

107TH CONGRESS
1ST SESSION

S. 358

To amend the Social Security Act to establish a Medicare Prescription Drug and Supplemental Benefit Program and for other purposes.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 15, 2001

Mr. BREAUX (for himself and Mr. FRIST) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend the Social Security Act to establish a Medicare Prescription Drug and Supplemental Benefit Program and for other purposes.

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 Prescription Drug and Modernization Act of
6 2001”.

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. Findings and purposes.

TITLE I—MEDICARE MANAGEMENT AND ADMINISTRATION

Subtitle A—Establishment of the Competitive Medicare Agency

Sec. 101. Establishment of the Competitive Medicare Agency.

“TITLE XXII—MEDICARE COMPETITION AND PRESCRIPTION DRUGS

“PART A—ESTABLISHMENT OF THE COMPETITIVE MEDICARE AGENCY

“Sec. 2201. Competitive Medicare Agency.

“Sec. 2202. Commissioner; Deputy Commissioner; other officers.

“Sec. 2203. Administrative duties of the Commissioner.

“Sec. 2204. Medicare Competition and Prescription Drug Advisory Board.”.

Sec. 102. Commissioner as member of the board of trustees of the medicare trust funds.

Sec. 103. Salary increase for the HCFA Administrator.

Subtitle B—Redefined Medicare Solvency Measures

Sec. 151. Requirements for annual financial reporting and oversight of medicare program.

TITLE II—MEDICARE PRESCRIPTION DRUG AND SUPPLEMENTAL BENEFIT PROGRAM

Sec. 201. Establishment of program.

“PART B—MEDICARE PRESCRIPTION DRUG AND SUPPLEMENTAL BENEFIT PROGRAM

“Sec. 2221. Establishment of Prescription Drug and Supplemental Benefit Program.

“Sec. 2222. Enrollment under program.

“Sec. 2223. Election of a Medicare Prescription Plus plan.

“Sec. 2224. Beneficiary information.

“Sec. 2225. Outpatient prescription drug and other supplemental benefits.

“Sec. 2226. Beneficiary protections.

“Sec. 2227. Requirements for entities offering Medicare Prescription Plus plans.

“Sec. 2228. Submission of Medicare Prescription Plus plans.

“Sec. 2229. Approval of Medicare Prescription Plus plans.

“Sec. 2230. Payments to Medicare Prescription Plus plans for benefits.

“Sec. 2231. Computation and collection of beneficiary share of premium.

“Sec. 2232. Additional prescription drug subsidies through reinsurance.

“Sec. 2233. Plan fees for administrative costs.

“Sec. 2234. Medicare prescription drug account.

“Sec. 2235. Secondary payer provisions.

“Sec. 2236. Definitions; treatment of references to provisions in Medicare+Choice program.”.

Sec. 202. Amendments to Federal Supplementary Medical Insurance Trust Fund.

Sec. 203. Prescription drug coverage under the Medicare+Choice program.

Sec. 204. Medicaid amendments.

“Sec. 1935. Special provisions relating to medicare prescription drug benefit.”.

Sec. 205. Medigap provisions.

TITLE III—MEDICARE+CHOICE COMPETITION PROGRAM

Sec. 301. Medicare+Choice competition program.

TITLE IV—MEDICARE BENEFICIARY OUTREACH AND EDUCATION

Sec. 401. Medicare Consumer Coalitions.

“PART C—MEDICARE CONSUMER COALITIONS

“Sec. 2281. Establishment of medicare consumer coalitions.”.

1 **SEC. 2. FINDINGS AND PURPOSES.**

2 (a) FINDINGS.—

3 (1) Based on the deliberations of the National
4 Bipartisan Commission on the Future of Medicare,
5 the medicare program under title XVIII of the So-
6 cial Security Act in its current form is
7 unsustainable, with the part A trust fund scheduled
8 to become insolvent in 2025.

9 (2) The medicare program relies on general rev-
10 enues to pay for 36 percent of total program ex-
11 penditures and will continue to use an increasing
12 share of general revenues. Part B outlays under
13 such program, $\frac{3}{4}$ of which are funded through gen-
14 eral revenues, have increased 38 percent over the
15 past 5 years, or about 5 percent faster than the
16 economy as a whole.

17 (3) Medicare’s spending, left unchecked, will
18 continue to consume an increasing share of the Fed-
19 eral budget, leaving little room for other priorities,

1 such as defense, education, debt reduction, tax cuts,
2 and domestic spending.

3 (4) Medicare's current benefit package is out-
4 dated in that it does not provide a prescription drug
5 benefit and limits beneficiary access to new tech-
6 nologies.

7 (5) Medicare only covers 53 percent of a bene-
8 ficiary's average health care costs and exposes bene-
9 ficiaries to large out-of-pocket liabilities.

10 (6) The number of beneficiaries in the medicare
11 program is estimated to more than double by the
12 end of 2030, due to the influx of 77,000,000 baby
13 boomers beginning in 2010.

14 (7) Each year there are fewer workers paying
15 payroll taxes to fund current medicare obligations,
16 evidenced by a decrease in the number of workers
17 per retiree from 4.5 in 1960 to 3.9 in 2000. This
18 number is expected to decline further to 2.8 in 2020.

19 (8) The Balanced Budget Act of 1997, the
20 Medicare, Medicaid, and SCHIP Balanced Budget
21 Refinement Act of 1999, and the Medicare, Med-
22 icaid, and SCHIP Benefits Improvement and Pro-
23 tection Act of 2000 underscore the need to fun-
24 damentally restructure the medicare program and

1 reduce Government micromanagement of that pro-
2 gram.

3 (b) PURPOSES.—The purposes of this Act are—

4 (1) to improve the Medicare+Choice program
5 by adopting a stable, competitive system that pro-
6 vides medicare beneficiaries with better and broader
7 health coverage and a greater variety of affordable
8 options from which to choose.

9 (2) to assist all medicare beneficiaries, espe-
10 cially those with low incomes, in obtaining coverage
11 for outpatient prescription drugs;

12 (3) to establish an independent executive
13 branch Competitive Medicare Agency outside of the
14 Health Care Financing Administration and the De-
15 partment of Health and Human Services based on
16 the Social Security Administration to administer the
17 outpatient prescription drug benefit and the
18 Medicare+Choice program;

19 (4) to increase the flexibility of the medicare
20 program and provide medicare beneficiaries timely
21 access to the latest advances in the practice of medi-
22 cine and delivery of care and to end the congres-
23 sional micromanagement over prices and delivery of
24 benefits currently administered through approxi-

1 mately 130,000 pages of rules and regulations estab-
2 lished under the medicare program; and

3 (5) to better determine the financial health of
4 the medicare program by establishing a mechanism
5 that monitors the total spending and revenues of the
6 medicare program and serves as an early warning
7 system that triggers congressional debate on policy
8 decisions and that takes into account recommenda-
9 tions of the Medicare Competition and Prescription
10 Drug Advisory Board.

11 **TITLE I—MEDICARE MANAGEMENT AND ADMINISTRATION**
12 **Subtitle A—Establishment of the**
13 **Competitive Medicare Agency**

15 **SEC. 101. ESTABLISHMENT OF THE COMPETITIVE MEDI-**
16 **CARE AGENCY.**

17 (a) IN GENERAL.—The Social Security Act (42
18 U.S.C. 301 et seq.) is amended by adding at the end the
19 following new title:

1 “TITLE XXII—MEDICARE COMPETITION AND
2 PRESCRIPTION DRUGS

3 “PART A—ESTABLISHMENT OF THE COMPETITIVE
4 MEDICARE AGENCY

5 “COMPETITIVE MEDICARE AGENCY

6 “SEC. 2201. (a) ESTABLISHMENT.—There is estab-
7 lished, as an independent agency in the executive branch
8 of the Government, a Medicare Competition Agency (in
9 this part referred to as the ‘Agency’).

10 “(b) DUTY.—

11 “(1) IN GENERAL.—It shall be the duty of the
12 Agency to administer the Medicare Prescription
13 Drug and Supplemental Benefit Program under part
14 B of this title and the Medicare+Choice program
15 under part C of title XVIII.

16 “(2) TRANSITION.—The Secretary of Health
17 and Human Services (in this title referred to as the
18 ‘Secretary’), the Commissioner of the Competitive
19 Medicare Agency, and the Administrator of the
20 Health Care Financing Administration shall estab-
21 lish an appropriate transition of responsibility in
22 order to redelegate the administration of part C
23 from the Secretary and the Administrator of the
24 Health Care Financing Administration to the Com-

1 “(B) CONTINUANCE IN OFFICE.—In any
2 case in which a successor does not take office
3 at the end of a Commissioner’s term of office,
4 such Commissioner may continue in office until
5 the appointment of a successor.

6 “(C) DELAYED APPOINTMENTS.—A Com-
7 missioner appointed to a term of office after the
8 commencement of such term may serve under
9 such appointment only for the remainder of
10 such term.

11 “(D) REMOVAL.—An individual serving in
12 the office of Commissioner may be removed
13 from office only pursuant to a finding by the
14 President of neglect of duty or malfeasance in
15 office.

16 “(4) RESPONSIBILITIES.—The Commissioner
17 shall be responsible for the exercise of all powers
18 and the discharge of all duties of the Agency, and
19 shall have authority and control over all personnel
20 and activities thereof. Responsibilities of the Com-
21 missioner shall include the following:

22 “(A) GENERAL RESPONSIBILITIES.—

23 “(i) ELIGIBILITY AND ENROLL-
24 MENT.—Coordinating determinations of
25 beneficiary eligibility and enrollment under

1 title XVIII and part B of this title with
2 the Commissioner of Social Security.

3 “(ii) CONTRACTING AUTHORITY.—En-
4 tering into, and enforcing, contracts with
5 entities for the offering of Medicare Pre-
6 scription Plus plans under part B of this
7 title.

8 “(iii) DISSEMINATION OF INFORMA-
9 TION.—Conducting information activities
10 under sections 1804 and 1851(d) of title
11 XVIII, and under part B of this title with
12 respect to benefits and limitations on pay-
13 ment under Medicare Prescription Plus
14 plans under part B of this title, including
15 a comparative analysis of such plans and
16 the quality of such plans in the area in
17 which the medicare beneficiary resides.
18 The information disseminated pursuant to
19 such activities shall be presented in a man-
20 ner so that medicare beneficiaries may
21 compare benefits under parts A and B of
22 title XVIII, part B of this title, and medi-
23 care supplemental policies under section
24 1882 with benefits under Medicare+Choice
25 plans under part C of title XVIII.

1 “(iv) DISSEMINATION OF APPEALS
2 RIGHTS INFORMATION.—Disseminating to
3 medicare beneficiaries a description of pro-
4 cedural rights (including grievance and ap-
5 peals procedures) of beneficiaries under the
6 original medicare fee-for-service program
7 under parts A and B of title XVIII, the
8 Medicare+Choice program under part C of
9 such title, and the Outpatient Prescription
10 Drug and Supplemental Benefit Program
11 under part B of this title.

12 “(v) BENEFICIARY EDUCATION PRO-
13 GRAM.—Establishing a medicare bene-
14 ficiary education program to provide time-
15 ly, readable, accurate, and understandable
16 information to medicare beneficiaries re-
17 garding Medicare Prescription Plus plan
18 options.

19 “(B) OTHER RESPONSIBILITIES.—The
20 Commissioner shall carry out any responsibility
21 provided for under part C of title XVIII or part
22 B of this title, including demonstration projects
23 carried out in part or in whole under such
24 parts, the programs of all-inclusive care for the
25 elderly (PACE program) under section 1894,

1 the social health maintenance organization
2 (SHMO) demonstration projects (referred to in
3 section 4104(c) of the Balanced Budget Act of
4 1997), and through a Medicare+Choice project
5 that demonstrates the application of capitation
6 payment rates for frail elderly medicare bene-
7 ficiaries through the use of an interdisciplinary
8 team and through the provision of primary care
9 services to such beneficiaries by means of such
10 a team at the nursing facility involved).

11 “(C) ANNUAL REPORTS.—Not later than
12 March 31 of each year, the Commissioner shall
13 submit to Congress and the President a report
14 on the administration of part C of title XVIII
15 and part B of this title during the previous fis-
16 cal year.

17 “(5) PROMULGATION OF RULES AND REGULA-
18 TIONS.—

19 “(A) IN GENERAL.—The Commissioner
20 may prescribe such rules and regulations as the
21 Commissioner determines necessary or appro-
22 priate to carry out the functions of the Agency.

23 “(B) RULEMAKING.—The regulations pre-
24 scribed by the Commissioner shall be subject to

1 the rulemaking procedures established under
2 section 553 of title 5, United States Code.

3 “(6) DELEGATION OF AUTHORITY.—

4 “(A) IN GENERAL.—The Commissioner
5 may assign duties, and delegate, or authorize
6 successive redelegations of, authority to act and
7 to render decisions, to such officers and employ-
8 ees of the Agency as the Commissioner may
9 find necessary.

10 “(B) EFFECT OF DELEGATION.—Within
11 the limitations of such delegations, redelega-
12 tions, or assignments, all official acts and deci-
13 sions of such officers and employees shall have
14 the same force and effect as though performed
15 or rendered by the Commissioner.

16 “(7) CONSULTATION WITH SECRETARY OF
17 HEALTH AND HUMAN SERVICES.—The Commis-
18 sioner and the Secretary shall consult, on an ongo-
19 ing basis, to ensure—

20 “(A) the coordination of the programs ad-
21 ministered by the Commissioner under part C
22 of title XVIII and part B of this title with the
23 programs administered by the Secretary under
24 parts A and B of title XVIII and under title
25 XIX; and

1 “(B) that adequate information concerning
2 benefits under parts A and B of title XVIII and
3 title XIX is available to the public.

4 “(b) DEPUTY COMMISSIONER OF THE COMPETITIVE
5 MEDICARE AGENCY.—

6 “(1) APPOINTMENT.—There shall be in the
7 Agency a Deputy Commissioner of the Competitive
8 Medicare Agency (in this part referred to as the
9 ‘Deputy Commissioner’) who shall be appointed by
10 the President, by and with the advice and consent
11 of the Senate.

12 “(2) TERM.—

13 “(A) IN GENERAL.—The Deputy Commis-
14 sioner shall be appointed for a term of 6 years.

15 “(B) CONTINUANCE IN OFFICE.—In any
16 case in which a successor does not take office
17 at the end of a Deputy Commissioner’s term of
18 office, such Deputy Commissioner may continue
19 in office until the entry upon office of such a
20 successor.

21 “(C) DELAYED APPOINTMENT.—A Deputy
22 Commissioner appointed to a term of office
23 after the commencement of such term may
24 serve under such appointment only for the re-
25 mainder of such term.

1 “(3) COMPENSATION.—The Deputy Commis-
2 sioner shall be compensated at the rate provided for
3 level II of the Executive Schedule.

4 “(4) DUTIES.—

5 “(A) IN GENERAL.—The Deputy Commis-
6 sioner shall perform such duties and exercise
7 such powers as the Commissioner shall from
8 time to time assign or delegate.

9 “(B) ACTING COMMISSIONER.—The Dep-
10 uty Commissioner shall be Acting Commissioner
11 of the Agency during the absence or disability
12 of the Commissioner, unless the President des-
13 ignates another officer of the Government as
14 Acting Commissioner, in the event of a vacancy
15 in the office of the Commissioner.

16 “(c) CHIEF ACTUARY.—

17 “(1) APPOINTMENT.—

18 “(A) IN GENERAL.—There shall be in the
19 Agency a Chief Actuary, who shall be appointed
20 by, and in direct line of authority to, the Com-
21 missioner.

22 “(B) QUALIFICATIONS.—The Chief Actu-
23 ary shall be appointed from individuals who
24 have demonstrated, by their education and ex-

1 perience, superior expertise in the actuarial
2 sciences.

3 “(C) DUTIES.—The Chief Actuary shall
4 serve as the chief actuarial officer of the Agen-
5 cy, and shall exercise such duties as are appro-
6 priate for the office of the Chief Actuary and
7 in accordance with professional standards of ac-
8 tuarial independence.

9 “(2) COMPENSATION.—The Chief Actuary shall
10 be compensated at the highest rate of basic pay for
11 the Senior Executive Service under section 5382(b)
12 of title 5, United States Code.

