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

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A BILL

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Prescription Drug and Modernization Act of 2001''.

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

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—

(1) Based on the deliberations of the National Bipartisan Commission on the Future of Medicare, the medicare program under title XVIII of the Social Security Act in its current form is unsustainable, with the part A trust fund scheduled to become insolvent in 2025.

(2) The medicare program relies on general revenues to pay for 36 percent of total program expenditures and will continue to use an increasing share of general revenues. Part B outlays under such program, ¾ of which are funded through general revenues, have increased 38 percent over the past 5 years, or about 5 percent faster than the economy as a whole.

(3) Medicare's spending, left unchecked, will continue to consume an increasing share of the Federal budget, leaving little room for other priorities,

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

(4) Medicare's current benefit package is outdated in that it does not provide a prescription drug benefit and limits beneficiary access to new technologies.

(5) Medicare only covers 53 percent of a beneficiary's average health care costs and exposes beneficiaries to large out-of-pocket liabilities.

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

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

(8) The Balanced Budget Act of 1997, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 underscore the need to fundamentally restructure the medicare program and

reduce Government micromanagement of that program.

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

(1) to improve the Medicare+Choice program by adopting a stable, competitive system that provides medicare beneficiaries with better and broader health coverage and a greater variety of affordable options from which to choose.

(2) to assist all medicare beneficiaries, especially those with low incomes, in obtaining coverage for outpatient prescription drugs;

(3) to establish an independent executive branch Competitive Medicare Agency outside of the Health Care Financing Administration and the Department of Health and Human Services based on the Social Security Administration to administer the outpatient prescription drug benefit and the Medicare+Choice program;

(4) to increase the flexibility of the medicare program and provide medicare beneficiaries timely access to the latest advances in the practice of medicine and delivery of care and to end the congressional micromanagement over prices and delivery of benefits currently administered through approxi-

mately 130,000 pages of rules and regulations established under the medicare program; and

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

TITLE I—MEDICARE MANAGEMENT AND ADMINISTRATION

Subtitle A—Establishment of the Competitive Medicare Agency

SEC. 101. ESTABLISHMENT OF THE COMPETITIVE MEDICARE AGENCY.

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

''TITLE XXII—MEDICARE COMPETITION AND PRESCRIPTION DRUGS

''PART A—ESTABLISHMENT OF THE COMPETITIVE MEDICARE AGENCY

''COMPETITIVE MEDICARE AGENCY

''SEC. 2201. (a) ESTABLISHMENT.—There is established, as an independent agency in the executive branch of the Government, a Medicare Competition Agency (in this part referred to as the 'Agency').

''(b) DUTY.—

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

''(2) TRANSITION.—The Secretary of Health and Human Services (in this title referred to as the 'Secretary'), the Commissioner of the Competitive Medicare Agency, and the Administrator of the Health Care Financing Administration shall establish an appropriate transition of responsibility in order to redelegate the administration of part C from the Secretary and the Administrator of the Health Care Financing Administration to the Com-

missioner as is appropriate to carry out the purposes of this section.

''(3) CONSTRUCTION.—Insofar as a responsibility of the Secretary or the Administrator of the Health Care Financing Administration is redelegated to the Commissioner of the Competitive Medicare Agency under this part, any reference to the Secretary or the Administrator of the Health Care Financing Administration in this title or title XI with respect to such responsibility is deemed to be a reference to such Commissioner.

''COMMISSIONER; DEPUTY COMMISSIONER; OTHER OFFICERS

''SEC. 2202. (a) COMMISSIONER OF THE COMPETITIVE MEDICARE AGENCY.—

''(1) APPOINTMENT.—There shall be in the Agency a Commissioner of the Competitive Medicare Agency (in this part referred to as the 'Commissioner') who shall be appointed by the President, by and with the advice and consent of the Senate.

''(2) COMPENSATION.—The Commissioner shall be compensated at the rate provided for level I of the Executive Schedule.

''(3) TERM.—

''(A) IN GENERAL.—The Commissioner shall be appointed for a term of 6 years.

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

''(C) DELAYED APPOINTMENTS.—A Commissioner appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

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

''(4) RESPONSIBILITIES.—The Commissioner shall be responsible for the exercise of all powers and the discharge of all duties of the Agency, and shall have authority and control over all personnel and activities thereof. Responsibilities of the Commissioner shall include the following:

''(A) GENERAL RESPONSIBILITIES.—

''(i) ELIGIBILITY AND ENROLLMENT.—Coordinating determinations of beneficiary eligibility and enrollment under

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

''(ii) CONTRACTING AUTHORITY.—Entering into, and enforcing, contracts with entities for the offering of Medicare Prescription Plus plans under part B of this title.

''(iii) DISSEMINATION OF INFORMATION.—Conducting information activities under sections 1804 and 1851(d) of title XVIII, and under part B of this title with respect to benefits and limitations on payment under Medicare Prescription Plus plans under part B of this title, including a comparative analysis of such plans and the quality of such plans in the area in which the medicare beneficiary resides. The information disseminated pursuant to such activities shall be presented in a manner so that medicare beneficiaries may compare benefits under parts A and B of title XVIII, part B of this title, and medicare supplemental policies under section 1882 with benefits under Medicare+Choice plans under part C of title XVIII.

''(iv) DISSEMINATION OF APPEALS RIGHTS INFORMATION.—Disseminating to medicare beneficiaries a description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program under parts A and B of title XVIII, the Medicare+Choice program under part C of such title, and the Outpatient Prescription Drug and Supplemental Benefit Program under part B of this title.

''(v) BENEFICIARY EDUCATION PROGRAM.—Establishing a medicare beneficiary education program to provide timely, readable, accurate, and understandable information to medicare beneficiaries regarding Medicare Prescription Plus plan options.

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

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

''(C) ANNUAL REPORTS.—Not later than March 31 of each year, the Commissioner shall submit to Congress and the President a report on the administration of part C of title XVIII and part B of this title during the previous fiscal year.

''(5) PROMULGATION OF RULES AND REGULATIONS.—

''(A) IN GENERAL.—The Commissioner may prescribe such rules and regulations as the Commissioner determines necessary or appropriate to carry out the functions of the Agency.

''(B) RULEMAKING.—The regulations prescribed by the Commissioner shall be subject to

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

''(6) DELEGATION OF AUTHORITY.—

''(A) IN GENERAL.—The Commissioner may assign duties, and delegate, or authorize successive redelegations of, authority to act and to render decisions, to such officers and employees of the Agency as the Commissioner may find necessary.

''(B) EFFECT OF DELEGATION.—Within the limitations of such delegations, redelegations, or assignments, all official acts and decisions of such officers and employees shall have the same force and effect as though performed or rendered by the Commissioner.

''(7) CONSULTATION WITH SECRETARY OF HEALTH AND HUMAN SERVICES.—The Commissioner and the Secretary shall consult, on an ongoing basis, to ensure—

''(A) the coordination of the programs administered by the Commissioner under part C of title XVIII and part B of this title with the programs administered by the Secretary under parts A and B of title XVIII and under title XIX; and

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

''(b) DEPUTY COMMISSIONER OF THE COMPETITIVE MEDICARE AGENCY.—

''(1) APPOINTMENT.—There shall be in the Agency a Deputy Commissioner of the Competitive Medicare Agency (in this part referred to as the 'Deputy Commissioner') who shall be appointed by the President, by and with the advice and consent of the Senate.

''(2) TERM.—

''(A) IN GENERAL.—The Deputy Commissioner shall be appointed for a term of 6 years.

''(B) CONTINUANCE IN OFFICE.—In any case in which a successor does not take office at the end of a Deputy Commissioner's term of office, such Deputy Commissioner may continue in office until the entry upon office of such a successor.

''(C) DELAYED APPOINTMENT.—A Deputy Commissioner appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(3) COMPENSATION.—The Deputy Commissioner shall be compensated at the rate provided for level II of the Executive Schedule.

''(4) DUTIES.—

''(A) IN GENERAL.—The Deputy Commissioner shall perform such duties and exercise such powers as the Commissioner shall from time to time assign or delegate.

''(B) ACTING COMMISSIONER.—The Deputy Commissioner shall be Acting Commissioner of the Agency during the absence or disability of the Commissioner, unless the President designates another officer of the Government as Acting Commissioner, in the event of a vacancy in the office of the Commissioner.

''(c) CHIEF ACTUARY.—

''(1) APPOINTMENT.—

''(A) IN GENERAL.—There shall be in the Agency a Chief Actuary, who shall be appointed by, and in direct line of authority to, the Commissioner.

''(B) QUALIFICATIONS.—The Chief Actuary shall be appointed from individuals who have demonstrated, by their education and ex-

perience, superior expertise in the actuarial sciences.

''(C) DUTIES.—The Chief Actuary shall serve as the chief actuarial officer of the Agency, and shall exercise such duties as are appropriate for the office of the Chief Actuary and in accordance with professional standards of actuarial independence.

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

''ADMINISTRATIVE DUTIES OF THE COMMISSIONER

''SEC. 2203. (a) PERSONNEL.—

''(1) IN GENERAL.—The Commissioner may employ, without regard to chapter 31 of title 5, United States Code, such officers and employees as are necessary to administer the activities to be carried out through the Competitive Medicare Agency.

''(2) FLEXIBILITY WITH RESPECT TO CIVIL SERVICE LAWS.—

''(A) IN GENERAL.—The staff of the Competitive Medicare Agency shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and, subject to subpara-

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

''(B) MAXIMUM RATE.—In no case may the rate of compensation determined under subparagraph (A) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(b) BUDGETARY MATTERS.—

''(1) SUBMISSION OF ANNUAL BUDGET.—The Commissioner shall prepare an annual budget for the Agency, which shall be submitted by the President to Congress without revision, together with the President's annual budget for the Agency.

''(2) APPROPRIATIONS REQUESTS.—

''(A) STAFFING AND PERSONNEL.—Appropriations requests for staffing and personnel of the Agency shall be based upon a comprehensive work force plan, which shall be established and revised from time to time by the Commissioner.

''(B) ADMINISTRATIVE EXPENSES.—Appropriations for administrative expenses of the

Agency are authorized to be provided on a biennial basis.

