 such policy,

1 in the case of an individual described in paragraph
2 (2) who seeks to enroll under the policy not later
3 than 63 days after the date of the termination of en-
4 rollment described in such paragraph and who sub-
5 mits evidence of the date of termination or
6 disenrollment along with the application for such
7 medicare supplemental policy.

8 (2) INDIVIDUAL COVERED.—An individual de-
9 scribed in this paragraph is an individual who—

10 (A) enrolls in a prescription drug plan
11 under part D of title XVIII of the Social Secu-
12 rity Act; and

13 (B) at the time of such enrollment was en-
14 rolled and terminates enrollment in a medicare
15 supplemental policy which has a benefit pack-
16 age classified as “H”, “I”, or “J” under the
17 standards referred to in paragraph (1)(A) or
18 terminates enrollment in a policy to which such
19 standards do not apply but which provides ben-
20 efits for prescription drugs.

21 (3) ENFORCEMENT.—The provisions of para-
22 graph (1) shall be enforced as though they were in-
23 cluded in section 1882(s) of the Social Security Act
24 (42 U.S.C. 1395ss(s)).

1 (4) DEFINITIONS.—For purposes of this sub-
2 section, the term “medicare supplemental policy”
3 has the meaning given such term in section 1882(g)
4 of the Social Security Act (42 U.S.C. 1395ss(g)).

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