13 “ADMINISTRATIVE DUTIES OF THE COMMISSIONER

14 “SEC. 2203. (a) PERSONNEL.—

15 “(1) IN GENERAL.—The Commissioner may
16 employ, without regard to chapter 31 of title 5,
17 United States Code, such officers and employees as
18 are necessary to administer the activities to be car-
19 ried out through the Competitive Medicare Agency.

20 “(2) FLEXIBILITY WITH RESPECT TO CIVIL
21 SERVICE LAWS.—

22 “(A) IN GENERAL.—The staff of the Com-
23 petitive Medicare Agency shall be appointed
24 without regard to the provisions of title 5,
25 United States Code, governing appointments in
26 the competitive service, and, subject to subpara-

1 graph (B), shall be paid without regard to the
2 provisions of chapters 51 and 53 of such title
3 (relating to classification and schedule pay
4 rates).

5 “(B) MAXIMUM RATE.—In no case may
6 the rate of compensation determined under sub-
7 paragraph (A) exceed the rate of basic pay pay-
8 able for level IV of the Executive Schedule
9 under section 5315 of title 5, United States
10 Code.

11 “(b) BUDGETARY MATTERS.—

12 “(1) SUBMISSION OF ANNUAL BUDGET.—The
13 Commissioner shall prepare an annual budget for
14 the Agency, which shall be submitted by the Presi-
15 dent to Congress without revision, together with the
16 President’s annual budget for the Agency.

17 “(2) APPROPRIATIONS REQUESTS.—

18 “(A) STAFFING AND PERSONNEL.—Appro-
19 priations requests for staffing and personnel of
20 the Agency shall be based upon a comprehen-
21 sive work force plan, which shall be established
22 and revised from time to time by the Commis-
23 sioner.

24 “(B) ADMINISTRATIVE EXPENSES.—Ap-
25 propriations for administrative expenses of the

1 Agency are authorized to be provided on a bien-
2 nial basis.

3 “(c) SEAL OF OFFICE.—

4 “(1) IN GENERAL.—The Commissioner shall
5 cause a seal of office to be made for the Agency of
6 such design as the Commissioner shall approve.

7 “(2) JUDICIAL NOTICE.—Judicial notice shall
8 be taken of the seal made under paragraph (1).

9 “(d) DATA EXCHANGES.—

10 “(1) DISCLOSURE OF RECORDS AND OTHER IN-
11 FORMATION.—Notwithstanding any other provision
12 of law (including subsection (b), (o), (p), (q), (r),
13 and (u) of section 552a of title 5, United States
14 Code)—

15 “(A) the Secretary shall disclose to the
16 Commissioner any record or information re-
17 quested in writing by the Commissioner for the
18 purpose of administering any program adminis-
19 tered by the Commissioner, if records or infor-
20 mation of such type were disclosed to the Ad-
21 ministrator of the Health Care Financing Ad-
22 ministration in the Department of Health and
23 Human Services under applicable rules, regula-
24 tions, and procedures in effect before the date

1 of enactment of the Medicare Prescription Drug
2 and Modernization Act of 2001; and

3 “(B) the Commissioner shall disclose to
4 the Secretary or to any State any record or in-
5 formation requested in writing by the Secretary
6 to be so disclosed for the purpose of admin-
7 istering any program administered by the Sec-
8 retary, if records or information of such type
9 were so disclosed under applicable rules, regula-
10 tions, and procedures in effect before the date
11 of enactment of the Medicare Prescription Drug
12 and Modernization Act of 2001.

13 “(2) EXCHANGE OF OTHER DATA.—The Com-
14 missioner and the Secretary shall periodically review
15 the need for exchanges of information not referred
16 to in paragraph (1) and shall enter into such agree-
17 ments as may be necessary and appropriate to pro-
18 vide information to each other or to States in order
19 to meet the programmatic needs of the requesting
20 agencies.

21 “(3) ROUTINE USE.—

22 “(A) IN GENERAL.—Any disclosure from a
23 system of records (as defined in section
24 552a(a)(5) of title 5, United States Code) pur-
25 suant to this subsection shall be made as a rou-

1 Medicare+Choice program under part C of title
2 XVIII.

3 “(2) REPORTS.—

4 “(A) IN GENERAL.—With respect to mat-
5 ters of the administration of part C of title
6 XVIII and part B of this title, the Board shall
7 submit to Congress and to the Commissioner of
8 the Competitive Medicare Agency such reports
9 as the Board determines appropriate. Each
10 such report may contain such recommendations
11 as the Board determines appropriate for legisla-
12 tive or administrative changes to improve the
13 administration of such parts. Each such report
14 shall be published in the Federal Register.

15 “(B) MAINTAINING INDEPENDENCE OF
16 BOARD.—The Board shall directly submit to
17 Congress reports required under subparagraph
18 (A). No officer or agency of the United States
19 may require the Board to submit to any officer
20 or agency of the United States for approval,
21 comments, or review, prior to the submission to
22 Congress of such reports.

23 “(c) STRUCTURE AND MEMBERSHIP OF THE
24 BOARD.—

1 “(1) MEMBERSHIP.—The Board shall be com-
2 posed of 7 members who shall be appointed as fol-
3 lows:

4 “(A) PRESIDENTIAL APPOINTMENTS.—

5 “(i) IN GENERAL.—3 members shall
6 be appointed by the President, by and with
7 the advice and consent of the Senate.

8 “(ii) LIMITATION.—Not more than 2
9 of such members shall be from the same
10 political party.

11 “(B) SENATORIAL APPOINTMENTS.—2

12 members (each member from a different polit-
13 ical party) shall be appointed by the President
14 pro tempore of the Senate with the advice of
15 the Chairman and the Ranking Minority Mem-
16 ber of the Committee on Finance of the Senate.

17 “(C) CONGRESSIONAL APPOINTMENTS.—2

18 members (each member from a different polit-
19 ical party) shall be appointed by the Speaker of
20 the House of Representatives, with the advice
21 of the Chairman and the Ranking Minority
22 Member of the Committee on Ways and Means
23 of the House of Representatives.

24 “(2) QUALIFICATIONS.—The members shall be
25 chosen on the basis of their integrity, impartiality,

1 and good judgment, and shall be individuals who
2 are, by reason of their education, experience, and at-
3 tainments, exceptionally qualified to perform the du-
4 ties of members of the Board.

5 “(d) TERMS OF APPOINTMENT.—

6 “(1) IN GENERAL.—Subject to paragraph (2)
7 each member of the Board shall serve for a term of
8 6 years.

9 “(2) CONTINUANCE IN OFFICE AND STAGGERED
10 TERMS.—

11 “(A) CONTINUANCE IN OFFICE.—A mem-
12 ber appointed to a term of office after the com-
13 mencement of such term may serve under such
14 appointment only for the remainder of such
15 term.

16 “(B) STAGGERED TERMS.—The terms of
17 service of the members initially appointed under
18 this section shall begin on January 1, 2003,
19 and expire as follows:

20 “(i) PRESIDENTIAL APPOINTMENTS.—

21 The terms of service of the members ini-
22 tially appointed by the President shall ex-
23 pire as designated by the President at the
24 time of nomination, 1 each at the end of—

25 “(I) 2 years;

1 “(II) 4 years; and

2 “(III) 6 years.

3 “(ii) SENATORIAL APPOINTMENTS.—

4 The terms of service of members initially
5 appointed by the President pro tempore of
6 the Senate shall expire as designated by
7 the President pro tempore of the Senate at
8 the time of nomination, 1 each at the end
9 of—

10 “(I) 3 years; and

11 “(II) 6 years.

12 “(iii) CONGRESSIONAL APPOINT-

13 MENTS.—The terms of service of members
14 initially appointed by the Speaker of the
15 House of Representatives shall expire as
16 designated by the Speaker of the House of
17 Representatives at the time of nomination,
18 1 each at the end of—

19 “(I) 4 years; and

20 “(II) 5 years.

21 “(C) REAPPOINTMENTS.—Any person ap-
22 pointed as a member of the Board may not
23 serve for more than 8 years.

24 “(D) VACANCIES.—Any member appointed
25 to fill a vacancy occurring before the expiration

1 of the term for which the member's predecessor
2 was appointed shall be appointed only for the
3 remainder of that term. A member may serve
4 after the expiration of that member's term until
5 a successor has taken office. A vacancy in the
6 Board shall be filled in the manner in which the
7 original appointment was made.

8 “(e) CHAIRPERSON.—A member of the Board shall
9 be designated by the President to serve as Chairperson
10 for a term of 4 years, coincident with the term of the
11 President, or until the designation of a successor.

12 “(f) EXPENSES AND PER DIEM.—Members of the
13 Board shall serve without compensation, except that, while
14 serving on business of the Board away from their homes
15 or regular places of business, members may be allowed
16 travel expenses, including per diem in lieu of subsistence,
17 as authorized by section 5703 of title 5, United States
18 Code, for persons in the Government employed intermit-
19 tently.

20 “(g) MEETING.—

21 “(1) IN GENERAL.—The Board shall meet at
22 the call of the Chairperson (in consultation with the
23 other members of the Board) not less than 4 times
24 each year to consider a specific agenda of issues, as

1 determined by the Chairperson in consultation with
2 the other members of the Board.

3 “(2) QUORUM.—Four members of the Board
4 (not more than 3 of whom may be of the same polit-
5 ical party) shall constitute a quorum for purposes of
6 conducting business.

7 “(h) FEDERAL ADVISORY COMMITTEE ACT.—The
8 Board shall be exempt from the provisions of the Federal
9 Advisory Committee Act (5 U.S.C. App.).

10 “(i) PERSONNEL.—

11 “(1) STAFF DIRECTOR.—The Board shall, with-
12 out regard to the provisions of title 5, United States
13 Code, relating to the competitive service, appoint a
14 Staff Director who shall be paid at a rate equivalent
15 to a rate established for the Senior Executive Serv-
16 ice under section 5382 of title 5, United States
17 Code.

18 “(2) STAFF.—

19 “(A) IN GENERAL.—The Board may em-
20 ploy, without regard to chapter 31 of title 5,
21 United States Code, such officers and employ-
22 ees as are necessary to administer the activities
23 to be carried out by the Board.

24 “(B) FLEXIBILITY WITH RESPECT TO
25 CIVIL SERVICE LAWS.—

1 “(i) IN GENERAL.—The staff of the
2 Board shall be appointed without regard to
3 the provisions of title 5, United States
4 Code, governing appointments in the com-
5 petitive service, and, subject to clause (ii),
6 shall be paid without regard to the provi-
7 sions of chapters 51 and 53 of such title
8 (relating to classification and schedule pay
9 rates).

10 “(ii) MAXIMUM RATE.—In no case
11 may the rate of compensation determined
12 under clause (i) exceed the rate of basic
13 pay payable for level IV of the Executive
14 Schedule under section 5315 of title 5,
15 United States Code.

16 “(j) AUTHORIZATION OF APPROPRIATIONS.—There
17 are authorized to be appropriated, out of the Federal Hos-
18 pital Insurance Trust Fund and the Federal Supplemental
19 Medical Insurance Trust Fund, and the general fund of
20 the Treasury, such sums as are necessary to carry out the
21 purposes of this section.”.

22 (b) EFFECTIVE DATE.—

23 (1) IN GENERAL.—The amendment made by
24 subsection (a) shall take effect on the date of enact-
25 ment of this Act.

1 (2) TIMING OF INITIAL APPOINTMENTS.—The
2 Commissioner and Deputy Commissioner of the
3 Competitive Medicare Agency may not be appointed
4 before March 1, 2002.

5 (3) DUTIES WITH RESPECT TO ELIGIBILITY DE-
6 TERMINATIONS AND ENROLLMENT.—The Commis-
7 sioner of the Competitive Medicare Agency shall
8 carry out enrollment under title XVIII of the Social
9 Security Act, make eligibility determinations under
10 such title, and carry out part C of such title for
11 years beginning on or after January 1, 2004.

12 **SEC. 102. COMMISSIONER AS MEMBER OF THE BOARD OF**
13 **TRUSTEES OF THE MEDICARE TRUST FUNDS.**

14 (a) IN GENERAL.—Sections 1817(b) and 1841(b) of
15 the Social Security Act (42 U.S.C. 1395i(b); 1395t(b)) are
16 each amended by striking “and the Secretary of Health
17 and Human Services, all ex officio,” and inserting “, the
18 Secretary of Health and Human Services, and the Com-
19 missioner of the Competitive Medicare Agency, all ex offi-
20 cio,”.

21 (b) EFFECTIVE DATE.—The amendments made by
22 this subsection shall take effect on March 1, 2002.

1 **SEC. 103. SALARY INCREASE FOR THE HCFA ADMINIS-**
 2 **TRATOR.**

3 (a) IN GENERAL.—Section 5314 of title 5, United
 4 States Code, is amended by adding at the end the fol-
 5 lowing:

6 “Administrator of the Health Care Financing
 7 Administration.”.

8 (b) CONFORMING AMENDMENT.—Section 5315 of
 9 such title is amended by striking “Administrator of the
 10 Health Care Financing Administration.”.

11 (c) EFFECTIVE DATE.—The amendments made by
 12 this subsection take effect on March 1, 2002.

13 **Subtitle B—Redefined Medicare**
 14 **Solvency Measures**

15 **SEC. 151. REQUIREMENTS FOR ANNUAL FINANCIAL RE-**
 16 **PORTING AND OVERSIGHT OF MEDICARE**
 17 **PROGRAM.**

18 (a) IN GENERAL.—Section 1817 of the Social Secu-
 19 rity Act (42 U.S.C. 1395i) is amended by adding at the
 20 end the following new subsection:

21 “(l) COMBINED REPORT ON OPERATION AND STATUS
 22 OF THE TRUST FUND AND THE FEDERAL SUPPLE-
 23 MENTARY MEDICAL INSURANCE TRUST FUND.—

24 “(1) IN GENERAL.—In addition to the duty of
 25 the Board of Trustees to report to Congress under
 26 subsection (b), on the date the Board submits the

1 report required under subsection (b)(2), the Board
2 shall submit to Congress a report on the operation
3 and status of the Trust Fund and the Federal Sup-
4 plementary Medical Insurance Trust Fund estab-
5 lished under section 1841, including the Medicare
6 Prescription Drug Account within such Trust Fund
7 (in this subsection referred to as the ‘Trust Funds’).
8 Such report shall include the following information:

9 “(A) OVERALL SPENDING FROM THE GEN-
10 ERAL FUND OF THE TREASURY.—A statement
11 of total amounts obligated during the preceding
12 fiscal year from the General Revenues of the
13 Treasury to the Trust Funds for payment for
14 benefits covered under this title and part B of
15 title XXII, stated in terms of the total amount
16 and in terms of the percentage such amount
17 bears to all other amounts obligated from such
18 General Revenues during such fiscal year.

19 “(B) HISTORICAL OVERVIEW OF SPEND-
20 ING.—From the date of the inception of the
21 program of insurance under this title through
22 the fiscal year involved, a statement of the total
23 amounts referred to in subparagraph (A).

24 “(C) 10-YEAR AND 50-YEAR PROJEC-
25 TIONS.—An estimate of total amounts referred

1 to in subparagraph (A) required to be obligated
2 for payment for benefits covered under this title
3 for each of the 10 fiscal years succeeding the
4 fiscal year involved and for the 50-year period
5 beginning with the succeeding fiscal year.

6 “(D) RELATION TO GDP GROWTH.—A
7 comparison of the rate of growth of the total
8 amounts referred to in subparagraph (A) to the
9 rate of growth in the gross domestic product for
10 the same period.

11 “(2) PUBLICATION.—Each report submitted
12 under paragraph (1) shall be published by the Com-
13 mittee on Ways and Means as a public document.”.

14 (b) EFFECTIVE DATE.—The amendment made by
15 subsection (a) shall apply with respect to fiscal years be-
16 ginning on or after the date of enactment of this Act.

17 (c) CONGRESSIONAL HEARINGS.—It is the sense of
18 Congress that the committees of jurisdiction shall hold
19 hearings on the reports submitted under section 1817(l)
20 (42 U.S.C. 1395i(l)) of the Social Security Act.