''(c) SEAL OF OFFICE.—

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

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

''(d) DATA EXCHANGES.—

''(1) DISCLOSURE OF RECORDS AND OTHER INFORMATION.—Notwithstanding any other provision of law (including subsection (b), (o), (p), (q), (r), and (u) of section 552a of title 5, United States Code)—

''(A) the Secretary shall disclose to the Commissioner any record or information requested in writing by the Commissioner for the purpose of administering any program administered by the Commissioner, if records or information of such type were disclosed to the Administrator of the Health Care Financing Administration in the Department of Health and Human Services under applicable rules, regulations, and procedures in effect before the date

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

''(B) the Commissioner shall disclose to the Secretary or to any State any record or information requested in writing by the Secretary to be so disclosed for the purpose of administering any program administered by the Secretary, if records or information of such type were so disclosed under applicable rules, regulations, and procedures in effect before the date of enactment of the Medicare Prescription Drug and Modernization Act of 2001.

''(2) EXCHANGE OF OTHER DATA.—The Commissioner and the Secretary shall periodically review the need for exchanges of information not referred to in paragraph (1) and shall enter into such agreements as may be necessary and appropriate to provide information to each other or to States in order to meet the programmatic needs of the requesting agencies.

''(3) ROUTINE USE.—

''(A) IN GENERAL.—Any disclosure from a system of records (as defined in section 552a(a)(5) of title 5, United States Code) pursuant to this subsection shall be made as a rou-

tine use under subsection (b)(3) of section 552a of such title (unless otherwise authorized under such section 552a).

''(B) COMPUTERIZED COMPARISON.—Any computerized comparison of records, including matching programs, between the Commissioner and the Secretary shall be conducted in accordance with subsections (o), (p), (q), (r), and (u) of section 552a of title 5, United States Code.

''(4) TIMELY ACTION.—The Commissioner and the Secretary shall each ensure that timely action is taken to establish any necessary routine uses for disclosures required under paragraph (1) or agreed to pursuant to paragraph (2).

''MEDICARE COMPETITION AND PRESCRIPTION DRUG ADVISORY BOARD

''SEC. 2204. (a) ESTABLISHMENT OF BOARD.—There is established a Medicare Competition and Prescription Drug Advisory Board (in this section referred to as the 'Board').

''(b) ADVICE ON POLICIES; REPORTS.—

''(1) ADVICE ON POLICIES.—On and after the date the Commissioner takes office, the Board shall advise the Commissioner on policies relating to the Medicare Competition and Prescription Drug Program under part B of this title and the

Medicare+Choice program under part C of title XVIII.

''(2) REPORTS.—

''(A) IN GENERAL.—With respect to matters of the administration of part C of title XVIII and part B of this title, the Board shall submit to Congress and to the Commissioner of the Competitive Medicare Agency such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of such parts. Each such report shall be published in the Federal Register.

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

''(c) STRUCTURE AND MEMBERSHIP OF THE BOARD.—

''(1) MEMBERSHIP.—The Board shall be composed of 7 members who shall be appointed as follows:

''(A) PRESIDENTIAL APPOINTMENTS.—

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

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

''(B) SENATORIAL APPOINTMENTS.—2 members (each member from a different political party) shall be appointed by the President pro tempore of the Senate with the advice of the Chairman and the Ranking Minority Member of the Committee on Finance of the Senate.

''(C) CONGRESSIONAL APPOINTMENTS.—2 members (each member from a different political party) shall be appointed by the Speaker of the House of Representatives, with the advice of the Chairman and the Ranking Minority Member of the Committee on Ways and Means of the House of Representatives.

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

and good judgment, and shall be individuals who are, by reason of their education, experience, and attainments, exceptionally qualified to perform the duties of members of the Board.

''(d) TERMS OF APPOINTMENT.—

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

''(2) CONTINUANCE IN OFFICE AND STAGGERED TERMS.—

''(A) CONTINUANCE IN OFFICE.—A member appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

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

''(i) PRESIDENTIAL APPOINTMENTS.—The terms of service of the members initially appointed by the President shall expire as designated by the President at the time of nomination, 1 each at the end of—

''(I) 2 years;

"(II) 4 years; and

"(III) 6 years.

"(ii) SENATORIAL APPOINTMENTS.—The terms of service of members initially appointed by the President pro tempore of the Senate shall expire as designated by the President pro tempore of the Senate at the time of nomination, 1 each at the end of—

"(I) 3 years; and

"(II) 6 years.

"(iii) CONGRESSIONAL APPOINTMENTS.—The terms of service of members initially appointed by the Speaker of the House of Representatives shall expire as designated by the Speaker of the House of Representatives at the time of nomination, 1 each at the end of—

"(I) 4 years; and

"(II) 5 years.

"(C) REAPPOINTMENTS.—Any person appointed as a member of the Board may not serve for more than 8 years.

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

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

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

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

''(g) MEETING.—

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

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

''(2) QUORUM.—Four members of the Board (not more than 3 of whom may be of the same political party) shall constitute a quorum for purposes of conducting business.

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

''(i) PERSONNEL.—

''(1) STAFF DIRECTOR.—The Board shall, without regard to the provisions of title 5, United States Code, relating to the competitive service, appoint a Staff Director who shall be paid at a rate equivalent to a rate established for the Senior Executive Service under section 5382 of title 5, United States Code.

''(2) STAFF.—

''(A) IN GENERAL.—The Board may employ, without regard to chapter 31 of title 5, United States Code, such officers and employees as are necessary to administer the activities to be carried out by the Board.

''(B) FLEXIBILITY WITH RESPECT TO CIVIL SERVICE LAWS.—

''(i) IN GENERAL.—The staff of the Board shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and, subject to clause (ii), shall be paid without regard to the provisions of chapters 51 and 53 of such title (relating to classification and schedule pay rates).

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

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, out of the Federal Hospital Insurance Trust Fund and the Federal Supplemental Medical Insurance Trust Fund, and the general fund of the Treasury, such sums as are necessary to carry out the purposes of this section.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act.

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

(3) DUTIES WITH RESPECT TO ELIGIBILITY DETERMINATIONS AND ENROLLMENT.—The Commissioner of the Competitive Medicare Agency shall carry out enrollment under title XVIII of the Social Security Act, make eligibility determinations under such title, and carry out part C of such title for years beginning on or after January 1, 2004.

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

(a) IN GENERAL.—Sections 1817(b) and 1841(b) of the Social Security Act (42 U.S.C. 1395i(b); 1395t(b)) are each amended by striking ''and the Secretary of Health and Human Services, all ex officio,'' and inserting '', the Secretary of Health and Human Services, and the Commissioner of the Competitive Medicare Agency, all ex officio,''.

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

SEC. 103. SALARY INCREASE FOR THE HCFA ADMINISTRATOR.

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

''Administrator of the Health Care Financing Administration.''.

(b) CONFORMING AMENDMENT.—Section 5315 of such title is amended by striking ''Administrator of the Health Care Financing Administration.''.

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

Subtitle B—Redefined Medicare Solvency Measures

SEC. 151. REQUIREMENTS FOR ANNUAL FINANCIAL REPORTING AND OVERSIGHT OF MEDICARE PROGRAM.

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

''(l) COMBINED REPORT ON OPERATION AND STATUS OF THE TRUST FUND AND THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—

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

report required under subsection (b)(2), the Board shall submit to Congress a report on the operation and status of the Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under section 1841, including the Medicare Prescription Drug Account within such Trust Fund (in this subsection referred to as the 'Trust Funds'). Such report shall include the following information:

''(A) OVERALL SPENDING FROM THE GENERAL FUND OF THE TREASURY.—A statement of total amounts obligated during the preceding fiscal year from the General Revenues of the Treasury to the Trust Funds for payment for benefits covered under this title and part B of title XXII, stated in terms of the total amount and in terms of the percentage such amount bears to all other amounts obligated from such General Revenues during such fiscal year.

''(B) HISTORICAL OVERVIEW OF SPENDING.—From the date of the inception of the program of insurance under this title through the fiscal year involved, a statement of the total amounts referred to in subparagraph (A).

''(C) 10-YEAR AND 50-YEAR PROJECTIONS.—An estimate of total amounts referred

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

''(D) RELATION TO GDP GROWTH.—A comparison of the rate of growth of the total amounts referred to in subparagraph (A) to the rate of growth in the gross domestic product for the same period.

''(2) PUBLICATION.—Each report submitted under paragraph (1) shall be published by the Committee on Ways and Means as a public document.''.

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

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

TITLE II—MEDICARE PRESCRIPTION DRUG AND SUPPLEMENTAL BENEFIT PROGRAM

SEC. 201. ESTABLISHMENT OF PROGRAM.

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

''PART B—MEDICARE PRESCRIPTION DRUG AND SUPPLEMENTAL BENEFIT PROGRAM

''ESTABLISHMENT OF PRESCRIPTION DRUG AND SUPPLEMENTAL BENEFIT PROGRAM

''SEC. 2221. (a) PROVISION OF BENEFIT.—The Commissioner shall establish a Prescription Drug and Supplemental Benefit Program under which an eligible beneficiary may voluntarily enroll and receive access to covered outpatient prescription drugs and other benefits through enrollment in a Medicare Prescription Plus plan offered by a private entity or a Medicare+Choice plan offered by a Medicare+Choice organization.

''(b) PROGRAM TO BEGIN IN 2004.—The Commissioner shall establish the program under this part in a manner so that benefits are first provided for months beginning with January 2004.

''(c) VOLUNTARY NATURE OF PROGRAM.—Nothing in this part shall be construed as requiring an eligible beneficiary to enroll in the program under this part.

''(d) FINANCING.—The costs of providing benefits under this part shall be payable from the Medicare Prescription Drug Account.

''(e) NO EFFECT ON TITLE XVIII BENEFITS.—The program under this part shall have no effect on the entitlement to benefits under title XVIII.

''ENROLLMENT UNDER PROGRAM

''SEC. 2222. (a) ESTABLISHMENT OF PROCESS.—

''(1) IN GENERAL.—The Commissioner shall establish a process through which an eligible beneficiary (including an eligible beneficiary enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization) may make an election to enroll under the program under this part. Except as otherwise provided in this section, such process shall be similar to the process for enrollment in part B under section 1837.

''(2) REQUIREMENT OF ENROLLMENT.—An eligible beneficiary must enroll under this part in order to be eligible to receive benefits under this part.

''(b) ENROLLMENT PERIOD.—

''(1) IN GENERAL.—Except as provided in paragraph (2) or (3), an eligible beneficiary may not en-

roll in the program under this part during any period after the beneficiary's initial enrollment period.

''(2) OPEN ENROLLMENT PERIOD FOR BENEFICIARIES CURRENTLY COVERED.—In the case of an individual who is entitled to part A of title XVIII and enrolled under part B of such title as of November 1, 2003, there shall be an open enrollment period of 6 months beginning on that date.