1 **TITLE II—MEDICARE PRESCRIP-**
 2 **TION DRUG AND SUPPLE-**
 3 **MENTAL BENEFIT PROGRAM**

4 **SEC. 201. ESTABLISHMENT OF PROGRAM.**

5 (a) IN GENERAL.—Title XXII of the Social Security
 6 Act, as added by section 101, is amended by adding at
 7 the end the following new part:

8 “PART B—MEDICARE PRESCRIPTION DRUG AND
 9 SUPPLEMENTAL BENEFIT PROGRAM

10 “ESTABLISHMENT OF PRESCRIPTION DRUG AND
 11 SUPPLEMENTAL BENEFIT PROGRAM

12 “SEC. 2221. (a) PROVISION OF BENEFIT.—The
 13 Commissioner shall establish a Prescription Drug and
 14 Supplemental Benefit Program under which an eligible
 15 beneficiary may voluntarily enroll and receive access to
 16 covered outpatient prescription drugs and other benefits
 17 through enrollment in a Medicare Prescription Plus plan
 18 offered by a private entity or a Medicare+Choice plan of-
 19 fered by a Medicare+Choice organization.

20 “(b) PROGRAM TO BEGIN IN 2004.—The Commis-
 21 sioner shall establish the program under this part in a
 22 manner so that benefits are first provided for months be-
 23 ginning with January 2004.

1 “(c) VOLUNTARY NATURE OF PROGRAM.—Nothing
2 in this part shall be construed as requiring an eligible ben-
3 efiary to enroll in the program under this part.

4 “(d) FINANCING.—The costs of providing benefits
5 under this part shall be payable from the Medicare Pre-
6 scription Drug Account.

7 “(e) NO EFFECT ON TITLE XVIII BENEFITS.—The
8 program under this part shall have no effect on the entitle-
9 ment to benefits under title XVIII.

10 “ENROLLMENT UNDER PROGRAM

11 “SEC. 2222. (a) ESTABLISHMENT OF PROCESS.—

12 “(1) IN GENERAL.—The Commissioner shall es-
13 tablish a process through which an eligible bene-
14 ficiary (including an eligible beneficiary enrolled in a
15 Medicare+Choice plan offered by a
16 Medicare+Choice organization) may make an elec-
17 tion to enroll under the program under this part.
18 Except as otherwise provided in this section, such
19 process shall be similar to the process for enrollment
20 in part B under section 1837.

21 “(2) REQUIREMENT OF ENROLLMENT.—An eli-
22 gible beneficiary must enroll under this part in order
23 to be eligible to receive benefits under this part.

24 “(b) ENROLLMENT PERIOD.—

25 “(1) IN GENERAL.—Except as provided in para-
26 graph (2) or (3), an eligible beneficiary may not en-

1 roll in the program under this part during any pe-
2 riod after the beneficiary's initial enrollment period.

3 “(2) OPEN ENROLLMENT PERIOD FOR BENE-
4 FICIARIES CURRENTLY COVERED.—In the case of an
5 individual who is entitled to part A of title XVIII
6 and enrolled under part B of such title as of Novem-
7 ber 1, 2003, there shall be an open enrollment pe-
8 riod of 6 months beginning on that date.

9 “(3) SPECIAL ENROLLMENT PERIOD FOR BENE-
10 FICIARIES THAT LOSE OTHER DRUG COVERAGE.—

11 “(A) IN GENERAL.—Subject to subpara-
12 graph (D), in the case of an applicable eligible
13 beneficiary, the Commissioner shall establish
14 procedures for permitting such beneficiary to
15 enroll under the program under this part.

16 “(B) APPLICABLE ELIGIBLE BENE-
17 FICIARY.—For purposes of this paragraph, the
18 term ‘applicable eligible beneficiary’ means an
19 eligible beneficiary who—

20 “(i) had applicable drug coverage; and

21 “(ii) involuntarily lost such coverage.

22 “(C) APPLICABLE DRUG COVERAGE DE-
23 FINED.—For purposes of subparagraph (B),
24 the term ‘applicable drug coverage’ means any
25 of the following prescription drug coverage:

1 “(i) MEDICAID PRESCRIPTION DRUG
2 COVERAGE.—Prescription drug coverage
3 under a medicaid plan under title XIX, in-
4 cluding through the Program of All-inclu-
5 sive Care for the Elderly (PACE) under
6 section 1934, through a social health main-
7 tenance organization (referred to in section
8 4104(c) of the Balanced Budget Act of
9 1997), or through a Medicare+Choice
10 project that demonstrates the application
11 of capitation payment rates for frail elderly
12 medicare beneficiaries through the use of a
13 interdisciplinary team and through the
14 provision of primary care services to such
15 beneficiaries by means of such a team at
16 the nursing facility involved.

17 “(ii) PRESCRIPTION DRUG COVERAGE
18 UNDER GROUP HEALTH PLAN.—Any out-
19 patient prescription drug coverage under a
20 group health plan, including a health bene-
21 fits plan under the Federal Employees
22 Health Benefit Plan under chapter 89 of
23 title 5, United States Code, and a qualified
24 retiree prescription drug plan (as defined
25 in section 2232(e)(1)).

1 “(iii) PRESCRIPTION DRUG COVERAGE
2 UNDER CERTAIN MEDIGAP POLICIES.—
3 Coverage under a medicare supplemental
4 policy under section 1882 that provides
5 benefits for prescription drugs (whether or
6 not such coverage conforms to the stand-
7 ards for packages of benefits under section
8 1882(p)(1)), but only if the policy was in
9 effect on January 1, 2004.

10 “(iv) STATE PHARMACEUTICAL AS-
11 SISTANCE PROGRAM.—Coverage of pre-
12 scription drugs under a State pharma-
13 ceutical assistance program.

14 “(v) VETERANS’ COVERAGE OF PRE-
15 SCRIPTION DRUGS.—Coverage of prescrip-
16 tion drugs for veterans under chapter 17
17 of title 38, United States Code.

18 “(D) REQUIREMENTS.—The procedures
19 established under subparagraph (A) shall re-
20 quire that an applicable eligible beneficiary—

21 “(i) seek to enroll under the program
22 not later than 63 days after the date that
23 the beneficiary lost applicable drug cov-
24 erage; and

1 “(ii) submit evidence of the date that
2 the beneficiary lost such coverage along
3 with the application for enrollment in the
4 program under this part.

5 “(4) STUDY AND REPORT ON PERMITTING PART
6 B ONLY INDIVIDUALS TO ENROLL IN PROGRAM.—

7 “(A) STUDY.—The Commissioner shall
8 conduct a study on the need for rules relating
9 to permitting individuals who are enrolled under
10 part B of title XVIII but are not entitled to
11 benefits under part A to buy into the program
12 under this part.

13 “(B) REPORT.—Not later than January 1,
14 2003, the Commissioner shall submit a report
15 to Congress on the study conducted under sub-
16 paragraph (A), together with any recommenda-
17 tions for legislation that the Commissioner de-
18 termines to be appropriate as a result of such
19 study.

20 “(c) PERIOD OF COVERAGE.—

21 “(1) IN GENERAL.—Except as provided in para-
22 graph (2) and subject to paragraph (3), an eligible
23 beneficiary’s coverage under the program under this
24 part shall be effective for the period provided in sec-

1 tion 1838, as if that section applied to the program
2 under this part.

3 “(2) ENROLLMENT DURING OPEN AND SPECIAL
4 ENROLLMENT.—Subject to paragraph (3), an eligi-
5 ble beneficiary who enrolls under the program under
6 this part pursuant to paragraph (2) or (3) of sub-
7 section (b) shall be entitled to the benefits under
8 this part beginning on the first day of the month fol-
9 lowing the month in which such enrollment occurs.

10 “(3) LIMITATION.—Coverage under this part
11 shall not begin prior to January 1, 2004.

12 “(d) PROGRAM COVERAGE TERMINATED BY TERMI-
13 NATION OF COVERAGE UNDER PARTS A AND B OF TITLE
14 XVIII.—

15 “(1) IN GENERAL.—In addition to the causes of
16 termination specified in section 1838, the Commis-
17 sioner shall terminate an individual’s coverage under
18 the program under this part if the individual is no
19 longer enrolled in both parts A and B of title XVIII.

20 “(2) EFFECTIVE DATE.—The termination de-
21 scribed in paragraph (1) shall be effective on the ef-
22 fective date of termination of coverage under part A
23 of title XVIII or (if earlier) under part B of such
24 title.

1 “(e) FIRST ENROLLMENT PERIOD.—The Commis-
 2 sioner shall ensure that eligible beneficiaries are permitted
 3 to enroll under this part prior to January 1, 2004, in
 4 order to ensure that coverage under this part is effective
 5 as of such date.

6 “ELECTION OF A MEDICARE PRESCRIPTION PLUS PLAN

7 “SEC. 2223. (a) IN GENERAL.—

8 “(1) PROCESS.—

9 “(A) IN GENERAL.—Subject to paragraph
 10 (2), the Commissioner shall establish a process
 11 through which an eligible beneficiary who is en-
 12 rolled under this part shall make an annual
 13 election to enroll in a Medicare Prescription
 14 Plus plan offered by an eligible entity that
 15 serves the geographic area in which the bene-
 16 ficiary resides.

17 “(B) RULES.—In establishing the process
 18 under subparagraph (A), the Commissioner
 19 shall use rules that are consistent with the rules
 20 for enrollment and disenrollment with a
 21 Medicare+Choice plan under section 1851,
 22 including—

23 “(i) annual, coordinated election peri-
 24 ods, which shall be coordinated with such
 25 periods under part C of title XVIII;

1 “(ii) special election periods under
2 subsection (e)(4) of section 1851; and

3 “(iii) the guaranteed issue require-
4 ments under subsection (g) of such section.

5 “(2) **MEDICARE+CHOICE ENROLLEES.**—An eli-
6 gible beneficiary who is enrolled under this part and
7 enrolled in a Medicare+Choice plan offered by a
8 Medicare+Choice organization shall receive coverage
9 of benefits under this part through such plan if such
10 plan provides qualified prescription drug coverage. If
11 the Medicare+Choice plan in which the beneficiary
12 is enrolled does not provide such coverage, the bene-
13 ficiary shall receive such coverage through the elec-
14 tion of a Medicare Prescription Plus plan offered by
15 an eligible entity under this part.

16 “(b) **ENSURING ACCESS TO PRESCRIPTION DRUG**
17 **COVERAGE IN AREAS WITH NO MEDICARE PRESCRIPTION**
18 **PLUS PLAN OR MEDICARE+CHOICE PLAN PROVIDING**
19 **DRUG COVERAGE AVAILABLE.**—The Commissioner—

20 “(1) shall establish procedures for the provision
21 of the benefits required under section 2225(a) to
22 each eligible beneficiary that resides in an area
23 where there are no Medicare Prescription Plus plans
24 or Medicare+Choice plans available that provide
25 qualified prescription drug coverage; and

1 “(2) may establish procedures that permit par-
2 tial risk-sharing arrangements under section
3 2227(a)(2)(A) with an entity if the Commissioner
4 determines that the establishment of such proce-
5 dures will generate bids in an area with no Medicare
6 Prescription Plus plans or Medicare+Choice plans
7 available that provide qualified prescription drug
8 coverage.

9 “BENEFICIARY INFORMATION

10 “SEC. 2224. (a) IN GENERAL.—The Commissioner
11 shall conduct activities that are designed to broadly dis-
12 seminate information to eligible beneficiaries (and pro-
13 spective eligible beneficiaries) regarding the coverage pro-
14 vided under this part.

15 “(b) REQUIREMENTS.—The activities conducted
16 under this subsection shall be—

17 “(1) similar to the activities performed by the
18 Commissioner under section 1851(d), including the
19 dissemination of comparative information; and

20 “(2) coordinated with the activities performed
21 by the Commissioner under such section and under
22 section 1804.

23 “OUTPATIENT PRESCRIPTION DRUG AND OTHER

24 SUPPLEMENTAL BENEFITS

25 “SEC. 2225. (a) REQUIREMENTS.—

1 “(1) IN GENERAL.—For purposes of this part
2 and part C of title XVIII, the term ‘qualified pre-
3 scription drug coverage’ means either of the fol-
4 lowing:

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

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

15 “(2) PERMITTING ADDITIONAL OUTPATIENT
16 PRESCRIPTION DRUG COVERAGE.—

17 “(A) IN GENERAL.—Subject to subpara-
18 graph (B) and section 2229(c)(2), nothing in
19 this part shall be construed as preventing quali-
20 fied prescription drug coverage from including
21 coverage of covered outpatient drugs that ex-
22 ceeds the coverage required under paragraph
23 (1).

24 “(B) REQUIREMENT.—An eligible entity
25 may not offer a Medicare Prescription Plus

1 plan that provides additional benefits pursuant
2 to subparagraph (A) in an area unless the eligi-
3 ble entity offering such plan also offers a Medi-
4 care Prescription Plus plan in the area that
5 only provides the coverage of prescription drugs
6 that is required under subsection (a)(1).

7 “(3) COST CONTROL MECHANISMS.—In pro-
8 viding qualified prescription drug coverage, the enti-
9 ty offering the Medicare Prescription Plus plan or
10 the Medicare+Choice plan may use cost control
11 mechanisms that are customarily used in employer-
12 sponsored health care plans that offer coverage for
13 outpatient prescription drugs, including the use of
14 formularies, tiered copayments, selective contracting
15 with providers of outpatient prescription drugs, and
16 mail order pharmacies.

17 “(b) PERMITTING BENEFITS IN ADDITION TO OUT-
18 PATIENT PRESCRIPTION DRUG COVERAGE.—

19 “(1) IN GENERAL.—Subject to paragraph (2)
20 and section 2229(c)(2), nothing in this part shall be
21 construed as preventing a Medicare Prescription
22 Plus plan from including coverage of benefits that
23 are in addition to the benefits available under title
24 XVIII, including coverage of beneficiary cost-sharing
25 for benefits under such title.

1 “(2) REQUIREMENTS.—An eligible entity may
2 not offer a Medicare Prescription Plus plan that
3 provides additional benefits pursuant to paragraph
4 (1) in an area unless—

5 “(A) the eligible entity offering such plan
6 also offers a Medicare Prescription Plus plan in
7 the area that only provides the coverage of pre-
8 scription drugs that is required under sub-
9 section (a)(1); and

10 “(B) if the additional benefits include any
11 of the core group of basic benefits described in
12 section 1882(p)(2)(B), the Medicare Prescrip-
13 tion Plus plan provides all of such core group
14 of basic benefits.

15 “(c) APPLICATION OF SECONDARY PAYOR PROVI-
16 SIONS.—The provisions of section 1852(a)(4) shall apply
17 under this part in the same manner as they apply under
18 part C of title XVIII.

19 “(d) STANDARD COVERAGE.—For purposes of this
20 part and part C of title XVIII, the ‘standard coverage’
21 is coverage of covered outpatient drugs that meets the fol-
22 lowing requirements:

23 “(1) DEDUCTIBLE.—The coverage has an an-
24 nual deductible—

25 “(A) for 2004, that is equal to \$250; or

1 “(B) for a subsequent year, that is equal
2 to the amount specified under this paragraph
3 for the previous year increased by the percent-
4 age specified in paragraph (5) for the year in-
5 volved.

6 Any amount determined under subparagraph (B)
7 that is not a multiple of \$5 shall be rounded to the
8 nearest multiple of \$5.

9 “(2) LIMITS ON COST-SHARING.—The coverage
10 has cost-sharing (for costs above the annual deduct-
11 ible specified in paragraph (1) and up to the initial
12 coverage limit under paragraph (3)) that is equal to
13 50 percent or that is actuarially consistent (using
14 processes established under subsection (g)) with an
15 average expected payment of 50 percent of such
16 costs.

17 “(3) INITIAL COVERAGE LIMIT.—Subject to
18 paragraph (4), the coverage has an initial coverage
19 limit on the maximum costs that may be recognized
20 for payment purposes (above the annual deduct-
21 ible)—

22 “(A) for 2004, that is equal to \$2,100; or

23 “(B) for a subsequent year, that is equal
24 to the amount specified in this paragraph for
25 the previous year, increased by the annual per-

1 centage increase described in paragraph (5) for
2 the year involved.

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

6 “(4) LIMITATION ON OUT-OF-POCKET EXPENDI-
7 TURES BY BENEFICIARY.—

8 “(A) IN GENERAL.—Notwithstanding para-
9 graph (3), the coverage provides benefits with-
10 out any cost-sharing after the individual has in-
11 curred costs (as described in subparagraph (C))
12 for covered outpatient drugs in a year equal to
13 the annual out-of-pocket limit specified in sub-
14 paragraph (B).

15 “(B) ANNUAL OUT-OF-POCKET LIMIT.—
16 For purposes of this part, the ‘annual out-of-
17 pocket limit’ specified in this subparagraph—

18 “(i) for 2004, is equal to \$6,000; or

19 “(ii) for a subsequent year, is equal to
20 the amount specified in the subparagraph
21 for the previous year, increased by the an-
22 nual percentage increase described in para-
23 graph (5) for the year involved.

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

4 “(C) APPLICATION.—In applying subpara-
5 graph (A)—

6 “(i) incurred costs shall only include
7 costs incurred for the annual deductible
8 (described in paragraph (1)), cost-sharing
9 (described in paragraph (2)), and amounts
10 for which benefits are not provided because
11 of the application of the initial coverage
12 limit described in paragraph (3); but

13 “(ii) costs shall be treated as incurred
14 without regard to whether the individual or
15 another person, including a State program,
16 has paid for such costs, but shall not be
17 counted insofar as such costs are covered
18 as benefits under a Medicare Prescription
19 Plus plan, a Medicare+Choice plan, or
20 other third-party coverage.

21 “(5) ANNUAL PERCENTAGE INCREASE.—For
22 purposes of this part, the annual percentage increase
23 specified in this paragraph for a year is equal to the
24 annual percentage increase in average per capita ag-
25 gregate expenditures for covered outpatient drugs in

1 the United States for medicare beneficiaries, as de-
2 termined by the Commissioner for the 12-month pe-
3 riod ending in July of the previous year.

4 “(e) ALTERNATIVE COVERAGE REQUIREMENTS.—A
5 Medicare Prescription Plus plan or Medicare+Choice plan
6 may provide a different prescription drug benefit design
7 from the standard coverage described in subsection (d) so
8 long as the following requirements are met:

9 “(1) ASSURING AT LEAST ACTUARIALLY EQUIV-
10 ALENT COVERAGE.—

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

16 “(B) ASSURING EQUIVALENT UNSUB-
17 SIDIZED VALUE OF COVERAGE.—The unsub-
18 sidized value of the coverage is at least equal to
19 the unsubsidized value of standard coverage.
20 For purposes of this subparagraph, the unsub-
21 sidized value of coverage is the amount by
22 which the actuarial value of the coverage (as
23 determined under subsection (g)) exceeds the
24 actuarial value of the reinsurance subsidy pay-

1 ments under section 2232 with respect to such
2 coverage.

3 “(C) ASSURING STANDARD PAYMENT FOR
4 COSTS AT INITIAL COVERAGE LIMIT.—The cov-
5 erage is designed, based upon an actuarially
6 representative pattern of utilization (as deter-
7 mined under subsection (g)), to provide for the
8 payment, with respect to costs incurred that are
9 equal to the sum of the deductible under sub-
10 section (d)(1) and the initial coverage limit
11 under subsection (d)(3), of an amount equal to
12 at least such initial coverage limit multiplied by
13 the percentage specified in subsection (d)(2).

14 Benefits other than qualified prescription drug cov-
15 erage shall not be taken into account for purposes
16 of this paragraph.

17 “(2) LIMITATION ON OUT-OF-POCKET EXPENDI-
18 TURES BY BENEFICIARIES.—The coverage provides
19 the limitation on out-of-pocket expenditures by bene-
20 ficiaries described in subsection (d)(4).

21 “(f) ACCESS TO NEGOTIATED PRICES.—Under quali-
22 fied prescription drug coverage offered by an eligible entity
23 or a Medicare+Choice organization, the entity or organi-
24 zation shall provide beneficiaries with access to negotiated
25 prices (including applicable discounts) used for payment

1 for covered outpatient drugs, regardless of the fact that
 2 no benefits may be payable under the coverage with re-
 3 spect to such drugs because of the application of cost-shar-
 4 ing or an initial coverage limit (described in subsection
 5 (d)(3)). In providing such access, the eligible entity or
 6 Medicare+Choice organization shall issue a card pursuant
 7 to section 2226(b)(1).

8 “(g) ACTUARIAL VALUATION; DETERMINATION OF
 9 ANNUAL PERCENTAGE INCREASES.—

10 “(1) PROCESSES.—For purposes of this section,
 11 the Commissioner shall establish processes and
 12 methods—

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

15 “(i) an actuarial valuation of standard
 16 coverage and of the reinsurance subsidy
 17 payments under section 2232;

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

20 “(iii) applying the same methodology
 21 for determinations of alternative coverage
 22 under subsection (e) as is used with re-
 23 spect to determinations of standard cov-
 24 erage under subsection (d); and

1 “(B) for determining annual percentage in-
2 creases described in subsection (d)(5).

3 “(2) USE OF OUTSIDE ACTUARIES.—Under the
4 processes under paragraph (1)(A), eligible entities
5 and Medicare+Choice organizations may use actu-
6 arial opinions certified by independent, qualified ac-
7 tuaries to establish actuarial values.

8 “BENEFICIARY PROTECTIONS

9 “SEC. 2226. (a) DISSEMINATION OF INFORMA-
10 TION.—

11 “(1) GENERAL INFORMATION.—An eligible enti-
12 ty offering a Medicare Prescription Plus plan shall
13 disclose, in a clear, accurate, and standardized form
14 to each enrollee at the time of enrollment and at
15 least annually thereafter, the information described
16 in section 1852(c)(1) relating to such plan. Such in-
17 formation includes the following:

18 “(A) Access to covered outpatient drugs.

19 “(B) How any formulary used by the enti-
20 ty functions.

21 “(C) Co-payments, coinsurance, and de-
22 ductible requirements.

23 “(D) Grievance and appeals procedures.

24 “(2) DISCLOSURE UPON REQUEST OF GENERAL
25 COVERAGE, UTILIZATION, AND GRIEVANCE INFORMA-
26 TION.—Upon request of an individual eligible to en-

1 roll in a Medicare Prescription Plus plan, the eligible
2 entity offering such plan shall provide the informa-
3 tion described in section 1852(c)(2) to such indi-
4 vidual.

5 “(3) RESPONSE TO BENEFICIARY QUESTIONS.—
6 An eligible entity offering a Medicare Prescription
7 Plus plan shall have a mechanism for providing spe-
8 cific information to enrollees upon request, including
9 information on specific changes in its formulary.

10 “(4) CLAIMS INFORMATION.—An eligible entity
11 offering a Medicare Prescription Plus plan must fur-
12 nish to enrolled individuals in a form easily under-
13 standable to such individuals an explanation of bene-
14 fits (in accordance with section 1806(a) or in a com-
15 parable manner) and a notice of the benefits in rela-
16 tion to initial coverage limit and annual out-of-pock-
17 et limit for the current year, whenever prescription
18 drug benefits are provided under this part (except
19 that such notice need not be provided more often
20 than monthly).

21 “(b) ACCESS TO COVERED OUTPATIENT DRUGS.—

22 “(1) ACCESS TO NEGOTIATED PRICES FOR PRE-
23 SCRIPTON DRUGS.—An eligible entity offering a
24 Medicare Prescription Plus plan shall issue such a
25 card that may be used by an enrolled beneficiary to

1 assure access to negotiated prices under section
2 2225(f) for the purchase of prescription drugs for
3 which coverage is not otherwise provided under the
4 Medicare Prescription Plus plan.

5 “(2) REQUIREMENTS ON DEVELOPMENT AND
6 APPLICATION OF FORMULARIES.—Insofar as an eli-
7 gible entity offering a Medicare Prescription Plus
8 plan uses a formulary with respect to qualified pre-
9 scription drug coverage, the following requirements
10 must be met:

11 “(A) INCLUSION OF DRUGS IN ALL THERA-
12 PEUTIC CATEGORIES.—The formulary must in-
13 clude drugs within all therapeutic categories
14 and classes of covered outpatient drugs (al-
15 though not necessarily for all drugs within such
16 categories and classes).

17 “(B) APPEALS AND EXCEPTIONS TO AP-
18 PPLICATION.—The eligible entity must have, as
19 part of the appeals process under subsection
20 (e)(2), a process for appeals for denials of cov-
21 erage based on such application of the for-
22 mulary.

23 “(c) COST AND UTILIZATION MANAGEMENT.—

24 “(1) IN GENERAL.—An eligible entity shall have
25 in place—

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

4 “(B) quality assurance measures to reduce
5 medical errors and adverse drug interactions,
6 which may include the measures described in
7 paragraph (2); and

8 “(C) a program to control fraud, abuse,
9 and waste.

10 “(2) MEASURES.—The measures described in
11 this paragraph are beneficiary education programs,
12 counseling, medication refill reminders, and special
13 packaging.

14 “(d) GRIEVANCE MECHANISM.—An eligible entity
15 shall provide meaningful procedures for hearing and re-
16 solving grievances between the eligible entity (including
17 any entity or individual through which the eligible entity
18 provides covered benefits) and enrollees in a Medicare Pre-
19 scription Plus plan offered by the eligible entity in accord-
20 ance with section 1852(f).

21 “(e) COVERAGE DETERMINATIONS, RECONSIDER-
22 ATIONS, AND APPEALS.—

23 “(1) IN GENERAL.—An eligible entity shall
24 meet the requirements of section 1852(g) with re-
25 spect to covered benefits under the Medicare Pre-

1 scription Plus plan it offers under this part in the
 2 same manner as such requirements apply to a
 3 Medicare+Choice organization with respect to bene-
 4 fits it offers under a Medicare+Choice plan under
 5 part C of title XVIII.

6 “(2) APPEALS OF FORMULARY DETERMINA-
 7 TIONS.—Consistent with the requirements of section
 8 1852(g), an eligible entity shall establish a process
 9 for appeals of formulary determinations.

10 “(f) CONFIDENTIALITY AND ACCURACY OF EN-
 11 ROLLEE RECORDS.—An eligible entity shall meet the re-
 12 quirements of section 1852(h) with respect to enrollees
 13 under this part in the same manner as such requirements
 14 apply to a Medicare+Choice organization with respect to
 15 enrollees under part C of title XVIII.

16 “(g) UNIFORM PREMIUM.—An eligible entity shall
 17 ensure that the premium for a Medicare Prescription Plus
 18 plan charged under this section is the same for all individ-
 19 uals enrolled in the plan in the same service area.

20 “REQUIREMENTS FOR ENTITIES OFFERING MEDICARE
 21 PRESCRIPTION PLUS PLANS

22 “SEC. 2227. (a) GENERAL REQUIREMENTS.—An eli-
 23 gible entity offering a Medicare Prescription Plus plan
 24 shall meet the following requirements:

25 “(1) LICENSURE.—Subject to subsection (c),
 26 the entity is organized and licensed under State law

1 as a risk-bearing entity eligible to offer health insur-
2 ance or health benefits coverage in each State in
3 which it offers a Medicare Prescription Plus plan.

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

5 “(A) IN GENERAL.—Except as provided
6 under section 2223(b)(2) and subject to sub-
7 paragraph (B), the entity assumes full financial
8 risk on a prospective basis for the benefits that
9 it offers under a Medicare Prescription Plus
10 plan and that is not covered under reinsurance
11 under section 2232.

12 “(B) REINSURANCE PERMITTED.—The en-

13 tity may obtain insurance or make other ar-
14 rangements for the cost of coverage provided to
15 any enrolled member under this part.

16 “(3) SOLVENCY FOR UNLICENSED ENTITIES.—

17 In the case of an eligible entity that is not described
18 in paragraph (1), the entity shall meet solvency
19 standards established by the Commissioner under
20 subsection (d).

21 “(b) CONTRACT REQUIREMENTS.—The Commis-

22 sioner shall not permit an eligible beneficiary to elect a
23 Medicare Prescription Plus plan offered by an eligible en-
24 tity under this part, and the entity shall not be eligible
25 for payments under section 2230, 2231(e), or 2232, unless

1 the Commissioner has entered into a contract under this
2 subsection with the entity with respect to the offering of
3 such plan. Such a contract with an entity may cover more
4 than 1 Medicare Prescription Plus plan. Such contract
5 shall provide that the entity agrees to comply with the ap-
6 plicable requirements and standards of this part and the
7 terms and conditions of payment as provided for in this
8 part.

9 “(c) WAIVER OF CERTAIN REQUIREMENTS TO EX-
10 PAND CHOICE.—

11 “(1) IN GENERAL.—In the case of an eligible
12 entity that seeks to offer a Medicare Prescription
13 Plus plan in a State, the Commissioner shall waive
14 the requirement of subsection (a)(1) that the entity
15 be licensed in that State if the Commissioner deter-
16 mines, based on the application and other evidence
17 presented to the Commissioner, that any of the
18 grounds for approval of the application described in
19 paragraph (2) have been met.

20 “(2) GROUNDS FOR APPROVAL.—The grounds
21 for approval under this paragraph are the grounds
22 for approval described in subparagraphs (B), (C),
23 and (D) of section 1855(a)(2), and also include the
24 application by a State of any grounds other than
25 those required under Federal law.

1 “(3) APPLICATION OF MEDICARE+CHOICE PSO
2 WAIVER PROCEDURES.—With respect to an applica-
3 tion for a waiver (or a waiver granted) under this
4 subsection, the provisions of subparagraphs (E), (F),
5 and (G) of section 1855(a)(2) shall apply.

6 “(4) LICENSURE DOES NOT SUBSTITUTE FOR
7 OR CONSTITUTE CERTIFICATION.—The fact that an
8 entity is licensed in accordance with subsection
9 (a)(1) does not deem the eligible entity to meet other
10 requirements imposed under this part for an eligible
11 entity.

12 “(5) REFERENCES TO CERTAIN PROVISIONS.—
13 For purposes of this subsection, in applying the pro-
14 visions of section 1855(a)(2) under this subsection
15 to Medicare Prescription Plus plans and eligible
16 entities—

17 “(A) any reference to a waiver application
18 under section 1855 shall be treated as a ref-
19 erence to a waiver application under paragraph
20 (1); and

21 “(B) any reference to solvency standards
22 were treated as a reference to solvency stand-
23 ards established under subsection (d).

24 “(d) SOLVENCY STANDARDS FOR NON-LICENSED
25 ENTITIES.—

1 “(1) ESTABLISHMENT.—The Commissioner
2 shall establish, by not later than October 1, 2002,
3 financial solvency and capital adequacy standards
4 that an entity that does not meet the requirements
5 of subsection (a)(1) must meet to qualify as an eligi-
6 ble entity under this part.

7 “(2) COMPLIANCE WITH STANDARDS.—An eligi-
8 ble entity that is not licensed by a State under sub-
9 section (a)(1) and for which a waiver application has
10 been approved under subsection (c) shall meet sol-
11 vency and capital adequacy standards established
12 under paragraph (1). The Commissioner shall estab-
13 lish certification procedures for such eligible entities
14 with respect to such solvency standards in the man-
15 ner described in section 1855(c)(2).

16 “(e) OTHER STANDARDS.—The Commissioner shall
17 establish by regulation other standards (not described in
18 subsection (d)) for eligible entities and Medicare Prescrip-
19 tion Plus plans consistent with, and to carry out, this part.
20 The Commissioner shall publish such regulations by Octo-
21 ber 1, 2002.

22 “(f) RELATION TO STATE LAWS.—

23 “(1) IN GENERAL.—The standards established
24 under this section shall supersede any State law or
25 regulation (including standards described in para-

1 graph (2)) with respect to Medicare Prescription
2 Plus plans which are offered by eligible entities
3 under this part to the extent such law or regulation
4 is inconsistent with such standards, in the same
5 manner as such laws and regulations are superseded
6 under section 1856(b)(3).

7 “(2) STANDARDS SPECIFICALLY SUPER-
8 SEDED.—State standards relating to the following
9 are superseded under this section:

10 “(A) Benefit requirements.

11 “(B) Requirements relating to inclusion or
12 treatment of providers.

13 “(C) Coverage determinations (including
14 related appeals and grievance processes).

15 “(3) PROHIBITION OF STATE IMPOSITION OF
16 PREMIUM TAXES.—No State may impose a premium
17 tax or similar tax with respect to premiums paid to
18 eligible entities for Medicare Prescription Plus plans
19 under this part, or with respect to any payments
20 made to such an entity by the Commissioner under
21 this part.

22 “SUBMISSION OF MEDICARE PRESCRIPTION PLUS PLANS

23 “SEC. 2228. (a) IN GENERAL.—Each eligible entity
24 that intends to offer a Medicare Prescription Plus plan
25 in a year (beginning with 2004) shall submit to the Com-
26 missioner, at such time and in such manner as the Com-

1 missioner may specify, such information as the Commis-
2 sioner may require, including the information described in
3 subsection (b).