''(3) SPECIAL ENROLLMENT PERIOD FOR BENEFICIARIES THAT LOSE OTHER DRUG COVERAGE.—

''(A) IN GENERAL.—Subject to subparagraph (D), in the case of an applicable eligible beneficiary, the Commissioner shall establish procedures for permitting such beneficiary to enroll under the program under this part.

''(B) APPLICABLE ELIGIBLE BENEFICIARY.—For purposes of this paragraph, the term 'applicable eligible beneficiary' means an eligible beneficiary who—

''(i) had applicable drug coverage; and

''(ii) involuntarily lost such coverage.

''(C) APPLICABLE DRUG COVERAGE DEFINED.—For purposes of subparagraph (B), the term 'applicable drug coverage' means any of the following prescription drug coverage:

"(i) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care for the Elderly (PACE) under section 1934, through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997), or through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

"(ii) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any outpatient prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan (as defined in section 2232(e)(1)).

''(iii) PRESCRIPTION DRUG COVERAGE UNDER CERTAIN MEDIGAP POLICIES.—Coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)), but only if the policy was in effect on January 1, 2004.

''(iv) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program.

''(v) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans under chapter 17 of title 38, United States Code.

''(D) REQUIREMENTS.—The procedures established under subparagraph (A) shall require that an applicable eligible beneficiary—

''(i) seek to enroll under the program not later than 63 days after the date that the beneficiary lost applicable drug coverage; and

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

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

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

''(B) REPORT.—Not later than January 1, 2003, the Commissioner shall submit a report to Congress on the study conducted under subparagraph (A), together with any recommendations for legislation that the Commissioner determines to be appropriate as a result of such study.

''(c) PERIOD OF COVERAGE.—

''(1) IN GENERAL.—Except as provided in paragraph (2) and subject to paragraph (3), an eligible beneficiary's coverage under the program under this part shall be effective for the period provided in sec-

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

''(2) ENROLLMENT DURING OPEN AND SPECIAL ENROLLMENT.—Subject to paragraph (3), an eligible beneficiary who enrolls under the program under this part pursuant to paragraph (2) or (3) of subsection (b) shall be entitled to the benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

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

''(d) PROGRAM COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PARTS A AND B OF TITLE XVIII.—

''(1) IN GENERAL.—In addition to the causes of termination specified in section 1838, the Commissioner shall terminate an individual's coverage under the program under this part if the individual is no longer enrolled in both parts A and B of title XVIII.

''(2) EFFECTIVE DATE.—The termination described in paragraph (1) shall be effective on the effective date of termination of coverage under part A of title XVIII or (if earlier) under part B of such title.

''(e) FIRST ENROLLMENT PERIOD.—The Commissioner shall ensure that eligible beneficiaries are permitted to enroll under this part prior to January 1, 2004, in order to ensure that coverage under this part is effective as of such date.

''ELECTION OF A MEDICARE PRESCRIPTION PLUS PLAN

''SEC. 2223. (a) IN GENERAL.—

''(1) PROCESS.—

''(A) IN GENERAL.—Subject to paragraph (2), the Commissioner shall establish a process through which an eligible beneficiary who is enrolled under this part shall make an annual election to enroll in a Medicare Prescription Plus plan offered by an eligible entity that serves the geographic area in which the beneficiary resides.

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

''(i) annual, coordinated election periods, which shall be coordinated with such periods under part C of title XVIII;

''(ii) special election periods under subsection (e)(4) of section 1851; and

''(iii) the guaranteed issue requirements under subsection (g) of such section.

''(2) MEDICARE+CHOICE ENROLLEES.—An eligible beneficiary who is enrolled under this part and enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization shall receive coverage of benefits under this part through such plan if such plan provides qualified prescription drug coverage. If the Medicare+Choice plan in which the beneficiary is enrolled does not provide such coverage, the beneficiary shall receive such coverage through the election of a Medicare Prescription Plus plan offered by an eligible entity under this part.

''(b) ENSURING ACCESS TO PRESCRIPTION DRUG COVERAGE IN AREAS WITH NO MEDICARE PRESCRIPTION PLUS PLAN OR MEDICARE+CHOICE PLAN PROVIDING DRUG COVERAGE AVAILABLE.—The Commissioner—

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

''(2) may establish procedures that permit partial risk-sharing arrangements under section 2227(a)(2)(A) with an entity if the Commissioner determines that the establishment of such procedures will generate bids in an area with no Medicare Prescription Plus plans or Medicare+Choice plans available that provide qualified prescription drug coverage.

''BENEFICIARY INFORMATION

''SEC. 2224. (a) IN GENERAL.—The Commissioner shall conduct activities that are designed to broadly disseminate information to eligible beneficiaries (and prospective eligible beneficiaries) regarding the coverage provided under this part.

''(b) REQUIREMENTS.—The activities conducted under this subsection shall be—

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

''(2) coordinated with the activities performed by the Commissioner under such section and under section 1804.

''OUTPATIENT PRESCRIPTION DRUG AND OTHER SUPPLEMENTAL BENEFITS

''SEC. 2225. (a) REQUIREMENTS.—

''(1) IN GENERAL.—For purposes of this part and part C of title XVIII, the term 'qualified prescription drug coverage' means either of the following:

''(A) STANDARD COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Standard coverage (as defined in subsection (d)) and access to negotiated prices under subsection (f).

''(B) ACTUARIALLY EQUIVALENT COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Coverage of covered outpatient drugs which meets the alternative coverage requirements of subsection (e) and access to negotiated prices under subsection (f).

''(2) PERMITTING ADDITIONAL OUTPATIENT PRESCRIPTION DRUG COVERAGE.—

''(A) IN GENERAL.—Subject to subparagraph (B) and section 2229(c)(2), nothing in this part shall be construed as preventing qualified prescription drug coverage from including coverage of covered outpatient drugs that exceeds the coverage required under paragraph (1).

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

plan that provides additional benefits pursuant to subparagraph (A) in an area unless the eligible entity offering such plan also offers a Medicare Prescription Plus plan in the area that only provides the coverage of prescription drugs that is required under subsection (a)(1).

''(3) COST CONTROL MECHANISMS.—In providing qualified prescription drug coverage, the entity offering the Medicare Prescription Plus plan or the Medicare+Choice plan may use cost control mechanisms that are customarily used in employer-sponsored health care plans that offer coverage for outpatient prescription drugs, including the use of formularies, tiered copayments, selective contracting with providers of outpatient prescription drugs, and mail order pharmacies.

''(b) PERMITTING BENEFITS IN ADDITION TO OUTPATIENT PRESCRIPTION DRUG COVERAGE.—

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

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

''(A) the eligible entity offering such plan also offers a Medicare Prescription Plus plan in the area that only provides the coverage of prescription drugs that is required under subsection (a)(1); and

''(B) if the additional benefits include any of the core group of basic benefits described in section 1882(p)(2)(B), the Medicare Prescription Plus plan provides all of such core group of basic benefits.

''(c) APPLICATION OF SECONDARY PAYOR PROVISIONS.—The provisions of section 1852(a)(4) shall apply under this part in the same manner as they apply under part C of title XVIII.

''(d) STANDARD COVERAGE.—For purposes of this part and part C of title XVIII, the 'standard coverage' is coverage of covered outpatient drugs that meets the following requirements:

''(1) DEDUCTIBLE.—The coverage has an annual deductible—

''(A) for 2004, that is equal to $250; or

''(B) for a subsequent year, that is equal to the amount specified under this paragraph for the previous year increased by the percentage specified in paragraph (5) for the year involved.

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

''(2) LIMITS ON COST-SHARING.—The coverage has cost-sharing (for costs above the annual deductible specified in paragraph (1) and up to the initial coverage limit under paragraph (3)) that is equal to 50 percent or that is actuarially consistent (using processes established under subsection (g)) with an average expected payment of 50 percent of such costs.

''(3) INITIAL COVERAGE LIMIT.—Subject to paragraph (4), the coverage has an initial coverage limit on the maximum costs that may be recognized for payment purposes (above the annual deductible)—

''(A) for 2004, that is equal to $2,100; or

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

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

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

''(4) LIMITATION ON OUT-OF-POCKET EXPENDITURES BY BENEFICIARY.—

''(A) IN GENERAL.—Notwithstanding paragraph (3), the coverage provides benefits without any cost-sharing after the individual has incurred costs (as described in subparagraph (C)) for covered outpatient drugs in a year equal to the annual out-of-pocket limit specified in subparagraph (B).

''(B) ANNUAL OUT-OF-POCKET LIMIT.—For purposes of this part, the 'annual out-of-pocket limit' specified in this subparagraph—

''(i) for 2004, is equal to $6,000; or

''(ii) for a subsequent year, is equal to the amount specified in the subparagraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

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

''(C) APPLICATION.—In applying subparagraph (A)—

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

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

''(5) ANNUAL PERCENTAGE INCREASE.—For purposes of this part, the annual percentage increase specified in this paragraph for a year is equal to the annual percentage increase in average per capita aggregate expenditures for covered outpatient drugs in

the United States for medicare beneficiaries, as determined by the Commissioner for the 12-month period ending in July of the previous year.

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

''(1) ASSURING AT LEAST ACTUARIALLY EQUIVALENT COVERAGE.—

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

''(B) ASSURING EQUIVALENT UNSUBSIDIZED VALUE OF COVERAGE.—The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard coverage. For purposes of this subparagraph, the unsubsidized value of coverage is the amount by which the actuarial value of the coverage (as determined under subsection (g)) exceeds the actuarial value of the reinsurance subsidy pay-

ments under section 2232 with respect to such coverage.

"(C) ASSURING STANDARD PAYMENT FOR COSTS AT INITIAL COVERAGE LIMIT.—The coverage is designed, based upon an actuarially representative pattern of utilization (as determined under subsection (g)), to provide for the payment, with respect to costs incurred that are equal to the sum of the deductible under subsection (d)(1) and the initial coverage limit under subsection (d)(3), of an amount equal to at least such initial coverage limit multiplied by the percentage specified in subsection (d)(2).

Benefits other than qualified prescription drug coverage shall not be taken into account for purposes of this paragraph.

"(2) LIMITATION ON OUT-OF-POCKET EXPENDITURES BY BENEFICIARIES.—The coverage provides the limitation on out-of-pocket expenditures by beneficiaries described in subsection (d)(4).