4 “(b) INFORMATION DESCRIBED.—The information
5 described in this subsection includes information on each
6 of the following:

7 “(1) A description of the benefits under the
8 plan, including any supplemental benefits pursuant
9 to section 2225(b).

10 “(2) Information on the actuarial value of the
11 qualified prescription drug coverage.

12 “(3) Information on the monthly premium to be
13 charged for all benefits, including an actuarial cer-
14 tification of—

15 “(A) the actuarial basis for such premium;

16 “(B) the portion of such premium attrib-
17 utable to benefits in excess of standard cov-
18 erage; and

19 “(C) the reduction in such premium result-
20 ing from the reinsurance subsidy payments pro-
21 vided under section 2232.

22 “(4) The service area for the plan.

23 “(5) Such other information as the Commis-
24 sioner may require to carry out this part.

1 “APPROVAL OF MEDICARE PRESCRIPTION PLUS PLANS

2 “SEC. 2229. (a) IN GENERAL.—The Commissioner
3 shall review the information filed under section 2228 and
4 shall approve or disapprove the Medicare Prescription
5 Plus plan.

6 “(b) NEGOTIATION.—In exercising such authority,
7 the Commissioner shall have the same authority to nego-
8 tiate the terms and conditions of the premiums submitted
9 and other terms and conditions of plans as the Director
10 of the Office of Personnel Management has with respect
11 to health benefits plans under chapter 89 of title 5, United
12 States Code.

13 “(c) SPECIAL RULES FOR APPROVAL.—

14 “(1) SERVICE AREA.—The Commissioner may
15 approve a service area submitted under section
16 2228(b)(4) only if the Commissioner finds that—

17 “(A) the use of such an area is consistent
18 with the purposes of this part; and

19 “(B) the service area for the plan is not
20 designed so as to discriminate based on the
21 health status, economic status, or prior receipt
22 of health care of eligible beneficiaries.

23 “(2) AVOIDANCE OF FAVORABLE SELECTION.—
24 The Commissioner may approve a Medicare Pre-

1 “COMPUTATION AND COLLECTION OF BENEFICIARY
2 SHARE OF PREMIUM

3 “SEC. 2231. (a) COMPUTATION.—

4 “(1) AMOUNT.—The annual beneficiary pre-
5 mium for enrollment in a Medicare Prescription Plus
6 plan providing coverage under this part for a year
7 shall be an amount equal to—

8 “(A) an amount equal to the full amount
9 of the premium approved under section 2229
10 for the plan in which the beneficiary is enrolled;
11 minus

12 “(B) the amount of the discount deter-
13 mined under subsection (b).

14 “(2) COLLECTION OF PREMIUM AMOUNT IN
15 SAME MANNER AS PART B PREMIUM.—

16 “(A) IN GENERAL.—The amount of the
17 annual beneficiary premium determined under
18 paragraph (1) shall be collected and credited to
19 the Medicare Prescription Drug Account in the
20 same manner as the monthly premium deter-
21 mined under section 1839 is collected and cred-
22 ited to the Federal Supplementary Medical In-
23 surance Trust Fund under section 1840.

24 “(B) INFORMATION NECESSARY FOR COL-
25 LECTION.—In order to carry out subparagraph

1 (A), the Commissioner shall transmit to the
2 Commissioner of Social Security—

3 “(i) at the beginning of each year, the
4 name, social security account number, and
5 annual beneficiary premium owed by each
6 individual enrolled in a Medicare Prescrip-
7 tion Plus plan for each month during the
8 year; and

9 “(ii) periodically throughout the year,
10 information to update the information pre-
11 viously transmitted under this paragraph
12 for the year.

13 “(b) DISCOUNTS FOR REQUIRED DRUG PORTION OF
14 PREMIUM.—

15 “(1) FULL PREMIUM DISCOUNT AND REDUC-
16 TION OF COST-SHARING FOR INDIVIDUALS WITH IN-
17 COME BELOW 135 PERCENT OF FEDERAL POVERTY
18 LEVEL.—In the case of a low-income individual (as
19 defined in paragraph (5)(A)) who is determined to
20 have income that does not exceed 135 percent of the
21 Federal poverty level, the individual is entitled under
22 this section—

23 “(A) to a premium discount equal to 100
24 percent of the amount described in subsection
25 (c); and

1 “(B) subject to subsection (d), to the sub-
2 stitution for the beneficiary cost-sharing de-
3 scribed in paragraphs (1) and (2) of section
4 2225(d) (up to the initial coverage limit speci-
5 fied in paragraph (3) of such section) of
6 amounts that are nominal.

7 “(2) SLIDING SCALE PREMIUM DISCOUNT FOR
8 INDIVIDUALS WITH INCOME ABOVE 135, BUT BELOW
9 150 PERCENT, OF FEDERAL POVERTY LEVEL.—In
10 the case of a low-income individual who is deter-
11 mined to have income that exceeds 135 percent, but
12 does not exceed 150 percent, of the Federal poverty
13 level, the individual is entitled under this section to
14 a premium discount determined on a linear sliding
15 scale ranging from 100 percent of the amount de-
16 scribed in subsection (c) for individuals with incomes
17 at 135 percent of such level to 25 percent of such
18 amount for individuals with incomes at 150 percent
19 of such level.

20 “(3) PREMIUM DISCOUNT FOR INDIVIDUALS
21 WITH INCOME ABOVE 150 PERCENT OF FEDERAL
22 POVERTY LEVEL.—In the case of an eligible bene-
23 ficiary who is not a low-income individual, the bene-
24 ficiary is entitled under this section to a premium

1 discount equal to 25 percent of the amount de-
2 scribed in subsection (c).

3 “(4) TAX TREATMENT OF PREMIUM DIS-
4 COUNT.—

5 “(A) IN GENERAL.—For purposes of the
6 Internal Revenue Code of 1986, the premium
7 discount determined under this subsection for
8 an eligible beneficiary for a year shall be in-
9 cluded in the gross income of the beneficiary for
10 the year.

11 “(B) STATEMENT OF TAXABLE AMOUNT.—
12 Not later than January 31 of each year (begin-
13 ning with 2005), the Commissioner shall
14 provide—

15 “(i) each eligible beneficiary enrolled
16 under this part with a statement that de-
17 scribes the amount of the discount that is
18 required to be included in the gross income
19 of the beneficiary for the previous year
20 pursuant to subparagraph (A); and

21 “(ii) the Secretary of the Treasury
22 with the information described in clause
23 (i).

24 “(5) DETERMINATION OF ELIGIBILITY.—

1 “(A) LOW-INCOME INDIVIDUAL DE-
2 FINED.—For purposes of this section, subject
3 to subparagraph (D), the term ‘low-income indi-
4 vidual’ means an individual who—

5 “(i) is eligible to enroll, and has en-
6 rolled, under this part;

7 “(ii) has income below 150 percent of
8 the Federal poverty line; and

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

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

22 “(C) INCOME DETERMINATIONS.—For pur-
23 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 low-income individual but may be eligible for fi-
16 nancial assistance with prescription drug ex-
17 penses under section 1935(e).

18 “(e) PREMIUM DISCOUNT AMOUNT.—The premium
19 discount amount described in this subsection for an eligi-
20 ble beneficiary residing in an area is an amount equal to—

21 “(1) in the case of an individual enrolled in a
22 Medicare Prescription Plus plan, the actuarial value
23 of the standard drug coverage provided under the
24 plan (determined without regard to any premium
25 discount under this section); and

1 “(2) in the case of an individual enrolled in a
2 Medicare+Choice plan that provides qualified pre-
3 scription drug coverage, the standard premium com-
4 puted under section 1851(j)(5)(A)(iii).

5 “(d) RULES IN APPLYING COST-SHARING SUB-
6 SIDIES.—

7 “(1) IN GENERAL.—In applying subsection
8 (b)(1)(B)—

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

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

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

21 “(2) LIMITATION ON CHARGES.—In the case of
22 a low-income individual receiving cost-sharing sub-
23 sidies under subsection (b)(1)(B), the eligible entity
24 may not charge more than a nominal amount in

1 cases in which the cost-sharing subsidy is provided
2 under such subsection.

3 “(e) ADMINISTRATION OF COST-SHARING PRO-
4 GRAM.—The Commissioner shall provide a process where-
5 by, in the case of a low-income individual who is eligible
6 for reduced cost-sharing under subsection (b)(1)(B) and
7 is enrolled in a Medicare Prescription Plus plan or a
8 Medicare+Choice plan under which qualified prescription
9 drug coverage is provided—

10 “(1) the Commissioner provides for a notifica-
11 tion of the eligible entity or Medicare+Choice orga-
12 nization involved that the individual is eligible for
13 such reduced cost-sharing;

14 “(2) the entity or organization involved reduces
15 the cost-sharing pursuant to this section and sub-
16 mits to the Commissioner information on the
17 amount of such reduction; and

18 “(3) the Commissioner periodically and on a
19 timely basis reimburses the entity or organization
20 for the amount of such reductions.

21 The reimbursement under paragraph (3) may be com-
22 puted on a capitated basis, taking into account the actu-
23 arial value of the reductions and with appropriate adjust-
24 ments to reflect differences in the risks actually involved.

25 “(f) RELATION TO MEDICAID PROGRAM.—

1 scription drug coverage under part C of title XVIII;
2 and

3 “(3) for medicare secondary payer eligible indi-
4 viduals (described in subsection (e)(3)(D)) who are
5 enrolled in a qualified retiree prescription drug plan.

6 This section constitutes budget authority in advance of ap-
7 propriations Acts and represents the obligation of the
8 Commissioner to provide for the payment of amounts pro-
9 vided under this section.

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

15 “(1) An eligible entity offering a Medicare Pre-
16 scription Plus plan under this part.

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

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

22 “(c) REINSURANCE PAYMENT AMOUNT.—

23 “(1) IN GENERAL.—Subject to subsection (e)(2)
24 and paragraph (4), the reinsurance payment amount
25 under this subsection for a qualified beneficiary (as

1 defined in subsection (f)(1)) for a coverage year (as
2 defined in subsection (f)(2)) is an amount equal to
3 80 percent of the allowable costs attributable to the
4 portion of the individual's gross covered prescription
5 drug costs for the year that exceeds \$7,050.

6 “(2) ALLOWABLE COSTS.—For purposes of this
7 section, the term ‘allowable costs’ means, with re-
8 spect to gross covered prescription drug costs under
9 a plan described in subsection (b) offered by a quali-
10 fying entity, the part of such costs that are actually
11 paid under the plan, but in no case more than the
12 part of such costs that would have been paid under
13 the plan if the prescription drug coverage under the
14 plan were standard coverage.

15 “(3) GROSS COVERED PRESCRIPTION DRUG
16 COSTS.—For purposes of this section, the term
17 ‘gross covered prescription drug costs’ means, with
18 respect to an enrollee with a qualifying entity under
19 a plan described in subsection (b) during a coverage
20 year, the costs incurred under the plan for covered
21 prescription drugs dispensed during the year, includ-
22 ing costs relating to the deductible, whether paid by
23 the enrollee or under the plan, regardless of whether
24 the coverage under the plan exceeds standard cov-

1 erage and regardless of when the payment for such
2 drugs is made.

3 “(4) INDEXING DOLLAR AMOUNT.—

4 “(A) AMOUNT FOR 2004.—The dollar
5 amount applied under paragraph (1) for 2004
6 shall be the dollar amount specified in such
7 paragraph.

8 “(B) FOR 2005.—The dollar amount ap-
9 plied under paragraph (1) for 2005 shall be the
10 dollar amount specified in such paragraph in-
11 creased by the annual percentage increase de-
12 scribed in section 2225(d)(5) for 2005.

13 “(C) FOR SUBSEQUENT YEARS.—The dol-
14 lar amount applied under paragraph (1) for a
15 year after 2005 shall be the dollar amount
16 (under this paragraph) applied under para-
17 graph (1) for the preceding year increased by
18 the annual percentage increase described in sec-
19 tion 2225(d)(5) for the year involved.

20 “(D) ROUNDING.—Any amount, deter-
21 mined under the preceding provisions of this
22 paragraph for a year, which is not a multiple of
23 \$5 shall be rounded to the nearest multiple of
24 \$5.

25 “(d) PAYMENT METHODS.—

1 “(1) IN GENERAL.—Payments under this sec-
2 tion shall be based on such a method as the Com-
3 missioner determines. The Commissioner may estab-
4 lish a payment method by which interim payments
5 of amounts under this section are made during a
6 year based on the Commissioner’s best estimate of
7 amounts that will be payable after obtaining all of
8 the information.

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

12 “(e) QUALIFIED RETIREE PRESCRIPTION DRUG
13 PLAN DEFINED.—

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

21 “(A) ASSURANCE.—The sponsor of the
22 plan shall annually attest, and provide such as-
23 surances as the Commissioner may require, that
24 the coverage meets the requirements for quali-
25 fied prescription drug coverage.

1 “(B) AUDITS.—The sponsor (and the plan)
2 shall maintain, and afford the Commissioner
3 access to, such records as the Commissioner
4 may require for purposes of audits and other
5 oversight activities necessary to ensure the ade-
6 quacy of prescription drug coverage, the accu-
7 racy of payments made, and such other matters
8 as may be appropriate.

9 “(C) OTHER REQUIREMENTS.—The spon-
10 sor of the plan shall comply with such other re-
11 quirements as the Commissioner finds nec-
12 essary to administer the program under this
13 section.

14 “(2) LIMITATION ON BENEFIT ELIGIBILITY.—
15 No payment shall be provided under this section
16 with respect to an individual who is enrolled under
17 a qualified retiree prescription drug plan unless the
18 individual is a medicare secondary payer eligible in-
19 dividual who—

20 “(A) is covered under the plan; and

21 “(B) is eligible to obtain qualified prescrip-
22 tion drug coverage under this part but did not
23 elect such coverage (either through a Medicare
24 Prescription Plus plan or through a
25 Medicare+Choice plan).

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

2 “(A) EMPLOYMENT-BASED RETIREE
3 HEALTH COVERAGE.—The term ‘employment-
4 based retiree health coverage’ means health in-
5 surance or other coverage of health care costs
6 for medicare secondary payer eligible individ-
7 uals (or for such individuals and their spouses
8 and dependents) based on their status as
9 former employees or labor union members.

10 “(B) EMPLOYER.—The term ‘employer’
11 has the meaning given such term by section
12 3(5) of the Employee Retirement Income Secu-
13 rity Act of 1974 (except that such term shall
14 include only employers of 2 or more employees).

15 “(C) SPONSOR.—The term ‘sponsor’
16 means a plan sponsor, as defined in section
17 3(16)(B) of the Employee Retirement Income
18 Security Act of 1974.

19 “(D) MEDICARE SECONDARY PAYER INDI-
20 VIDUAL.—The term ‘medicare secondary payer
21 eligible individual’ means, with respect to a
22 plan, an individual who is covered under the
23 plan and with respect to whom the plan is not
24 a primary plan (as defined in section
25 1862(b)(2)(A)).

1 “(f) GENERAL DEFINITIONS.—For purposes of this
2 section:

3 “(1) QUALIFIED BENEFICIARY.—The term
4 ‘qualified beneficiary’ means an individual who—

5 “(A) is enrolled with a Medicare Prescrip-
6 tion Plus plan under this part;

7 “(B) is enrolled with a Medicare+Choice
8 plan that provides qualified prescription drug
9 coverage under part C of title XVIII; or

10 “(C) is covered as a medicare secondary
11 payer eligible individual under a qualified re-
12 tiree prescription drug plan.

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

18 “PLAN FEES FOR ADMINISTRATIVE COSTS

19 “SEC. 2233. (a) IN GENERAL.—The Commissioner
20 may levy on Medicare Prescription Plus plans and
21 Medicare+Choice plans that provide drug coverage pursu-
22 ant to this part an assessment sufficient to pay the esti-
23 mated expenses of the Commissioner for administering the
24 program under this part.

25 “(b) DEPOSITS AND USE.—The assessments de-
26 scribed in subsection (a) shall be—

1 “(1) deposited into the Medicare Prescription
2 Drug Account; and

3 “(2) available for administering the program
4 under this part without regard to amounts provided
5 for in advance by appropriations Acts.

6 “MEDICARE PRESCRIPTION DRUG ACCOUNT

7 “SEC. 2234. (a) ESTABLISHMENT.—There is created
8 within the Federal Supplementary Medical Insurance
9 Trust Fund established under section 1841 an account to
10 be known as the ‘Medicare Prescription Drug Account’.