"(f) ACCESS TO NEGOTIATED PRICES.—Under qualified prescription drug coverage offered by an eligible entity or a Medicare+Choice organization, the entity or organization shall provide beneficiaries with access to negotiated prices (including applicable discounts) used for payment

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

''(g) ACTUARIAL VALUATION; DETERMINATION OF ANNUAL PERCENTAGE INCREASES.—

''(1) PROCESSES.—For purposes of this section, the Commissioner shall establish processes and methods—

''(A) for determining the actuarial valuation of prescription drug coverage, including—

''(i) an actuarial valuation of standard coverage and of the reinsurance subsidy payments under section 2232;

''(ii) the use of generally accepted actuarial principles and methodologies; and

''(iii) applying the same methodology for determinations of alternative coverage under subsection (e) as is used with respect to determinations of standard coverage under subsection (d); and

''(B) for determining annual percentage increases described in subsection (d)(5).

''(2) USE OF OUTSIDE ACTUARIES.—Under the processes under paragraph (1)(A), eligible entities and Medicare+Choice organizations may use actuarial opinions certified by independent, qualified actuaries to establish actuarial values.

''BENEFICIARY PROTECTIONS

''SEC. 2226. (a) DISSEMINATION OF INFORMATION.—

''(1) GENERAL INFORMATION.—An eligible entity offering a Medicare Prescription Plus plan shall disclose, in a clear, accurate, and standardized form to each enrollee at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such plan. Such information includes the following:

''(A) Access to covered outpatient drugs.

''(B) How any formulary used by the entity functions.

''(C) Co-payments, coinsurance, and deductible requirements.

''(D) Grievance and appeals procedures.

''(2) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an individual eligible to en-

roll in a Medicare Prescription Plus plan, the eligible entity offering such plan shall provide the information described in section 1852(c)(2) to such individual.

''(3) RESPONSE TO BENEFICIARY QUESTIONS.—An eligible entity offering a Medicare Prescription Plus plan shall have a mechanism for providing specific information to enrollees upon request, including information on specific changes in its formulary.

''(4) CLAIMS INFORMATION.—An eligible entity offering a Medicare Prescription Plus plan must furnish to enrolled individuals in a form easily understandable to such individuals an explanation of benefits (in accordance with section 1806(a) or in a comparable manner) and a notice of the benefits in relation to initial coverage limit and annual out-of-pocket limit for the current year, whenever prescription drug benefits are provided under this part (except that such notice need not be provided more often than monthly).

''(b) ACCESS TO COVERED OUTPATIENT DRUGS.—

''(1) ACCESS TO NEGOTIATED PRICES FOR PRESCRIPTION DRUGS.—An eligible entity offering a Medicare Prescription Plus plan shall issue such a card that may be used by an enrolled beneficiary to

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

''(2) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—Insofar as an eligible entity offering a Medicare Prescription Plus plan uses a formulary with respect to qualified prescription drug coverage, the following requirements must be met:

''(A) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES.—The formulary must include drugs within all therapeutic categories and classes of covered outpatient drugs (although not necessarily for all drugs within such categories and classes).

''(B) APPEALS AND EXCEPTIONS TO APPLICATION.—The eligible entity must have, as part of the appeals process under subsection (e)(2), a process for appeals for denials of coverage based on such application of the formulary.

''(c) COST AND UTILIZATION MANAGEMENT.—

''(1) IN GENERAL.—An eligible entity shall have in place—

''(A) an effective cost and drug utilization management program, including appropriate incentives to use generic drugs, when appropriate;

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

''(C) a program to control fraud, abuse, and waste.

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

''(d) GRIEVANCE MECHANISM.—An eligible entity shall provide meaningful procedures for hearing and resolving grievances between the eligible entity (including any entity or individual through which the eligible entity provides covered benefits) and enrollees in a Medicare Prescription Plus plan offered by the eligible entity in accordance with section 1852(f).

''(e) COVERAGE DETERMINATIONS, RECONSIDERATIONS, AND APPEALS.—

''(1) IN GENERAL.—An eligible entity shall meet the requirements of section 1852(g) with respect to covered benefits under the Medicare Pre-

scription Plus plan it offers under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C of title XVIII.

''(2) APPEALS OF FORMULARY DETERMINATIONS.—Consistent with the requirements of section 1852(g), an eligible entity shall establish a process for appeals of formulary determinations.

''(f) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—An eligible entity shall meet the requirements of section 1852(h) with respect to enrollees under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to enrollees under part C of title XVIII.

''(g) UNIFORM PREMIUM.—An eligible entity shall ensure that the premium for a Medicare Prescription Plus plan charged under this section is the same for all individuals enrolled in the plan in the same service area.

''REQUIREMENTS FOR ENTITIES OFFERING MEDICARE PRESCRIPTION PLUS PLANS

''SEC. 2227. (a) GENERAL REQUIREMENTS.—An eligible entity offering a Medicare Prescription Plus plan shall meet the following requirements:

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

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

''(2) ASSUMPTION OF FULL FINANCIAL RISK.—

''(A) IN GENERAL.—Except as provided under section 2223(b)(2) and subject to subparagraph (B), the entity assumes full financial risk on a prospective basis for the benefits that it offers under a Medicare Prescription Plus plan and that is not covered under reinsurance under section 2232.

''(B) REINSURANCE PERMITTED.—The entity may obtain insurance or make other arrangements for the cost of coverage provided to any enrolled member under this part.

''(3) SOLVENCY FOR UNLICENSED ENTITIES.—In the case of an eligible entity that is not described in paragraph (1), the entity shall meet solvency standards established by the Commissioner under subsection (d).

''(b) CONTRACT REQUIREMENTS.—The Commissioner shall not permit an eligible beneficiary to elect a Medicare Prescription Plus plan offered by an eligible entity under this part, and the entity shall not be eligible for payments under section 2230, 2231(e), or 2232, unless

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

''(c) WAIVER OF CERTAIN REQUIREMENTS TO EXPAND CHOICE.—

''(1) IN GENERAL.—In the case of an eligible entity that seeks to offer a Medicare Prescription Plus plan in a State, the Commissioner shall waive the requirement of subsection (a)(1) that the entity be licensed in that State if the Commissioner determines, based on the application and other evidence presented to the Commissioner, that any of the grounds for approval of the application described in paragraph (2) have been met.

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

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

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

"(5) REFERENCES TO CERTAIN PROVISIONS.—For purposes of this subsection, in applying the provisions of section 1855(a)(2) under this subsection to Medicare Prescription Plus plans and eligible entities—

"(A) any reference to a waiver application under section 1855 shall be treated as a reference to a waiver application under paragraph (1); and

"(B) any reference to solvency standards were treated as a reference to solvency standards established under subsection (d).

"(d) SOLVENCY STANDARDS FOR NON-LICENSED ENTITIES.—

''(1) ESTABLISHMENT.—The Commissioner shall establish, by not later than October 1, 2002, financial solvency and capital adequacy standards that an entity that does not meet the requirements of subsection (a)(1) must meet to qualify as an eligible entity under this part.

''(2) COMPLIANCE WITH STANDARDS.—An eligible entity that is not licensed by a State under subsection (a)(1) and for which a waiver application has been approved under subsection (c) shall meet solvency and capital adequacy standards established under paragraph (1). The Commissioner shall establish certification procedures for such eligible entities with respect to such solvency standards in the manner described in section 1855(c)(2).

''(e) OTHER STANDARDS.—The Commissioner shall establish by regulation other standards (not described in subsection (d)) for eligible entities and Medicare Prescription Plus plans consistent with, and to carry out, this part. The Commissioner shall publish such regulations by October 1, 2002.

''(f) RELATION TO STATE LAWS.—

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

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

''(2) STANDARDS SPECIFICALLY SUPERSEDED.—State standards relating to the following are superseded under this section:

''(A) Benefit requirements.

''(B) Requirements relating to inclusion or treatment of providers.

''(C) Coverage determinations (including related appeals and grievance processes).

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

''SUBMISSION OF MEDICARE PRESCRIPTION PLUS PLANS

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

missioner may specify, such information as the Commissioner may require, including the information described in subsection (b).

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

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

''(2) Information on the actuarial value of the qualified prescription drug coverage.

''(3) Information on the monthly premium to be charged for all benefits, including an actuarial certification of—

''(A) the actuarial basis for such premium;

''(B) the portion of such premium attributable to benefits in excess of standard coverage; and

''(C) the reduction in such premium resulting from the reinsurance subsidy payments provided under section 2232.

''(4) The service area for the plan.

''(5) Such other information as the Commissioner may require to carry out this part.

''APPROVAL OF MEDICARE PRESCRIPTION PLUS PLANS

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

''(b) NEGOTIATION.—In exercising such authority, the Commissioner shall have the same authority to negotiate the terms and conditions of the premiums submitted and other terms and conditions of plans as the Director of the Office of Personnel Management has with respect to health benefits plans under chapter 89 of title 5, United States Code.

''(c) SPECIAL RULES FOR APPROVAL.—

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

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

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

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

scription Plus plan submitted under section 2228 only if the benefits under such plan—

"(A) include the required benefits under section 2225(a)(1); and

"(B) are not designed in such a manner that the Commissioner finds is likely to result in favorable selection of eligible beneficiaries.

"PAYMENTS TO MEDICARE PRESCRIPTION PLUS PLANS FOR BENEFITS

"SEC. 2230. (a) IN GENERAL.—Subject to subsection (b), for each year (beginning with 2004), the Commissioner shall pay to each eligible entity offering a Medicare Prescription Plus plan in which an eligible beneficiary is enrolled an amount equal to—

"(1) the full amount of the premium approved under section 2229 on behalf of each eligible beneficiary enrolled in such plan for the year; minus

"(2) the amount of any fees imposed on the entity pursuant to section 2233).

"(b) PAYMENT TERMS.—Payment under this section to an eligible entity offering a Medicare Prescription Plus plan shall be made in a manner determined by the Commissioner and based upon the manner in which payments are made under section 1853(a) (relating to payments to Medicare+Choice organizations).

''COMPUTATION AND COLLECTION OF BENEFICIARY SHARE OF PREMIUM

''SEC. 2231. (a) COMPUTATION.—

''(1) AMOUNT.—The annual beneficiary premium for enrollment in a Medicare Prescription Plus plan providing coverage under this part for a year shall be an amount equal to—

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

''(B) the amount of the discount determined under subsection (b).

''(2) COLLECTION OF PREMIUM AMOUNT IN SAME MANNER AS PART B PREMIUM.—

''(A) IN GENERAL.—The amount of the annual beneficiary premium determined under paragraph (1) shall be collected and credited to the Medicare Prescription Drug Account in the same manner as the monthly premium determined under section 1839 is collected and credited to the Federal Supplementary Medical Insurance Trust Fund under section 1840.

''(B) INFORMATION NECESSARY FOR COLLECTION.—In order to carry out subparagraph

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

"(i) at the beginning of each year, the name, social security account number, and annual beneficiary premium owed by each individual enrolled in a Medicare Prescription Plus plan for each month during the year; and

"(ii) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.

"(b) DISCOUNTS FOR REQUIRED DRUG PORTION OF PREMIUM.—

"(1) FULL PREMIUM DISCOUNT AND REDUCTION OF COST-SHARING FOR INDIVIDUALS WITH INCOME BELOW 135 PERCENT OF FEDERAL POVERTY LEVEL.—In the case of a low-income individual (as defined in paragraph (5)(A)) who is determined to have income that does not exceed 135 percent of the Federal poverty level, the individual is entitled under this section—

"(A) to a premium discount equal to 100 percent of the amount described in subsection (c); and

"(B) subject to subsection (d), to the substitution for the beneficiary cost-sharing described in paragraphs (1) and (2) of section 2225(d) (up to the initial coverage limit specified in paragraph (3) of such section) of amounts that are nominal.

"(2) SLIDING SCALE PREMIUM DISCOUNT FOR INDIVIDUALS WITH INCOME ABOVE 135, BUT BELOW 150 PERCENT, OF FEDERAL POVERTY LEVEL.—In the case of a low-income individual who is determined to have income that exceeds 135 percent, but does not exceed 150 percent, of the Federal poverty level, the individual is entitled under this section to a premium discount determined on a linear sliding scale ranging from 100 percent of the amount described in subsection (c) for individuals with incomes at 135 percent of such level to 25 percent of such amount for individuals with incomes at 150 percent of such level.

"(3) PREMIUM DISCOUNT FOR INDIVIDUALS WITH INCOME ABOVE 150 PERCENT OF FEDERAL POVERTY LEVEL.—In the case of an eligible beneficiary who is not a low-income individual, the beneficiary is entitled under this section to a premium

discount equal to 25 percent of the amount described in subsection (c).

"(4) TAX TREATMENT OF PREMIUM DISCOUNT.—

"(A) IN GENERAL.—For purposes of the Internal Revenue Code of 1986, the premium discount determined under this subsection for an eligible beneficiary for a year shall be included in the gross income of the beneficiary for the year.

"(B) STATEMENT OF TAXABLE AMOUNT.—Not later than January 31 of each year (beginning with 2005), the Commissioner shall provide—

"(i) each eligible beneficiary enrolled under this part with a statement that describes the amount of the discount that is required to be included in the gross income of the beneficiary for the previous year pursuant to subparagraph (A); and

"(ii) the Secretary of the Treasury with the information described in clause (i).

"(5) DETERMINATION OF ELIGIBILITY.—

"(A) LOW-INCOME INDIVIDUAL DEFINED.—For purposes of this section, subject to subparagraph (D), the term 'low-income individual' means an individual who—

"(i) is eligible to enroll, and has enrolled, under this part;

"(ii) has income below 150 percent of the Federal poverty line; and

"(iii) meets the resources requirement described in section 1905(p)(1)(C).

"(B) DETERMINATIONS.—The determination of whether an individual residing in a State is a low-income individual and the amount of such individual's income shall be determined under the State medicaid plan for the State under section 1935(a). In the case of a State that does not operate such a medicaid plan (either under title XIX or under a statewide waiver granted under section 1115), such determination shall be made under arrangements made by the Commissioner.

"(C) INCOME DETERMINATIONS.—For purposes of applying this section—

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

"(ii) the term 'Federal poverty line' means the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(D) TREATMENT OF TERRITORIAL RESIDENTS.—In the case of an individual who is not a resident of the 50 States or the District of Columbia, the individual is not eligible to be a low-income individual but may be eligible for financial assistance with prescription drug expenses under section 1935(e).

"(c) PREMIUM DISCOUNT AMOUNT.—The premium discount amount described in this subsection for an eligible beneficiary residing in an area is an amount equal to—

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

"(2) in the case of an individual enrolled in a Medicare+Choice plan that provides qualified prescription drug coverage, the standard premium computed under section 1851(j)(5)(A)(iii).

"(d) RULES IN APPLYING COST-SHARING SUBSIDIES.—

"(1) IN GENERAL.—In applying subsection (b)(1)(B)—

"(A) the maximum amount of subsidy that may be provided with respect to an enrollee for a year may not exceed 95 percent of the maximum cost-sharing described in such subsection that may be incurred for standard coverage;

"(B) the Commissioner shall determine what is 'nominal' taking into account the rules applied under section 1916(a)(3); and

"(C) nothing in this part shall be construed as preventing a plan or provider from waiving or reducing the amount of cost-sharing otherwise applicable.

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

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

''(e) ADMINISTRATION OF COST-SHARING PROGRAM.—The Commissioner shall provide a process whereby, in the case of a low-income individual who is eligible for reduced cost-sharing under subsection (b)(1)(B) and is enrolled in a Medicare Prescription Plus plan or a Medicare+Choice plan under which qualified prescription drug coverage is provided—

''(1) the Commissioner provides for a notification of the eligible entity or Medicare+Choice organization involved that the individual is eligible for such reduced cost-sharing;

''(2) the entity or organization involved reduces the cost-sharing pursuant to this section and submits to the Commissioner information on the amount of such reduction; and

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

The reimbursement under paragraph (3) may be computed on a capitated basis, taking into account the actuarial value of the reductions and with appropriate adjustments to reflect differences in the risks actually involved.

''(f) RELATION TO MEDICAID PROGRAM.—

''(1) IN GENERAL.—For provisions providing for eligibility determinations, and additional financing, under the medicaid program, see section 1935.

''(2) MEDICAID PROVIDING WRAP AROUND BENEFITS.—The coverage provided under this part is primary payor to benefits for prescribed drugs provided under the medicaid program under title XIX.

''ADDITIONAL PRESCRIPTION DRUG SUBSIDIES THROUGH REINSURANCE

''SEC. 2232. (a) REINSURANCE SUBSIDY PAYMENT.—In order to reduce premium levels applicable to qualified prescription drug coverage for all medicare beneficiaries, to reduce adverse selection among Medicare Prescription Plus plans and Medicare+Choice plans that provide qualified prescription drug coverage, and to promote the participation of eligible entities under this part, the Commissioner shall provide in accordance with this section for payment to a qualifying entity (as defined in subsection (b)) of the reinsurance payment amount (as defined in subsection (c)) for excess costs incurred in providing qualified prescription drug coverage—

''(1) for individuals enrolled with a Medicare Prescription Plus plan under this part;

''(2) for individuals enrolled with a Medicare+Choice plan that provides qualified pre-

scription drug coverage under part C of title XVIII; and

''(3) for medicare secondary payer eligible individuals (described in subsection (e)(3)(D)) who are enrolled in a qualified retiree prescription drug plan.

This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Commissioner to provide for the payment of amounts provided under this section.

''(b) QUALIFYING ENTITY DEFINED.—For purposes of this section, the term 'qualifying entity' means any of the following that has entered into an agreement with the Commissioner to provide the Commissioner with such information as may be required to carry out this section:

''(1) An eligible entity offering a Medicare Prescription Plus plan under this part.

''(2) A Medicare+Choice organization that provides qualified prescription drug coverage under a Medicare+Choice plan under part C of title XVIII.

''(3) The sponsor of a qualified retiree prescription drug plan (as defined in subsection (e)).

''(c) REINSURANCE PAYMENT AMOUNT.—

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

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

''(2) ALLOWABLE COSTS.—For purposes of this section, the term 'allowable costs' means, with respect to gross covered prescription drug costs under a plan described in subsection (b) offered by a qualifying entity, the part of such costs that are actually paid under the plan, but in no case more than the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were standard coverage.

''(3) GROSS COVERED PRESCRIPTION DRUG COSTS.—For purposes of this section, the term 'gross covered prescription drug costs' means, with respect to an enrollee with a qualifying entity under a plan described in subsection (b) during a coverage year, the costs incurred under the plan for covered prescription drugs dispensed during the year, including costs relating to the deductible, whether paid by the enrollee or under the plan, regardless of whether the coverage under the plan exceeds standard cov-

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

''(4) INDEXING DOLLAR AMOUNT.—

''(A) AMOUNT FOR 2004.—The dollar amount applied under paragraph (1) for 2004 shall be the dollar amount specified in such paragraph.

''(B) FOR 2005.—The dollar amount applied under paragraph (1) for 2005 shall be the dollar amount specified in such paragraph increased by the annual percentage increase described in section 2225(d)(5) for 2005.

''(C) FOR SUBSEQUENT YEARS.—The dollar amount applied under paragraph (1) for a year after 2005 shall be the dollar amount (under this paragraph) applied under paragraph (1) for the preceding year increased by the annual percentage increase described in section 2225(d)(5) for the year involved.

''(D) ROUNDING.—Any amount, determined under the preceding provisions of this paragraph for a year, which is not a multiple of $5 shall be rounded to the nearest multiple of $5.

''(d) PAYMENT METHODS.—

''(1) IN GENERAL.—Payments under this section shall be based on such a method as the Commissioner determines. The Commissioner may establish a payment method by which interim payments of amounts under this section are made during a year based on the Commissioner's best estimate of amounts that will be payable after obtaining all of the information.

''(2) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Medicare Prescription Drug Account.

''(e) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN DEFINED.—

''(1) IN GENERAL.—For purposes of this section, the term 'qualified retiree prescription drug plan' means employment-based retiree health coverage (as defined in paragraph (3)(A)) if, with respect to an individual enrolled (or eligible to be enrolled) under this part who is covered under the plan, the following requirements are met:

''(A) ASSURANCE.—The sponsor of the plan shall annually attest, and provide such assurances as the Commissioner may require, that the coverage meets the requirements for qualified prescription drug coverage.

"(B) AUDITS.—The sponsor (and the plan) shall maintain, and afford the Commissioner access to, such records as the Commissioner may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage, the accuracy of payments made, and such other matters as may be appropriate.

"(C) OTHER REQUIREMENTS.—The sponsor of the plan shall comply with such other requirements as the Commissioner finds necessary to administer the program under this section.

"(2) LIMITATION ON BENEFIT ELIGIBILITY.—No payment shall be provided under this section with respect to an individual who is enrolled under a qualified retiree prescription drug plan unless the individual is a medicare secondary payer eligible individual who—

"(A) is covered under the plan; and

"(B) is eligible to obtain qualified prescription drug coverage under this part but did not elect such coverage (either through a Medicare Prescription Plus plan or through a Medicare+Choice plan).