11 “(b) AMOUNTS IN ACCOUNT.—

12 “(1) IN GENERAL.—The Medicare Prescription
13 Drug Account shall consist of—

14 “(A) such amounts as may be deposited in,
15 or appropriated to, such account as provided in
16 this part; and

17 “(B) such gifts and bequests as may be
18 made as provided in section 201(i)(1).

19 “(2) SEPARATION OF FUNDS.—Funds provided
20 under this part to the Medicare Prescription Drug
21 Account shall be kept separate from all other funds
22 within the Federal Supplemental Medical Insurance
23 Trust Fund.

24 “(c) PAYMENTS FROM ACCOUNT.—

25 “(1) IN GENERAL.—The Managing Trustee
26 shall pay from time to time from the Medicare Pre-

1 scription Drug Account such amounts as the Com-
2 missioner certifies are necessary to make the pay-
3 ments provided for by this part, and the payments
4 with respect to administrative expenses in accord-
5 ance with section 201(g).

6 “(2) TRANSFERS TO MEDICAID ACCOUNT FOR
7 INCREASED ADMINISTRATIVE COSTS.—The Man-
8 aging Trustee shall transfer from time to time from
9 the Account to the Grants to States for Medicaid ac-
10 count amounts the Secretary certifies are attrib-
11 utable to increases in payment resulting from the
12 application of a higher Federal matching percentage
13 under section 1935(b).

14 “(d) DEPOSITS INTO ACCOUNT.—

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

21 “(2) APPROPRIATIONS TO COVER GOVERNMENT
22 CONTRIBUTIONS.—There are authorized to be appro-
23 priated from time to time, out of any moneys in the
24 Treasury not otherwise appropriated, to the Ac-

1 count, an amount equivalent to the amount of pay-
 2 ments made from the Account, reduced by—

3 “(1) the amount transferred to the Ac-
 4 count under paragraph (1);

5 “(2) the beneficiary premiums collected
 6 and credited to the account under section
 7 2231(b)(2); and

8 “(3) fees collected and credited to the ac-
 9 count under section 2233.

10 “SECONDARY PAYER PROVISIONS

11 “SEC. 2235. The provisions of section 1862(b) shall
 12 apply to the benefits provided under this part.

13 “DEFINITIONS; TREATMENT OF REFERENCES TO
 14 PROVISIONS IN MEDICARE+CHOICE PROGRAM

15 “SEC. 2236. (a) DEFINITIONS.—In this part:

16 “(1) COMMISSIONER.—The term ‘Commis-
 17 sioner’ means the Commissioner of the Competitive
 18 Medicare Agency.

19 “(2) COVERED OUTPATIENT DRUG.—

20 “(A) IN GENERAL.—Except as provided in
 21 this subparagraph (B), the term ‘covered out-
 22 patient drug’ means—

23 “(i) a drug that may be dispensed
 24 only upon a prescription and that is de-
 25 scribed in clause (i) or (ii) of section
 26 1927(k)(2)(A); or

1 “(ii) a biological product or insulin de-
2 scribed in subparagraph (B) or (C) of such
3 section.

4 “(B) EXCLUSIONS.—

5 “(i) IN GENERAL.—The term ‘covered
6 outpatient drug’ does not include drugs or
7 classes of drugs, or their medical uses,
8 which may be excluded from coverage or
9 otherwise restricted under section
10 1927(d)(2), other than subparagraph (E)
11 thereof (relating to smoking cessation
12 agents).

13 “(ii) AVOIDANCE OF DUPLICATE COV-
14 ERAGE.—A drug prescribed for an indi-
15 vidual that would otherwise be a covered
16 outpatient drug under this part shall not
17 be so considered if payment for such drug
18 is available under part A or B of title
19 XVIII (but shall be so considered if such
20 payment is not available because benefits
21 under part A or B of title XVIII have been
22 exhausted), without regard to whether the
23 individual is entitled to benefits under such
24 part A or enrolled under such part B.

1 “(3) ELIGIBLE BENEFICIARY.—The term ‘eligi-
2 ble beneficiary’ means an individual that is entitled
3 to benefits under part A of title XVIII and enrolled
4 under part B of such title.

5 “(4) ELIGIBLE ENTITY.—The term ‘eligible en-
6 tity’ means any risk-bearing entity that the Commis-
7 sioner determines to be appropriate to provide eligi-
8 ble beneficiaries with the benefits under a Medicare
9 Prescription Plus plan, including—

10 “(A) a pharmaceutical benefit management
11 company;

12 “(B) a wholesale or retail pharmacist deliv-
13 ery system;

14 “(C) an insurer (including an insurer that
15 offers medicare supplemental policies under sec-
16 tion 1882);

17 “(D) another entity; or

18 “(E) any combination of the entities de-
19 scribed in subparagraphs (A) through (D).

20 “(5) INITIAL COVERAGE LIMIT.—The term ‘ini-
21 tial coverage limit’ means the limit as established
22 under section 2225(d)(3), or, in the case of coverage
23 that is not standard coverage, the comparable limit
24 (if any) established under the coverage.

1 “(6) MEDICARE+CHOICE ORGANIZATION;
2 MEDICARE+CHOICE PLAN.—The terms
3 ‘Medicare+Choice organization’ and
4 ‘Medicare+Choice plan’ have the meanings given
5 such terms in subsections (a)(1) and (b)(1), respec-
6 tively, of section 1859 (relating to definitions relat-
7 ing to Medicare+Choice organizations and plans).

8 “(7) MEDICARE PRESCRIPTION DRUG AC-
9 COUNT.—The term ‘Medicare Prescription Drug Ac-
10 count’ means the Medicare Prescription Drug Ac-
11 count established under section 2234 and located
12 within the Federal Supplementary Medical Insur-
13 ance Trust Fund established under section 1841.

14 “(8) MEDICARE PRESCRIPTION PLUS PLAN.—
15 The term ‘Medicare Prescription Plus plan’ means a
16 health benefits plan that the Commissioner has ap-
17 proved under section 2229.

18 “(9) STANDARD COVERAGE.—The term ‘stand-
19 ard coverage’ means the coverage described in sec-
20 tion 2225(d).

21 “(b) APPLICATION OF MEDICARE+CHOICE PROVI-
22 SIONS UNDER THIS PART.—For purposes of applying pro-
23 visions of part C of title XVIII under this part with re-
24 spect to a Medicare Prescription Plus plan and an eligible

1 entity, unless otherwise provided in this part such provi-
 2 sions shall be applied as if—

3 “(1) any reference to a Medicare+Choice plan
 4 included a reference to a Medicare Prescription Plus
 5 plan;

6 “(2) any reference to a provider-sponsored or-
 7 ganization included a reference to an eligible entity;

8 “(3) any reference to a contract under section
 9 1857 included a reference to a contract under sec-
 10 tion 2227(b); and

11 “(4) any reference to part C of title XVIII in-
 12 cluded a reference to this part.”.

13 (b) SUBMISSION OF LEGISLATIVE PROPOSAL.—Not
 14 later than 6 months after the date of enactment of this
 15 Act, the Secretary of Health and Human Services and the
 16 Commissioner of the Competitive Medicare Agency shall
 17 submit to the appropriate committees of Congress a legis-
 18 lative proposal providing for such technical and con-
 19 forming amendments in the law as are required by the
 20 provisions of this Act.

21 **SEC. 202. AMENDMENTS TO FEDERAL SUPPLEMENTARY**
 22 **MEDICAL INSURANCE TRUST FUND.**

23 Section 1841 of the Social Security Act (42 U.S.C.
 24 1395t) is amended—

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

1 (A) by striking “and” after “section
2 201(i)(1)”;

3 (B) by inserting before the period the fol-
4 lowing: “, and such amounts as may be depos-
5 ited in, or appropriated to, the Medicare Pre-
6 scription Drug Account established by section
7 2234”;

8 (2) in subsection (g), by inserting after “by this
9 part,” the following: “the payments provided for
10 under the Prescription Drug and Supplemental Ben-
11 efit Program under part B of title XVIII (in which
12 case the payments shall come from the Medicare
13 Prescription Drug Account in the Supplementary
14 Medical Insurance Trust Fund),”;

15 (3) in the first sentence of subsection (h), by
16 inserting “(or the Commissioner of the Competitive
17 Medicare Agency by reason of section 2235 (in
18 which case the payments shall come from the Medi-
19 care Prescription Drug Account within such Trust
20 Fund))” after “Human Services”; and

21 (4) in the first sentence of subsection (i), by in-
22 sserting “(or the Commissioner of the Competitive
23 Medicare Agency by reason of section 2235 (in
24 which case the payments shall come from the Medi-

1 care Prescription Drug Account within such Trust
 2 Fund))” after “Human Services”.

3 **SEC. 203. PRESCRIPTION DRUG COVERAGE UNDER THE**
 4 **MEDICARE+CHOICE PROGRAM.**

5 (a) IN GENERAL.—Section 1851 of the Social Secu-
 6 rity Act (42 U.S.C. 1395w–21) is amended by adding at
 7 the end the following new subsection:

8 “(j) AVAILABILITY OF PRESCRIPTION DRUG BENE-
 9 FITS.—

10 “(1) IN GENERAL.—A Medicare+Choice orga-
 11 nization may not offer prescription drug coverage
 12 (other than that required under parts A and B) to
 13 an enrollee under a Medicare+Choice plan unless
 14 such drug coverage is at least qualified prescription
 15 drug coverage and unless the requirements of this
 16 subsection with respect to such coverage are met.

17 “(2) COMPLIANCE WITH ADDITIONAL BENE-
 18 FICIARY PROTECTIONS.—With respect to the offer-
 19 ing of qualified prescription drug coverage by a
 20 Medicare+Choice organization under a
 21 Medicare+Choice plan, the organization and plan
 22 shall meet the requirements of section 2226, includ-
 23 ing requirements relating to information dissemina-
 24 tion and grievance and appeals, in the same manner
 25 as they apply to an eligible entity and a Medicare

1 Prescription Plus plan under part B of title XXII.
2 The Commissioner of the Competitive Medicare
3 Agency shall waive such requirements to the extent
4 the Administrator determines that such require-
5 ments duplicate requirements otherwise applicable to
6 the organization or plan under this part.

7 “(3) TREATMENT OF COVERAGE.—Except as
8 provided in this subsection, qualified prescription
9 drug coverage offered under this subsection shall be
10 treated under this part in the same manner as sup-
11 plemental health care benefits described in section
12 1852(a)(3)(A).

13 “(4) AVAILABILITY OF COST-SHARING SUB-
14 SIDIES FOR LOW-INCOME ENROLLEES AND REINSUR-
15 ANCE SUBSIDY PAYMENTS FOR ORGANIZATIONS.—
16 For provisions—

17 “(A) providing cost-sharing subsidies to
18 low-income individuals receiving qualified pre-
19 scription drug coverage through a
20 Medicare+Choice plan, see section 2231; and

21 “(B) providing a Medicare+Choice organi-
22 zation with reinsurance subsidy payments for
23 providing qualified prescription drug coverage
24 under this part, see section 2232.

1 “(5) SPECIFICATION OF SEPARATE AND STAND-
2 ARD PREMIUM.—

3 “(A) IN GENERAL.—For purposes of ap-
4 plying section 1854 and determining the pre-
5 mium discount under section 2231(c) with re-
6 spect to qualified prescription drug coverage of-
7 fered under this subsection under a plan, the
8 Medicare+Choice organization shall compute
9 and publish the following:

10 “(i) SEPARATE PRESCRIPTION DRUG
11 PREMIUM.—A premium for prescription
12 drug benefits that constitutes qualified
13 prescription drug coverage that is separate
14 from other coverage under the plan.

15 “(ii) PORTION OF COVERAGE ATTRIB-
16 UTABLE TO STANDARD BENEFITS.—The
17 ratio of the actuarial value of standard
18 coverage to the actuarial value of the
19 qualified prescription drug coverage offered
20 under the plan.

21 “(iii) PORTION OF PREMIUM ATTRIB-
22 UTABLE TO STANDARD BENEFITS.—A
23 standard premium equal to the product of
24 the premium described in clause (i) and
25 the ratio under clause (ii).

1 The premium under clause (i) shall be com-
2 puted without regard to any reduction in the
3 premium permitted under subparagraph (B).

4 “(B) REDUCTION OF PREMIUMS AL-
5 LOWED.—Nothing in this subsection shall be
6 construed as preventing a Medicare+Choice or-
7 ganization from reducing the amount of a pre-
8 mium charged for prescription drug coverage
9 because of the application of subsections
10 (f)(1)(A) and (i)(2)(A) of section 1854 to other
11 coverage.

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

17 “(7) QUALIFIED PRESCRIPTION DRUG COV-
18 ERAGE; STANDARD COVERAGE.—For purposes of
19 this part, the terms ‘qualified prescription drug cov-
20 erage’ and ‘standard coverage’ have the meanings
21 given such terms in section 2225.”.

22 (b) CONFORMING AMENDMENTS.—Section
23 1851(a)(1) of the Social Security Act (42 U.S.C. 1395w-
24 21(a)(1)) is amended—

1 (1) by inserting “(other than qualified prescrip-
2 tion drug benefits)” after “benefits”;

3 (2) by striking the period at the end of sub-
4 paragraph (B) and inserting a comma; and

5 (3) by adding at the end the following flush lan-
6 guage:

7 “and may elect qualified prescription drug coverage
8 in accordance with part B of title XXII.”.

9 (c) EFFECTIVE DATE.—The amendments made by
10 this section apply to coverage provided on or after January
11 1, 2004.

12 **SEC. 204. MEDICAID AMENDMENTS.**

13 (a) DETERMINATIONS OF ELIGIBILITY FOR LOW-IN-
14 COME SUBSIDIES.—

15 (1) REQUIREMENT.—Section 1902 of the Social
16 Security Act (42 U.S.C. 1396a) is amended in sub-
17 section (a)—

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

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

22 (C) by inserting after paragraph (65) the
23 following new paragraph:

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

1 (2) NEW SECTION.—Title XIX of the Social Se-
2 curity Act (42 U.S.C. 1396 et seq.) is 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 2231;

17 “(2) inform the Commissioner of the Competi-
18 tive Medicare Agency of such determinations in
19 cases in which such eligibility is established; and

20 “(3) otherwise provide such Commissioner with
21 such information as may be required to carry out
22 part B of title XXII (including section 2231).

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 2004, 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 2005, 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 2006, 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 2007, 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 2007, 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 the
21 Social Security Act, as inserted by subsection (a)(2),
22 is amended by adding at the end the following new
23 subsection:

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 1 of the 50 States
6 or the District of Columbia for a calendar quarter
7 in a year (beginning with 2004) 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 2231 (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) 2004 is 90 percent;

8 “(B) 2005 is 80 percent;

9 “(C) 2006 is 70 percent;

10 “(D) 2007 is 60 percent; or

11 “(E) a year after 2007 is 50 percent.”.

12 (c) MEDICAID PROVIDING WRAP-AROUND BENE-
13 FITS.—Section 1935 of the Social Security Act, as so in-
14 serted and amended, is further amended by adding at the
15 end the 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 Plus
20 Plan under part B of title XXII (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 Medicare Pre-

1 scription Plus plan or the Medicare+Choice plan se-
2 lected by 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 the program under part B of title
10 XXII.”.

11 (d) TREATMENT OF TERRITORIES.—

12 (1) IN GENERAL.—Section 1935 of the Social
13 Security Act, as so inserted and amended, is further
14 amended—

15 (A) in subsection (a)(1), by inserting “sub-
16 ject to subsection (e),” after “section 1903”;

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

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 (as defined in section 2236(2)) to low-in-
16 come medicare beneficiaries; and

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

21 “(3) INCREASED AMOUNT.—

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

1 “(i) the aggregate amount specified in
2 subparagraph (B); and

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

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

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

11 “(ii) a subsequent year, is equal to the
12 aggregate amount specified in this sub-
13 paragraph for the previous year increased
14 by the annual percentage increase specified
15 in section 2225(d)(5) for the year involved.

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

20 (2) CONFORMING AMENDMENT.—Section
21 1108(f) of the Social Security Act (42 U.S.C.
22 1308(f)) is amended by inserting “and section
23 1935(e)(1)(B)” after “Subject to subsection (g)”.