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

''(A) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage of health care costs for medicare secondary payer eligible individuals (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

''(B) EMPLOYER.—The term 'employer' has the meaning given such term by section 3(5) of the Employee Retirement Income Security Act of 1974 (except that such term shall include only employers of 2 or more employees).

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

''(D) MEDICARE SECONDARY PAYER INDIVIDUAL.—The term 'medicare secondary payer eligible individual' means, with respect to a plan, an individual who is covered under the plan and with respect to whom the plan is not a primary plan (as defined in section 1862(b)(2)(A)).

''(f) GENERAL DEFINITIONS.—For purposes of this section:

''(1) QUALIFIED BENEFICIARY.—The term 'qualified beneficiary' means an individual who—

''(A) is enrolled with a Medicare Prescription Plus plan under this part;

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

''(C) is covered as a medicare secondary payer eligible individual under a qualified retiree prescription drug plan.

''(2) COVERAGE YEAR.—The term 'coverage year' means a calendar year in which covered outpatient drugs are dispensed if a claim for payment is made under the plan for such drugs, regardless of when the claim is paid.

''PLAN FEES FOR ADMINISTRATIVE COSTS

''SEC. 2233. (a) IN GENERAL.—The Commissioner may levy on Medicare Prescription Plus plans and Medicare+Choice plans that provide drug coverage pursuant to this part an assessment sufficient to pay the estimated expenses of the Commissioner for administering the program under this part.

''(b) DEPOSITS AND USE.—The assessments described in subsection (a) shall be—

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

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

''MEDICARE PRESCRIPTION DRUG ACCOUNT

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

''(b) AMOUNTS IN ACCOUNT.—

''(1) IN GENERAL.—The Medicare Prescription Drug Account shall consist of—

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

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

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

''(c) PAYMENTS FROM ACCOUNT.—

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

scription Drug Account such amounts as the Commissioner certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 201(g).

''(2) TRANSFERS TO MEDICAID ACCOUNT FOR INCREASED ADMINISTRATIVE COSTS.—The Managing Trustee shall transfer from time to time from the Account to the Grants to States for Medicaid account amounts the Secretary certifies are attributable to increases in payment resulting from the application of a higher Federal matching percentage under section 1935(b).

''(d) DEPOSITS INTO ACCOUNT.—

''(1) MEDICAID TRANSFER.—There is hereby transferred to the Account, from amounts appropriated for Grants to States for Medicaid, amounts equivalent to the aggregate amount of the reductions in payments under section 1903(a)(1) attributable to the application of section 1935(c).

''(2) APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Ac-

count, an amount equivalent to the amount of payments made from the Account, reduced by—

"(1) the amount transferred to the Account under paragraph (1);

"(2) the beneficiary premiums collected and credited to the account under section 2231(b)(2); and

"(3) fees collected and credited to the account under section 2233.

"SECONDARY PAYER PROVISIONS

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

"DEFINITIONS; TREATMENT OF REFERENCES TO PROVISIONS IN MEDICARE+CHOICE PROGRAM

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

"(1) COMMISSIONER.—The term 'Commissioner' means the Commissioner of the Competitive Medicare Agency.

"(2) COVERED OUTPATIENT DRUG.—

"(A) IN GENERAL.—Except as provided in this subparagraph (B), the term 'covered outpatient drug' means—

"(i) a drug that may be dispensed only upon a prescription and that is described in clause (i) or (ii) of section 1927(k)(2)(A); or

"(ii) a biological product or insulin described in subparagraph (B) or (C) of such section.

"(B) EXCLUSIONS.—

"(i) IN GENERAL.—The term 'covered outpatient drug' does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents).

"(ii) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this part shall not be so considered if payment for such drug is available under part A or B of title XVIII (but shall be so considered if such payment is not available because benefits under part A or B of title XVIII have been exhausted), without regard to whether the individual is entitled to benefits under such part A or enrolled under such part B.

''(3) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual that is entitled to benefits under part A of title XVIII and enrolled under part B of such title.

''(4) ELIGIBLE ENTITY.—The term 'eligible entity' means any risk-bearing entity that the Commissioner determines to be appropriate to provide eligible beneficiaries with the benefits under a Medicare Prescription Plus plan, including—

''(A) a pharmaceutical benefit management company;

''(B) a wholesale or retail pharmacist delivery system;

''(C) an insurer (including an insurer that offers medicare supplemental policies under section 1882);

''(D) another entity; or

''(E) any combination of the entities described in subparagraphs (A) through (D).

''(5) INITIAL COVERAGE LIMIT.—The term 'initial coverage limit' means the limit as established under section 2225(d)(3), or, in the case of coverage that is not standard coverage, the comparable limit (if any) established under the coverage.

''(6) MEDICARE+CHOICE ORGANIZATION; MEDICARE+CHOICE PLAN.—The terms 'Medicare+Choice organization' and 'Medicare+Choice plan' have the meanings given such terms in subsections (a)(1) and (b)(1), respectively, of section 1859 (relating to definitions relating to Medicare+Choice organizations and plans).

''(7) MEDICARE PRESCRIPTION DRUG ACCOUNT.—The term 'Medicare Prescription Drug Account' means the Medicare Prescription Drug Account established under section 2234 and located within the Federal Supplementary Medical Insurance Trust Fund established under section 1841.

''(8) MEDICARE PRESCRIPTION PLUS PLAN.—The term 'Medicare Prescription Plus plan' means a health benefits plan that the Commissioner has approved under section 2229.

''(9) STANDARD COVERAGE.—The term 'standard coverage' means the coverage described in section 2225(d).

''(b) APPLICATION OF MEDICARE+CHOICE PROVISIONS UNDER THIS PART.—For purposes of applying provisions of part C of title XVIII under this part with respect to a Medicare Prescription Plus plan and an eligible

entity, unless otherwise provided in this part such provisions shall be applied as if—

''(1) any reference to a Medicare+Choice plan included a reference to a Medicare Prescription Plus plan;

''(2) any reference to a provider-sponsored organization included a reference to an eligible entity;

''(3) any reference to a contract under section 1857 included a reference to a contract under section 2227(b); and

''(4) any reference to part C of title XVIII included a reference to this part.''.

(b) SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services and the Commissioner of the Competitive Medicare Agency shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this Act.

SEC. 202. AMENDMENTS TO FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.

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

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

(A) by striking ''and'' after ''section 201(i)(1)''; and

(B) by inserting before the period the following: '', and such amounts as may be deposited in, or appropriated to, the Medicare Prescription Drug Account established by section 2234'';

(2) in subsection (g), by inserting after ''by this part,'' the following: ''the payments provided for under the Prescription Drug and Supplemental Benefit Program under part B of title XVIII (in which case the payments shall come from the Medicare Prescription Drug Account in the Supplementary Medical Insurance Trust Fund),'';

(3) in the first sentence of subsection (h), by inserting ''(or the Commissioner of the Competitive Medicare Agency by reason of section 2235 (in which case the payments shall come from the Medicare Prescription Drug Account within such Trust Fund))'' after ''Human Services''; and

(4) in the first sentence of subsection (i), by inserting ''(or the Commissioner of the Competitive Medicare Agency by reason of section 2235 (in which case the payments shall come from the Medi-

care Prescription Drug Account within such Trust Fund))'' after ''Human Services''.

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

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

''(j) AVAILABILITY OF PRESCRIPTION DRUG BENEFITS.—

''(1) IN GENERAL.—A Medicare+Choice organization may not offer prescription drug coverage (other than that required under parts A and B) to an enrollee under a Medicare+Choice plan unless such drug coverage is at least qualified prescription drug coverage and unless the requirements of this subsection with respect to such coverage are met.

''(2) COMPLIANCE WITH ADDITIONAL BENEFICIARY PROTECTIONS.—With respect to the offering of qualified prescription drug coverage by a Medicare+Choice organization under a Medicare+Choice plan, the organization and plan shall meet the requirements of section 2226, including requirements relating to information dissemination and grievance and appeals, in the same manner as they apply to an eligible entity and a Medicare

Prescription Plus plan under part B of title XXII. The Commissioner of the Competitive Medicare Agency shall waive such requirements to the extent the Administrator determines that such requirements duplicate requirements otherwise applicable to the organization or plan under this part.

''(3) TREATMENT OF COVERAGE.—Except as provided in this subsection, qualified prescription drug coverage offered under this subsection shall be treated under this part in the same manner as supplemental health care benefits described in section 1852(a)(3)(A).

''(4) AVAILABILITY OF COST-SHARING SUBSIDIES FOR LOW-INCOME ENROLLEES AND REINSURANCE SUBSIDY PAYMENTS FOR ORGANIZATIONS.—For provisions—

''(A) providing cost-sharing subsidies to low-income individuals receiving qualified prescription drug coverage through a Medicare+Choice plan, see section 2231; and

''(B) providing a Medicare+Choice organization with reinsurance subsidy payments for providing qualified prescription drug coverage under this part, see section 2232.

''(5) SPECIFICATION OF SEPARATE AND STANDARD PREMIUM.—

''(A) IN GENERAL.—For purposes of applying section 1854 and determining the premium discount under section 2231(c) with respect to qualified prescription drug coverage offered under this subsection under a plan, the Medicare+Choice organization shall compute and publish the following:

''(i) SEPARATE PRESCRIPTION DRUG PREMIUM.—A premium for prescription drug benefits that constitutes qualified prescription drug coverage that is separate from other coverage under the plan.

''(ii) PORTION OF COVERAGE ATTRIBUTABLE TO STANDARD BENEFITS.—The ratio of the actuarial value of standard coverage to the actuarial value of the qualified prescription drug coverage offered under the plan.

''(iii) PORTION OF PREMIUM ATTRIBUTABLE TO STANDARD BENEFITS.—A standard premium equal to the product of the premium described in clause (i) and the ratio under clause (ii).

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

''(B) REDUCTION OF PREMIUMS ALLOWED.—Nothing in this subsection shall be construed as preventing a Medicare+Choice organization from reducing the amount of a premium charged for prescription drug coverage because of the application of subsections (f)(1)(A) and (i)(2)(A) of section 1854 to other coverage.

''(6) TRANSITION IN INITIAL ENROLLMENT PERIOD.—Notwithstanding any other provision of this part, the annual, coordinated election period under subsection (e)(3)(B) for 2004 shall be the 6-month period beginning with November 2003.

''(7) QUALIFIED PRESCRIPTION DRUG COVERAGE; STANDARD COVERAGE.—For purposes of this part, the terms 'qualified prescription drug coverage' and 'standard coverage' have the meanings given such terms in section 2225.''.

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

(1) by inserting ''(other than qualified prescription drug benefits)'' after ''benefits'';

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

(3) by adding at the end the following flush language:

''and may elect qualified prescription drug coverage in accordance with part B of title XXII.''.

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

SEC. 204. MEDICAID AMENDMENTS.

(a) DETERMINATIONS OF ELIGIBILITY FOR LOW-INCOME SUBSIDIES.—

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

(A) by striking ''and'' at the end of paragraph (64);

(B) by striking the period at the end of paragraph (65) and inserting ''; and''; and

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

''(66) provide for making eligibility determinations under section 1935(a).''.

(2) NEW SECTION.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended—

(A) by redesignating section 1935 as section 1936; and

(B) by inserting after section 1934 the following new section:

''SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

''SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGIBILITY DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—As a condition of its State plan under this title under section 1902(a)(66) and receipt of any Federal financial assistance under section 1903(a), a State shall—

''(1) make determinations of eligibility for premium and cost-sharing subsidies under (and in accordance with) section 2231;

''(2) inform the Commissioner of the Competitive Medicare Agency of such determinations in cases in which such eligibility is established; and

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

''(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE COSTS.—

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

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

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

''(B) For expenditures attributable to costs incurred during 2005, the otherwise applicable Federal matching rate shall be increased by 40 percent of the percentage otherwise payable (but for this subsection) by the State.

''(C) For expenditures attributable to costs incurred during 2006, the otherwise applicable Federal matching rate shall be increased by 60 percent of the percentage otherwise payable (but for this subsection) by the State.

''(D) For expenditures attributable to costs incurred during 2007, the otherwise applicable Federal matching rate shall be increased by 80

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

''(E) For expenditures attributable to costs incurred after 2007, the otherwise applicable Federal matching rate shall be increased to 100 percent.

''(2) COORDINATION.—The State shall provide the Secretary with such information as may be necessary to properly allocate administrative expenditures described in paragraph (1) that may otherwise be made for similar eligibility determinations.''.

(b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID RESPONSIBILITY FOR PREMIUM AND COST-SHARING SUBSIDIES FOR DUALLY ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—Section 1903(a)(1) of the Social Security Act (42 U.S.C. 1396b(a)(1)) is amended by inserting before the semicolon the following: '', reduced by the amount computed under section 1935(c)(1) for the State and the quarter''.

(2) AMOUNT DESCRIBED.—Section 1935 of the Social Security Act, as inserted by subsection (a)(2), is amended by adding at the end the following new subsection:

"(c) FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION DRUG COSTS FOR DUALLY ELIGIBLE BENEFICIARIES.—

"(1) IN GENERAL.—For purposes of section 1903(a)(1), for a State that is 1 of the 50 States or the District of Columbia for a calendar quarter in a year (beginning with 2004) the amount computed under this subsection is equal to the product of the following:

"(A) MEDICARE SUBSIDIES.—The total amount of payments made in the quarter under section 2231 (relating to premium and cost-sharing prescription drug subsidies for low-income medicare beneficiaries) that are attributable to individuals who are residents of the State and are entitled to benefits with respect to prescribed drugs under the State plan under this title (including such a plan operating under a waiver under section 1115).

"(B) STATE MATCHING RATE.—A proportion computed by subtracting from 100 percent the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State and the quarter.

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

''(2) PHASE-OUT PROPORTION.—For purposes of paragraph (1)(C), the 'phase-out proportion' for a calendar quarter in—

''(A) 2004 is 90 percent;

''(B) 2005 is 80 percent;

''(C) 2006 is 70 percent;

''(D) 2007 is 60 percent; or

''(E) a year after 2007 is 50 percent.''.

(c) MEDICAID PROVIDING WRAP-AROUND BENEFITS.—Section 1935 of the Social Security Act, as so inserted and amended, is further amended by adding at the end the following new subsection:

''(d) ADDITIONAL PROVISIONS.—

''(1) MEDICAID AS SECONDARY PAYOR.—In the case of an individual dually entitled to qualified prescription drug coverage under a Prescription Plus Plan under part B of title XXII (or under a Medicare+Choice plan under part C of such title) and medical assistance for prescribed drugs under this title, medical assistance shall continue to be provided under this title for prescribed drugs to the extent payment is not made under the Medicare Pre-

scription Plus plan or the Medicare+Choice plan selected by the individual.

''(2) CONDITION.—A State may require, as a condition for the receipt of medical assistance under this title with respect to prescription drug benefits for an individual eligible to obtain qualified prescription drug coverage described in paragraph (1), that the individual elect qualified prescription drug coverage under the program under part B of title XXII.''.

(d) TREATMENT OF TERRITORIES.—

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

(A) in subsection (a)(1), by inserting ''subject to subsection (e),'' after ''section 1903'';

(B) in subsection (c)(1), by inserting ''subject to subsection (e),'' after ''1903(a)''; and

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

''(e) TREATMENT OF TERRITORIES.—

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

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

''(B) if the State establishes a plan described in paragraph (2) (for providing medical assistance with respect to the provision of prescription drugs to medicare beneficiaries), the amount otherwise determined under section 1108(f) (as increased under section 1108(g)) for the State shall be increased by the amount specified in paragraph (3).

''(2) PLAN.—The plan described in this paragraph is a plan that—

''(A) provides medical assistance with respect to the provision of covered outpatient drugs (as defined in section 2236(2)) to low-income medicare beneficiaries; and

''(B) assures that additional amounts received by the State that are attributable to the operation of this subsection are used only for such assistance.

''(3) INCREASED AMOUNT.—

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

''(i) the aggregate amount specified in subparagraph (B); and

''(ii) the amount specified in section 1108(g)(1) for that State, divided by the sum of the amounts specified in such section for all such States.

''(B) AGGREGATE AMOUNT.—The aggregate amount specified in this subparagraph for—

''(i) 2004, is equal to $20,000,000; or

''(ii) a subsequent year, is equal to the aggregate amount specified in this subparagraph for the previous year increased by the annual percentage increase specified in section 2225(d)(5) for the year involved.

''(4) REPORT.—The Secretary shall submit to Congress a report on the application of this subsection and may include in the report such recommendations as the Secretary deems appropriate.''.

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

SEC. 205. MEDIGAP PROVISIONS.

(a) IN GENERAL.—Notwithstanding any other provision of law, no new medicare supplemental policy that provides coverage of expenses for prescription drugs may be issued under section 1882 of the Social Security Act on or after January 1, 2004, to an individual unless it replaces a medicare supplemental policy that was issued to that individual and that provided some coverage of expenses for prescription drugs.

(b) ISSUANCE OF SUBSTITUTE POLICIES IF OBTAINING PRESCRIPTION DRUG COVERAGE THROUGH MEDICARE.—

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

(A) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as ''A'', ''B'', ''C'', ''D'', ''E'', ''F'', or ''G'' (under the standards established under subsection (p)(2) of section 1882 of the Social Security Act (42 U.S.C. 1395ss)) and that is offered and is available for issuance to new enrollees by such issuer;

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

perience, receipt of health care, or medical condition; and

(C) may not impose an exclusion of benefits based on a preexisting condition under such policy,

in the case of an individual described in paragraph (2) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such paragraph and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

(2) INDIVIDUAL COVERED.—An individual described in this paragraph is an individual who—

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

(B) at the time of such enrollment was enrolled and terminates enrollment in a medicare supplemental policy which has a benefit package classified as ''H'', ''I'', or ''J'' under the standards referred to in paragraph (1)(A) or terminates enrollment in a policy to which such standards do not apply but which provides benefits for prescription drugs.

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

(4) DEFINITIONS.—For purposes of this subsection, the term ''medicare supplemental policy'' has the meaning given such term in section 1882(g) of the Social Security Act (42 U.S.C. 1395ss(g)).

(c) MEDIGAP PROTECTIONS FOR INDIVIDUALS WHO LOSE MEDICARE PRESCRIPTION PLUS PLAN COVERAGE.—Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended—

(1) in subsection (d)(3)—

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

''(ix) Nothing in this subparagraph shall be construed as preventing the sale of 1 medicare supplemental policy and 1 Medicare Prescription Plus plan to an individual, except that the sale of such a policy or plan may not duplicate any health benefits under any policy or plan owned by the individual.''; and

(B) in subparagraph (B)(iii)—

(i) in subclause (I), by striking ''(II) and (III)'' and inserting ''(II), (III), and (IV)'';

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

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

''(III) If the statement required by clause (i) is obtained and indicates that the individual is enrolled in 1 medicare supplemental policy or 1 Medicare Prescription Plus plan, the sale of another policy or plan is not in violation of clause (i) if such other policy or plan does not duplicate health benefits under the policy or plan in which the individual is enrolled.'';

(2) in subsection (g)(1), by inserting '', Medicare Prescription Plus plan,'' after ''Medicare+Choice plan''; and

(3) in subsection (s)(3)(B)—

(A) in clause (ii), by inserting ''is enrolled with an eligible entity under a Medicare Prescription Plus plan under part B of title XXII or'' after ''section 1851(e)(4) or the individual'';

(B) in clause (v)(II), by inserting ''with any eligible entity under a Medicare Prescription Plus plan under part B of title XXII,'' after ''under part C,''; and

(C) in clause (vi), by inserting ", in a Medicare Prescription Plus plan under part B of title XXII," after "under part C"; and

TITLE III—MEDICARE+CHOICE COMPETITION PROGRAM

SEC. 301. MEDICARE+CHOICE COMPETITION PROGRAM.

(a) PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS BASED ON RISK-ADJUSTED BIDS.—

(1) MONTHLY PAYMENTS.—Section 1853(a)(1)(A) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(A)) is amended by adding at the end the following new sentences: "For each year (beginning with 2004), under a contract under section 1857, the Commissioner shall make to each Medicare+Choice organization, with respect to coverage of an individual for a month under this part in a Medicare+Choice payment area, monthly payments with respect to benefits under parts A and B combined in accordance with subsection (c)(8), reduced by the amount of any reduction elected under section 1854(f)(1)(E). For rules relating to payment of the Medicare+Choice monthly supplemental beneficiary premium or any prescription drug premium, see section 1854(j).".

(2) ANNUAL DETERMINATION AND ANNOUNCEMENT OF PAYMENT FACTORS.—

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

(i) in paragraph (1), by striking ''the calendar year concerned'' and all that follows and inserting ''the calendar year concerned with respect to each Medicare+Choice payment area, the following:

''(A) The benchmark amount (as defined in paragraph (5)(A)).

''(B) The county-specific monthly per capita costs (as defined in paragraph (5)(B)).

''(C) The demographic adjustment factors to be used in making payment for individual enrollees (as defined in paragraph (5)(C)).