1 **SEC. 205. MEDIGAP PROVISIONS.**

2 (a) IN GENERAL.—Notwithstanding any other provi-
3 sion of law, no new medicare supplemental policy that pro-
4 vides coverage of expenses for prescription drugs may be
5 issued under section 1882 of the Social Security Act on
6 or after January 1, 2004, to an individual unless it re-
7 places a medicare supplemental policy that was issued to
8 that individual and that provided some coverage of ex-
9 penses for prescription drugs.

10 (b) ISSUANCE OF SUBSTITUTE POLICIES IF OBTAIN-
11 ING PRESCRIPTION DRUG COVERAGE THROUGH MEDI-
12 CARE.—

13 (1) IN GENERAL.—The issuer of a medicare
14 supplemental policy—

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

24 (B) may not discriminate in the pricing of
25 such policy, because of health status, claims ex-

1 perience, receipt of health care, or medical con-
2 dition; and

3 (C) may not impose an exclusion of bene-
4 fits based on a preexisting condition under such
5 policy,

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

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

15 (A) enrolls in a Medicare Prescription Plus
16 plan under part B of title XXII of the Social
17 Security Act (as added by section 201); and

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

1 (3) ENFORCEMENT.—The provisions of para-
 2 graph (1) shall be enforced as though such provi-
 3 sions were included in section 1882(s) of the Social
 4 Security Act (42 U.S.C. 1395ss(s)).

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

9 (c) MEDIGAP PROTECTIONS FOR INDIVIDUALS WHO
 10 LOSE MEDICARE PRESCRIPTION PLUS PLAN COV-
 11 ERAGE.—Section 1882 of the Social Security Act (42
 12 U.S.C. 1395ss) is amended—

13 (1) in subsection (d)(3)—

14 (A) in subparagraph (A), by adding at the
 15 end the following:

16 “(ix) Nothing in this subparagraph shall be construed
 17 as preventing the sale of 1 medicare supplemental policy
 18 and 1 Medicare Prescription Plus plan to an individual,
 19 except that the sale of such a policy or plan may not dupli-
 20 cate any health benefits under any policy or plan owned
 21 by the individual.”; and

22 (B) in subparagraph (B)(iii)—

23 (i) in subclause (I), by striking “(II)
 24 and (III)” and inserting “(II), (III), and
 25 (IV)”;

1 (ii) by redesignating subclause (III) as
2 subclause (IV); and

3 (iii) by inserting after subclause (II)
4 the following:

5 “(III) If the statement required by clause (i) is ob-
6 tained and indicates that the individual is enrolled in 1
7 medicare supplemental policy or 1 Medicare Prescription
8 Plus plan, the sale of another policy or plan is not in viola-
9 tion of clause (i) if such other policy or plan does not du-
10 plicate health benefits under the policy or plan in which
11 the individual is enrolled.”;

12 (2) in subsection (g)(1), by inserting “, Medi-
13 care Prescription Plus plan,” after
14 “Medicare+Choice plan”; and

15 (3) in subsection (s)(3)(B)—

16 (A) in clause (ii), by inserting “is enrolled
17 with an eligible entity under a Medicare Pre-
18 scription Plus plan under part B of title XXII
19 or” after “section 1851(e)(4) or the indi-
20 vidual”;

21 (B) in clause (v)(II), by inserting “with
22 any eligible entity under a Medicare Prescrip-
23 tion Plus plan under part B of title XXII,”
24 after “under part C,”; and

1 (C) in clause (vi), by inserting “, in a
 2 Medicare Prescription Plus plan under part B
 3 of title XXII,” after “under part C”; and

4 **TITLE III—MEDICARE+CHOICE**
 5 **COMPETITION PROGRAM**

6 **SEC. 301. MEDICARE+CHOICE COMPETITION PROGRAM.**

7 (a) PAYMENTS TO MEDICARE+CHOICE ORGANIZA-
 8 TIONS BASED ON RISK-ADJUSTED BIDS.—

9 (1) MONTHLY PAYMENTS.—Section
 10 1853(a)(1)(A) of the Social Security Act (42 U.S.C.
 11 1395w–23(a)(1)(A)) is amended by adding at the
 12 end the following new sentences: “For each year (be-
 13 ginning with 2004), under a contract under section
 14 1857, the Commissioner shall make to each
 15 Medicare+Choice organization, with respect to cov-
 16 erage of an individual for a month under this part
 17 in a Medicare+Choice payment area, monthly pay-
 18 ments with respect to benefits under parts A and B
 19 combined in accordance with subsection (c)(8), re-
 20 duced by the amount of any reduction elected under
 21 section 1854(f)(1)(E). For rules relating to payment
 22 of the Medicare+Choice monthly supplemental bene-
 23 ficiary premium or any prescription drug premium,
 24 see section 1854(j).”.

1 (2) ANNUAL DETERMINATION AND ANNOUNCE-
2 MENT OF PAYMENT FACTORS.—

3 (A) IN GENERAL.—Section 1853(b) (42
4 U.S.C. 1395w-23(b)) is amended—

5 (i) in paragraph (1), by striking “the
6 calendar year concerned” and all that fol-
7 lows and inserting “the calendar year con-
8 cerned with respect to each
9 Medicare+Choice payment area, the fol-
10 lowing:

11 “(A) The benchmark amount (as defined
12 in paragraph (5)(A)).

13 “(B) The county-specific monthly per cap-
14 ita costs (as defined in paragraph (5)(B)).

15 “(C) The demographic adjustment factors
16 to be used in making payment for individual en-
17 rollees (as defined in paragraph (5)(C)).

18 “(D) The ESRD adjustment (as defined in
19 paragraph (5)(D)).

20 “(E) The health status adjustment (as de-
21 fined in paragraph (5)(E)).”.

22 (ii) in paragraph (3), by striking
23 “monthly adjusted” and all that follows be-
24 fore the period at the end and inserting
25 “the payment rates under this part for

1 each individual enrolled in the
 2 Medicare+Choice plan offered by the
 3 Medicare+Choice organization for the
 4 year”; and

5 (iii) by adding at the end the fol-
 6 lowing new paragraph:

7 “(5) DEFINITIONS RELATING TO FACTORS
 8 USED IN ADJUSTING BIDS FOR MEDICARE+CHOICE
 9 ORGANIZATIONS AND IN DETERMINING ENROLLEE
 10 PREMIUMS.—In this part:

11 “(A) BENCHMARK AMOUNT.—

12 “(i) IN GENERAL.—The term ‘bench-
 13 mark amount’ means, for a payment area,
 14 an amount equal to the greater of—

15 “(I) except as provided in clause
 16 (ii), $\frac{1}{12}$ of the annual
 17 Medicare+Choice capitation rate that
 18 would have applied in that payment
 19 area under paragraphs (1) through
 20 (7) of subsection (c); or

21 “(II) the county-specific monthly
 22 per capita costs for such area.

23 “(ii) PHASE-OUT OF MINIMUM
 24 AMOUNT AND BLENDED CAPITATION
 25 RATE.—If the amount calculated under

1 clause (i)(I) for a year for all payment
2 areas is equal to either the minimum
3 amount or the blended capitation rate, for
4 all subsequent years the Commissioner
5 shall not calculate the rates described in
6 that clause and the amount under such
7 clause instead shall be equal to the county-
8 specific monthly per capita costs.

9 “(B) COUNTY-SPECIFIC MONTHLY PER
10 CAPITA COSTS.—

11 “(i) IN GENERAL.—Subject to clause
12 (ii), the term ‘county-specific monthly per
13 capita costs’ means the amount of payment
14 in a Medicare+Choice payment area for
15 benefits under this title and associated
16 claims processing costs for individuals enti-
17 tled to benefits under part A and individ-
18 uals enrolled in the program under part B
19 who are not enrolled in a Medicare+Choice
20 plan under this part. The Commissioner
21 shall determine such amount in a manner
22 similar to the manner in which the Sec-
23 retary determined the adjusted average per
24 capita cost under section 1876, except that
25 such determination shall include in such

1 amount any amounts that would have been
2 paid under this title if individuals entitled
3 to benefits under this title had not received
4 services from facilities of the Department
5 of Veterans Affairs or the Department of
6 Defense.

7 “(ii) EXCLUSION OF GME COSTS.—
8 The calculation of costs under clause (i)
9 shall not take into account any amounts
10 attributable to—

11 “(I) payments for costs of grad-
12 uate medical education under section
13 1886(h); or

14 “(II) payments for indirect costs
15 of medical education under section
16 1886(d)(5)(B).

17 “(C) DEMOGRAPHIC ADJUSTMENT FAC-
18 TORS.—The term ‘demographic adjustment fac-
19 tors’ means such factors as age, disability sta-
20 tus, gender, and institutional status, so as to
21 ensure actuarial equivalence. The Commissioner
22 may add to, modify, or substitute for such fac-
23 tors, if such changes will improve the deter-
24 mination of actuarial equivalence, and in that

1 event the Commissioner will make comparable
2 adjustments to the benchmark amounts.

3 “(D) ESRD ADJUSTMENT FACTOR.—The
4 term ‘ESRD adjustment factor’ means the ad-
5 justment established by the Commissioner
6 under section 1851(a)(3)(B) that applies with
7 respect to enrolled individuals who have end-
8 stage renal disease.

9 “(E) HEALTH STATUS ADJUSTMENT FAC-
10 TOR.—The term ‘health status adjustment fac-
11 tor’ means the health status adjustment imple-
12 mented under subsection (a)(3)(C) until such
13 time as the Commissioner develops a health sta-
14 tus adjustment factor that takes into account
15 the specific health care needs of
16 Medicare+Choice eligible individuals who do
17 not have end-stage renal disease based on the
18 delivery of care in all settings, which method-
19 ology shall be phased in equally over a 10-year
20 period, beginning with 2005, or (if later) the
21 date on which such factor is developed.

22 (3) SUBMISSION OF BIDS BY
23 MEDICARE+CHOICE ORGANIZATIONS.—Section
24 1854(a) of the Social Security Act (42 U.S.C.
25 1395w-24(a)) is amended—

1 (A) in paragraph (1), by striking “Not
2 later than July 1” and inserting “Subject to
3 paragraph (6), not later than July 1”; and

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

5 “(6) SUBMISSION OF BIDS BY
6 MEDICARE+CHOICE ORGANIZATIONS.—

7 “(A) IN GENERAL.—For each year (begin-
8 ning with 2004), each Medicare+Choice organi-
9 zation shall submit to the Commissioner, in a
10 form and manner specified by the Commis-
11 sioner and for each Medicare+Choice plan
12 which it intends to offer in a service area in the
13 following year—

14 “(i) notice of such intent and informa-
15 tion on the service area and plan type for
16 each plan;

17 “(ii) the information described in
18 paragraph (2) for the type of plan in-
19 volved; and

20 “(iii) the enrollment capacity (if any)
21 in relation to the plan and area.

22 “(B) INFORMATION REQUIRED FOR COM-
23 PETITIVE PLANS.—The information described
24 in this paragraph is as follows:

1 “(i) The monthly plan bid for the pro-
2 vision of benefits.

3 “(ii) The actuarial value of the reduc-
4 tion in cost-sharing for benefits under
5 parts A and B included in each plan bid
6 and a description of the cost-sharing for
7 such benefits.

8 “(iii) The actuarial value of any addi-
9 tional benefits required under subsection
10 (i), a description of cost-sharing for such
11 benefits, and such other information as the
12 Commissioner considers necessary.

13 “(iv) The actuarial value of any sup-
14 plemental benefits, the monthly supple-
15 mental premium (if any) for such benefits,
16 a description of any cost-sharing for such
17 benefits, and such other information as the
18 Commissioner considers necessary.

19 “(v) For each Medicare+Choice pay-
20 ment area, the assumptions used with re-
21 spect to the number of—

22 “(I) enrolled individuals who are
23 entitled to benefits under parts A and
24 enrolled under part B who do not
25 have end-stage renal disease; and

1 “(II) such enrolled individuals
2 who have end-stage renal disease.”.

3 (4) COMMISSIONER’S DETERMINATION OF PAY-
4 MENT AMOUNT.—Section 1853(c) of the Social Se-
5 curity Act (42 U.S.C. 1395w-23(c)) is amended—

6 (A) in paragraph (1), by striking “subject
7 to paragraphs (6)(C) and (7)” and inserting
8 “subject to paragraphs (6)(C), (7), and (8)”;

9 (B) by adding at the end the following new
10 paragraph:

11 “(8) COMMISSIONER’S DETERMINATION OF PAY-
12 MENT AMOUNT.—

13 “(A) ADJUSTMENT OF BIDS.—The Com-
14 missioner shall adjust plan bids submitted
15 under section 1854(a)(6) based on the demo-
16 graphic adjustment factors, the ESRD adjust-
17 ment factor, and the health status adjustment
18 factor (as defined in subparagraphs (C), (D),
19 and (E), respectively, of subsection (b)(5)).

20 “(B) DETERMINATION OF BENCHMARK
21 PER COUNTY.—For each year (beginning with
22 2004), the Commissioner shall determine the
23 benchmark amount (as defined in subparagraph
24 (A) of subsection (b)(5)) for each
25 Medicare+Choice payment area and shall ad-

1 just such amount based on the demographic ad-
2 justment factors, the ESRD adjustment factor,
3 and the health status adjustment factor (as de-
4 fined in subparagraphs (C), (D), and (E), re-
5 spectively, of such section).

6 “(C) COMPARISON TO PLAN BENCHMARK
7 AMOUNT.—

8 “(i) IN GENERAL.—The Commissioner
9 shall compare the organization’s bid (as
10 adjusted under subparagraph (A)) to the
11 benchmark amount (as adjusted under
12 subparagraph (B)) to determine the pay-
13 ment amount under clause (ii).

14 “(ii) DETERMINATION OF PAYMENT
15 AMOUNT.—The Commissioner shall deter-
16 mine the monthly payment to a
17 Medicare+Choice organization with respect
18 to each individual enrolled in a
19 Medicare+Choice plan as follows:

20 “(I) IF BID DOES NOT EXCEED
21 BENCHMARK.—If the
22 Medicare+Choice organization’s bid
23 (as adjusted under subparagraph (A))
24 does not exceed the benchmark
25 amount (as adjusted under subpara-

1 graph (B)), the monthly payment
2 shall be the benchmark amount, ad-
3 justed to account for the demographic
4 adjustment factors, health status ad-
5 justment factor, and (if applicable)
6 the ESRD adjustment factor of the
7 individual enrollee, minus 25 percent
8 of the difference between the bid and
9 the benchmark amount determined
10 under section 1854(i)(2)(A).

11 “(II) IF BID EXCEEDS BENCH-
12 MARK.—If the organization’s bid (as
13 adjusted under subparagraph (A)) ex-
14 ceeds the benchmark amount (as ad-
15 justed under subparagraph (B)), the
16 monthly payment shall be the bid, ad-
17 justed to account for the demographic
18 adjustment factors, health status ad-
19 justment factor, and (if applicable)
20 the ESRD adjustment factor of the
21 individual enrollee.”.

22 (b) PREMIUMS.—

23 (1) DETERMINATION OF PREMIUM AMOUNT.—
24 Section 1854 of the Social Security Act (42 U.S.C.

1 1395w–24) is amended by adding at the end the fol-
2 lowing new subsections:

3 “(i) DETERMINATION OF MEDICARE PREMIUM RE-
4 DUCTION AND MEDICARE+CHOICE MONTHLY SUPPLE-
5 MENTAL BENEFICIARY PREMIUM.—

6 “(1) IN GENERAL.—Notwithstanding subsection
7 (b) and subject to paragraph (2), for each year (be-
8 ginning with 2004), the Commissioner shall deter-
9 mine the difference between the organization’s bid
10 (submitted under subsection (a)(6) and adjusted
11 under section 1853(c)(8)(A)) and the plan’s bench-
12 mark amount (as adjusted under 1853(c)(8)(B)) to
13 determine the amount of any medicare premium re-
14 duction, prescription drug premium reduction, re-
15 duction in plan cost-sharing, or additional benefits
16 required under paragraph (2)(A), or the
17 Medicare+Choice monthly supplemental beneficiary
18 premium for plan enrollees.

19 “(2) ADJUSTMENT.—

20 “(A) BIDS BELOW THE BENCHMARK.—
21 Notwithstanding subsection (f) (except for
22 paragraph (1)(E) of such subsection), if the or-
23 ganization’s bid is lower than the plan’s bench-
24 mark amount, 75 percent of the difference de-
25 termined under paragraph (1) shall be returned

1 to the enrollee in the form of, at the option of
2 the organization offering the plan—

3 “(i) a monthly medicare premium re-
4 duction for individuals enrolled in the plan
5 in accordance with subsection (f)(1)(E);

6 “(ii) a prescription drug premium re-
7 duction pursuant to subsection (j)(5)(B);

8 “(iii) a reduction in the actuarial
9 value of plan cost-sharing for plan enroll-
10 ees;

11 “(iv) such additional benefits as the
12 organization may specify; or

13 “(v) any combination of the reduc-
14 tions and benefits described in clauses (i)
15 through (iv).

16 “(B) BIDS ABOVE THE BENCHMARK.—If
17 the organization’s bid is higher than the bench-
18 mark amount, the difference determined under
19 paragraph (1) shall be the Medicare+Choice
20 monthly supplemental beneficiary premium for
21 individuals enrolled in the plan.

22 “(j) RULES RELATING TO PREMIUMS OWED BY
23 MEDICARE+CHOICE ENROLLEES.—In the case of any
24 Medicare+Choice monthly supplemental beneficiary pre-
25 mium under subsection (i)(2)(B) or any prescription drug

1 premium under section 1851(j) that an individual is re-
2 sponsible for under a Medicare+Choice plan in which the
3 individual is enrolled, the following rules shall apply:

4 “(1) COMMISSIONER SHALL PAY THE DRUG
5 PREMIUM TO THE ENTITY.—

6 “(A) IN GENERAL.—The Commissioner
7 shall pay to the Medicare+Choice organization
8 offering the Medicare+Choice plan the full
9 amount of the prescription drug premium under
10 section 1851(j) that the individual is respon-
11 sible for under the plan.

12 “(B) PAYMENTS FROM MEDICARE PRE-
13 SCRIPTION DRUG ACCOUNT.—Payments under
14 subparagraph (A) shall be made from the Medi-
15 care Prescription Drug Account within the Fed-
16 eral Supplementary Medical Insurance Trust
17 Fund under section 1841.

18 “(2) PREMIUM DISCOUNT FOR DRUG BENE-
19 FITS.—Subject to paragraph (4), the individual shall
20 be entitled to the premium discount for prescription
21 drugs determined under section 2231.

22 “(3) COLLECTION OF SUPPLEMENTAL AND
23 DRUG PREMIUMS IN SAME MANNER AS PART B PRE-
24 MIUM.—

1 “(A) SUPPLEMENTAL PREMIUM.—The
2 amount of any Medicare+Choice monthly sup-
3 plemental beneficiary premium that an indi-
4 vidual is responsible for under the plan shall be
5 collected and credited to the Federal Hospital
6 Insurance Trust Fund and the Federal Supple-
7 mentary Medical Insurance Trust Fund—

8 “(i) in such proportion as the Com-
9 missioner determines appropriate; and

10 “(ii) in the same manner as the
11 monthly premium determined under sec-
12 tion 1839 is collected and credited to the
13 Federal Supplementary Medical Insurance
14 Trust Fund under section 1840.

15 “(B) DRUG PREMIUM.—Subject to the ap-
16 plication of the premium discounts available
17 under section 2231, the amount of any pre-
18 mium drug premium that an individual is re-
19 sponsible for under the plan shall be collected
20 and credited to the Medicare Prescription Drug
21 Account within the Federal Supplementary
22 Medical Insurance Trust Fund under section
23 1841 in the same manner as the monthly pre-
24 mium determined under section 1839 is col-
25 lected and credited to the Federal Supple-

1 mentary Medical Insurance Trust Fund under
2 section 1840.

3 “(C) INFORMATION NECESSARY FOR COL-
4 LECTION.—In order to carry out subparagraph
5 (A), the Commissioner shall transmit to the
6 Commissioner of Social Security—

7 “(i) at the beginning of each year, the
8 name, social security account number, and
9 the Medicare+Choice monthly supple-
10 mental beneficiary premium and prescrip-
11 tion drug premium owed by the individual
12 for each month during the year; and

13 “(ii) periodically throughout the year,
14 information to update the information pre-
15 viously transmitted under this paragraph
16 for the year.

17 “(4) DISCOUNT REDUCED IF GREATER THAN
18 COMBINED PREMIUMS.—In the case of an individual
19 whose premium discount determined under section
20 2231(b) is equal to or less than the sum of any the
21 Medicare+Choice monthly supplemental beneficiary
22 premium and any prescription drug premium (after
23 any reduction described in section 1851(j)(5)(B)) for
24 the Medicare+Choice plan in which the individual is

1 enrolled, the premium subsidy shall be deemed to be
2 an amount equal to such sum.”.

3 (2) LIMITATION ON ENROLLEE LIABILITY FOR
4 SUPPLEMENTAL BENEFITS.—Section 1854(e)(2) of
5 the Social Security Act (42 U.S.C. 1395w–24(e)(2))
6 is amended by striking “If the Medicare+Choice or-
7 ganization” and inserting “Except as provided in
8 subsection (i)(2)(B), if the Medicare+Choice organi-
9 zation”.

10 (c) ALLOWING PLANS TO INCLUDE REDUCTIONS
11 AND OTHER BENEFITS IN THEIR BASIC BENEFITS.—Sec-
12 tion 1852(a)(1)(B) of the Social Security Act (42 U.S.C.
13 1395w–22(a)(1)) is amended—

14 (1) by inserting “(i)” after “(B)”; and

15 (2) by adding at the end the following new
16 clause:

17 “(ii) for 2004 and each subsequent year,
18 at plan option, the reductions and benefits de-
19 scribed in section 1854(i)(2)(A).”.

20 (d) TRANSITION TO ESRD ELIGIBILITY.—Section
21 1851(a)(3)(B) of the Social Security Act (42 U.S.C.
22 1395w–21(a)(3)(B)) is amended by inserting “until such
23 time as the Commissioner establishes an ESRD adjust-
24 ment factor that takes into account the specific health
25 care needs of such individuals based on a delivery of care

1 in all settings (to be phased-in in such manner as the
2 Commissioner deems appropriate)” after “determined to
3 have end-stage renal disease”.

4 (e) CONFORMING AMENDMENTS.—

5 (1) PREMIUM REDUCTIONS UNDER PART B.—

6 (A) AMOUNT OF PREMIUMS.—Section
7 1839(a)(2) of the Social Security Act (42
8 U.S.C. 1395r(a)(2)), as amended by section
9 606(a)(2)(B)(i) of the Medicare, Medicaid, and
10 SCHIP Benefits Improvement and Protection
11 Act of 2000 (as enacted into law by section
12 1(a)(6) of Public Law 106–554), is amended by
13 striking “and to reflect 80 percent of any re-
14 duction elected under section 1854(f)(1)(E)”
15 and inserting “and to comply with section
16 1854(i)(2)(A) (including an adjustment to re-
17 flect 80 percent of any reduction elected under
18 section 1854(f)(1)(E)).”.

19 (B) PAYMENT OF PREMIUMS.—Section
20 1840(i) of the Social Security Act (42 U.S.C.
21 1395s(i)), as added by section 606(a)(2)(B)(ii)
22 of the Medicare, Medicaid, and SCHIP Benefits
23 Improvement and Protection Act of 2000 (as
24 enacted into law by section 1(a)(6) of Public
25 Law 106–554), is amended by striking “to re-

1 flect 80 percent of any reduction elected under
2 section 1854(f)(1)(E)” and inserting “deter-
3 mined under section 1854(i)(2)(A)(i) (including
4 an adjustment to reflect 80 percent of any re-
5 duction elected under section 1854(f)(1)(E))”.

6 (2) CONTINUATION OF ENROLLMENT PER-
7 MITTED.—Section 1851(b)(1)(B) of the Social Secu-
8 rity Act (42 U.S.C. 1395w–21(b)(1)(B)) is amended
9 by striking “section 1852(a)(1)(A)” and inserting
10 “section 1852(a)(1)”.

11 (3) NATIONAL COVERAGE DETERMINATIONS.—
12 Section 1852(a)(5) of the Social Security Act (42
13 U.S.C. 1395w–22(a)(5)) is amended by inserting
14 “(or, for 2004 and each subsequent fiscal year, the
15 county-specific monthly per capita costs)” after “the
16 annual Medicare+Choice capitation rate”.

17 (4) DISCLOSURE REQUIREMENTS.—Section
18 1852(c)(1)(F) of the Social Security Act (42 U.S.C.
19 1395w–22(c)(1)(F)) is amended by striking clause
20 (i) and redesignating clauses (ii) and (iii) as clauses
21 (i) and (ii), respectively.

22 (5) GEOGRAPHIC ADJUSTMENT.—Section
23 1853(d)(3)(B) of the Social Security Act (42 U.S.C.
24 1395w–23(e)(3)(B)) is amended—

1 (A) in the heading, by striking “BUDGET
2 NEUTRALITY”;

3 (B) by striking “adjust the payment rates”
4 and all that follows through “that would have
5 been made” and inserting “adjust the bench-
6 mark amounts otherwise established under this
7 section for Medicare+Choice payment areas in
8 the State in a manner so that the weighted av-
9 erage of the benchmark amounts under this
10 section in the State equals the weighted average
11 of benchmark amounts that would have been
12 applicable”.

13 (6) MEDICARE+CHOICE MONTHLY BASIC BENE-
14 FICIARY PREMIUM.—Section 1854(b)(2)(A) of the
15 Social Security Act (42 U.S.C. 1395w-24(b)(2)(A))
16 is amended by striking “the amount authorized to be
17 charged” and all that follows and inserting “the
18 amount required to be charged for the plan.”.

19 (7) COMMISSIONER DEFINED.—Section 1859(a)
20 of the Social Security Act (42 U.S.C. 1395w-28(a))
21 is amended by adding at the end the following new
22 paragraph:

23 “(3) COMMISSIONER.—The term ‘Commis-
24 sioner’ means the Commissioner of the Competitive

1 Medicare Agency appointed under section
2 2202(a)(1).”.

3 (f) INCLUSION OF COSTS OF VA AND DOD MILITARY
4 FACILITY SERVICES TO MEDICARE-ELIGIBLE BENE-
5 FICIARIES.—Section 1853(e) of the Social Security Act
6 (42 U.S.C. 1395w–23(e)) (as amended by subsection
7 (a)(4)) is amended by adding at the end the following new
8 paragraph:

9 “(9) INCLUSION OF COSTS OF VA AND DOD
10 MILITARY FACILITY SERVICES TO MEDICARE-ELIGI-
11 BLE BENEFICIARIES.—For purposes of determining
12 the blended capitation rate under subparagraph (A)
13 of paragraph (1) and the minimum percentage in-
14 crease under subparagraph (C) of such paragraph
15 for a year, the annual per capita rate of payment for
16 1997 determined under section 1876(a)(1)(C) shall
17 be adjusted to include in such rate the Commis-
18 sioner’s estimate, on a per capita basis, of the
19 amount of additional payments that would have been
20 made in the area involved under this title if individ-
21 uals entitled to benefits under this title had not re-
22 ceived services from facilities of the Department of
23 Veterans Affairs or the Department of Defense.”.

24 (g) EFFECTIVE DATE.—The amendments made by
25 this section shall take effect on January 1, 2004.

1 **TITLE IV—MEDICARE BENE-**
 2 **FICIARY OUTREACH AND**
 3 **EDUCATION**

4 **SEC. 401. MEDICARE CONSUMER COALITIONS.**

5 Title XXII of the Social Security Act (as added by
 6 section 101) is amended by adding at the end the following
 7 new part:

8 “PART C—MEDICARE CONSUMER COALITIONS

9 “ESTABLISHMENT OF MEDICARE CONSUMER COALITIONS

10 “SEC. 2281. (a) ESTABLISHMENT OF MEDICARE
 11 CONSUMER COALITIONS.—The Commissioner of the Com-
 12 petitive Medicare Agency (in this part referred to as the
 13 ‘Commissioner’) may establish Medicare Consumer Coali-
 14 tions (as defined in subsection (b)) to conduct information
 15 programs described in subsection (e).

16 “(b) MEDICARE CONSUMER COALITION DEFINED.—
 17 In this section, the term ‘Medicare Consumer Coalition’
 18 means an entity that is a nonprofit organization operated
 19 under the direction of a board of directors that is pri-
 20 marily composed of eligible beneficiaries.

21 “(c) REQUEST FOR PROPOSALS; SELECTION OF
 22 MEDICARE CONSUMER COALITIONS.—If the Commis-
 23 sioner elects to establish Medicare Consumer Coalitions
 24 under subsection (a), the Commissioner shall—

1 “(1) develop and disseminate a request for pro-
2 posals to establish Medicare Consumer Coalitions in
3 such areas as the Commissioner determines appro-
4 priate to assist in conducting the information pro-
5 grams described in subsection (a); and

6 “(2) select a proposal to establish a Medicare
7 Consumer Coalition to conduct the information pro-
8 grams in each such area.

9 “(d) PAYMENT TO MEDICARE CONSUMER COALI-
10 TIONS.—The Commissioner shall pay to each Medicare
11 Consumer Coalition for which a proposal has been selected
12 under subsection (c)(2) an amount equal to the sum of
13 any costs incurred—

14 “(1) in conducting the information programs
15 under subsection (e); and

16 “(2) in the hiring of staff to conduct the infor-
17 mation programs under such subsection.

18 “(e) INFORMATION PROGRAMS.—The information
19 programs described in this subsection are those activities
20 that are the responsibilities of the Commissioner under
21 clause (iii) of section 2202(a)(4) (relating to dissemination
22 of information), clause (iv) of such section (relating to dis-
23 semination of appeals rights information), and clause (v)
24 of such section (relating to beneficiary education pro-
25 grams). If the Commissioner selects a Medicare Consumer

1 Coalition to conduct such programs, the programs shall
2 include the following:

3 “(1) CONTENTS.—A comparison among the
4 original fee-for-service program under parts A and B
5 of title XVIII, available Medicare+Choice plans
6 under part C of such title, and available Medicare
7 Prescription Plus plans under part B as follows:

8 “(A) BENEFITS.—A comparison of the
9 benefits provided under each plan and program.

10 “(B) QUALITY AND PERFORMANCE.—The
11 quality and performance of each plan and pro-
12 gram.

13 “(C) BENEFICIARY COSTS.—The costs to
14 eligible beneficiaries enrolled under each plan
15 and program.

16 “(D) CONSUMER SATISFACTION SUR-
17 VEYS.—The results of consumer satisfaction
18 surveys regarding each plan and program.

19 “(E) ADDITIONAL INFORMATION.—Such
20 additional information as the Commissioner
21 may prescribe.

22 “(2) INFORMATION STANDARDS.—If the Com-
23 missioner establishes Medicare Consumer Coalitions,
24 the Commissioner shall develop standards to ensure
25 that the information provided to eligible beneficiaries

1 under the information programs is complete, accu-
2 rate, and uniform.

3 “(3) REVIEW OF INFORMATION.—

4 “(A) IN GENERAL.—Subject to subpara-
5 graph (B), the Commissioner may prescribe the
6 procedures and conditions under which a Medi-
7 care Consumer Coalition may disseminate infor-
8 mation to eligible beneficiaries to ensure the co-
9 ordination of Federal, State, and local outreach
10 efforts to eligible beneficiaries.

11 “(B) DEADLINE.—Any information pro-
12 posed to be furnished to eligible beneficiaries
13 under this section shall be submitted to the
14 Commissioner not later than 45 days before the
15 date on which the information is to be dissemi-
16 nated to such beneficiaries.

17 “(4) CONSULTATION.—In order to conduct the
18 information programs under subsection (a), Medi-
19 care Consumer Coalitions may consult with the Ad-
20 ministrator of the Health Care Financing Adminis-
21 tration, entities that offer Medicare+Choice plans,
22 Medicare Prescription Plus plans, and public and
23 private purchasers of health care benefits.

24 “(f) REPORT.—If the Commissioner establishes
25 Medicare Consumer Coalitions under this section, not

1 later than December 31, 2004, the Commissioner shall
2 submit to the appropriate committees of Congress a report
3 on the performance of any Medicare Consumer Coalitions,
4 including an assessment of the effectiveness of the out-
5 reach efforts conducted under this section.

6 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
7 are authorized to be appropriated to carry out this section
8 such sums as may be necessary.

9 “(h) EFFECTIVE DATE.—If the Commissioner estab-
10 lishes Medicare Consumer Coalitions, the Commissioner
11 should establish such Coalitions under this section in a
12 manner that ensures that the information programs con-
13 ducted by Medicare Consumer Coalitions begin not later
14 than January 1, 2004.”.

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