''(D) The ESRD adjustment (as defined in paragraph (5)(D)).

''(E) The health status adjustment (as defined in paragraph (5)(E)).''.

(ii) in paragraph (3), by striking ''monthly adjusted'' and all that follows before the period at the end and inserting ''the payment rates under this part for

each individual enrolled in the Medicare+Choice plan offered by the Medicare+Choice organization for the year''; and

(iii) by adding at the end the following new paragraph:

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

''(A) BENCHMARK AMOUNT.—

''(i) IN GENERAL.—The term 'benchmark amount' means, for a payment area, an amount equal to the greater of—

''(I) except as provided in clause (ii), 1/12 of the annual Medicare+Choice capitation rate that would have applied in that payment area under paragraphs (1) through (7) of subsection (c); or

''(II) the county-specific monthly per capita costs for such area.

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

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

''(B) COUNTY-SPECIFIC MONTHLY PER CAPITA COSTS.—

''(i) IN GENERAL.—Subject to clause (ii), the term 'county-specific monthly per capita costs' means the amount of payment in a Medicare+Choice payment area for benefits under this title and associated claims processing costs for individuals entitled to benefits under part A and individuals enrolled in the program under part B who are not enrolled in a Medicare+Choice plan under this part. The Commissioner shall determine such amount in a manner similar to the manner in which the Secretary determined the adjusted average per capita cost under section 1876, except that such determination shall include in such

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

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

''(I) payments for costs of graduate medical education under section 1886(h); or

''(II) payments for indirect costs of medical education under section 1886(d)(5)(B).

''(C) DEMOGRAPHIC ADJUSTMENT FACTORS.—The term 'demographic adjustment factors' means such factors as age, disability status, gender, and institutional status, so as to ensure actuarial equivalence. The Commissioner may add to, modify, or substitute for such factors, if such changes will improve the determination of actuarial equivalence, and in that

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

"(D) ESRD ADJUSTMENT FACTOR.—The term 'ESRD adjustment factor' means the adjustment established by the Commissioner under section 1851(a)(3)(B) that applies with respect to enrolled individuals who have end-stage renal disease.

"(E) HEALTH STATUS ADJUSTMENT FACTOR.—The term 'health status adjustment factor' means the health status adjustment implemented under subsection (a)(3)(C) until such time as the Commissioner develops a health status adjustment factor that takes into account the specific health care needs of Medicare+Choice eligible individuals who do not have end-stage renal disease based on the delivery of care in all settings, which methodology shall be phased in equally over a 10-year period, beginning with 2005, or (if later) the date on which such factor is developed.

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

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

(B) by adding at the end the following:

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

''(A) IN GENERAL.—For each year (beginning with 2004), each Medicare+Choice organization shall submit to the Commissioner, in a form and manner specified by the Commissioner and for each Medicare+Choice plan which it intends to offer in a service area in the following year—

''(i) notice of such intent and information on the service area and plan type for each plan;

''(ii) the information described in paragraph (2) for the type of plan involved; and

''(iii) the enrollment capacity (if any) in relation to the plan and area.

''(B) INFORMATION REQUIRED FOR COMPETITIVE PLANS.—The information described in this paragraph is as follows:

''(i) The monthly plan bid for the provision of benefits.

''(ii) The actuarial value of the reduction in cost-sharing for benefits under parts A and B included in each plan bid and a description of the cost-sharing for such benefits.

''(iii) The actuarial value of any additional benefits required under subsection (i), a description of cost-sharing for such benefits, and such other information as the Commissioner considers necessary.

''(iv) The actuarial value of any supplemental benefits, the monthly supplemental premium (if any) for such benefits, a description of any cost-sharing for such benefits, and such other information as the Commissioner considers necessary.

''(v) For each Medicare+Choice payment area, the assumptions used with respect to the number of—

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

''(II) such enrolled individuals who have end-stage renal disease.''.

(4) COMMISSIONER'S DETERMINATION OF PAYMENT AMOUNT.—Section 1853(c) of the Social Security Act (42 U.S.C. 1395w–23(c)) is amended—

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

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

''(8) COMMISSIONER'S DETERMINATION OF PAYMENT AMOUNT.—

''(A) ADJUSTMENT OF BIDS.—The Commissioner shall adjust plan bids submitted under section 1854(a)(6) based on the demographic adjustment factors, the ESRD adjustment factor, and the health status adjustment factor (as defined in subparagraphs (C), (D), and (E), respectively, of subsection (b)(5)).

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

just such amount based on the demographic adjustment factors, the ESRD adjustment factor, and the health status adjustment factor (as defined in subparagraphs (C), (D), and (E), respectively, of such section).

''(C) COMPARISON TO PLAN BENCHMARK AMOUNT.—

''(i) IN GENERAL.—The Commissioner shall compare the organization's bid (as adjusted under subparagraph (A)) to the benchmark amount (as adjusted under subparagraph (B)) to determine the payment amount under clause (ii).

''(ii) DETERMINATION OF PAYMENT AMOUNT.—The Commissioner shall determine the monthly payment to a Medicare+Choice organization with respect to each individual enrolled in a Medicare+Choice plan as follows:

''(I) IF BID DOES NOT EXCEED BENCHMARK.—If the Medicare+Choice organization's bid (as adjusted under subparagraph (A)) does not exceed the benchmark amount (as adjusted under subpara-

graph (B)), the monthly payment shall be the benchmark amount, adjusted to account for the demographic adjustment factors, health status adjustment factor, and (if applicable) the ESRD adjustment factor of the individual enrollee, minus 25 percent of the difference between the bid and the benchmark amount determined under section 1854(i)(2)(A).

''(II) IF BID EXCEEDS BENCHMARK.—If the organization's bid (as adjusted under subparagraph (A)) exceeds the benchmark amount (as adjusted under subparagraph (B)), the monthly payment shall be the bid, adjusted to account for the demographic adjustment factors, health status adjustment factor, and (if applicable) the ESRD adjustment factor of the individual enrollee.''.

(b) PREMIUMS.—

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

1395w–24) is amended by adding at the end the following new subsections:

"(i) DETERMINATION OF MEDICARE PREMIUM REDUCTION AND MEDICARE+CHOICE MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—

"(1) IN GENERAL.—Notwithstanding subsection (b) and subject to paragraph (2), for each year (beginning with 2004), the Commissioner shall determine the difference between the organization's bid (submitted under subsection (a)(6) and adjusted under section 1853(c)(8)(A)) and the plan's benchmark amount (as adjusted under 1853(c)(8)(B)) to determine the amount of any medicare premium reduction, prescription drug premium reduction, reduction in plan cost-sharing, or additional benefits required under paragraph (2)(A), or the Medicare+Choice monthly supplemental beneficiary premium for plan enrollees.

"(2) ADJUSTMENT.—

"(A) BIDS BELOW THE BENCHMARK.—Notwithstanding subsection (f) (except for paragraph (1)(E) of such subsection), if the organization's bid is lower than the plan's benchmark amount, 75 percent of the difference determined under paragraph (1) shall be returned

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

"(i) a monthly medicare premium reduction for individuals enrolled in the plan in accordance with subsection (f)(1)(E);

"(ii) a prescription drug premium reduction pursuant to subsection (j)(5)(B);

"(iii) a reduction in the actuarial value of plan cost-sharing for plan enrollees;

"(iv) such additional benefits as the organization may specify; or

"(v) any combination of the reductions and benefits described in clauses (i) through (iv).

"(B) BIDS ABOVE THE BENCHMARK.—If the organization's bid is higher than the benchmark amount, the difference determined under paragraph (1) shall be the Medicare+Choice monthly supplemental beneficiary premium for individuals enrolled in the plan.

"(j) RULES RELATING TO PREMIUMS OWED BY MEDICARE+CHOICE ENROLLEES.—In the case of any Medicare+Choice monthly supplemental beneficiary premium under subsection (i)(2)(B) or any prescription drug

premium under section 1851(j) that an individual is responsible for under a Medicare+Choice plan in which the individual is enrolled, the following rules shall apply:

''(1) COMMISSIONER SHALL PAY THE DRUG PREMIUM TO THE ENTITY.—

''(A) IN GENERAL.—The Commissioner shall pay to the Medicare+Choice organization offering the Medicare+Choice plan the full amount of the prescription drug premium under section 1851(j) that the individual is responsible for under the plan.

''(B) PAYMENTS FROM MEDICARE PRESCRIPTION DRUG ACCOUNT.—Payments under subparagraph (A) shall be made from the Medicare Prescription Drug Account within the Federal Supplementary Medical Insurance Trust Fund under section 1841.

''(2) PREMIUM DISCOUNT FOR DRUG BENEFITS.—Subject to paragraph (4), the individual shall be entitled to the premium discount for prescription drugs determined under section 2231.

''(3) COLLECTION OF SUPPLEMENTAL AND DRUG PREMIUMS IN SAME MANNER AS PART B PREMIUM.—

''(A) SUPPLEMENTAL PREMIUM.—The amount of any Medicare+Choice monthly supplemental beneficiary premium that an individual is responsible for under the plan shall be collected and credited to the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund—

''(i) in such proportion as the Commissioner determines appropriate; and

''(ii) in the same manner as the monthly premium determined under section 1839 is collected and credited to the Federal Supplementary Medical Insurance Trust Fund under section 1840.

''(B) DRUG PREMIUM.—Subject to the application of the premium discounts available under section 2231, the amount of any premium drug premium that an individual is responsible for under the plan shall be collected and credited to the Medicare Prescription Drug Account within the Federal Supplementary Medical Insurance Trust Fund under section 1841 in the same manner as the monthly premium determined under section 1839 is collected and credited to the Federal Supple-

mentary Medical Insurance Trust Fund under section 1840.

''(C) INFORMATION NECESSARY FOR COLLECTION.—In order to carry out subparagraph (A), the Commissioner shall transmit to the Commissioner of Social Security—

''(i) at the beginning of each year, the name, social security account number, and the Medicare+Choice monthly supplemental beneficiary premium and prescription drug premium owed by the individual for each month during the year; and

''(ii) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.

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

enrolled, the premium subsidy shall be deemed to be an amount equal to such sum.''.

(2) LIMITATION ON ENROLLEE LIABILITY FOR SUPPLEMENTAL BENEFITS.—Section 1854(e)(2) of the Social Security Act (42 U.S.C. 1395w–24(e)(2)) is amended by striking ''If the Medicare+Choice organization'' and inserting ''Except as provided in subsection (i)(2)(B), if the Medicare+Choice organization''.

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

(1) by inserting ''(i)'' after ''(B)''; and

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

''(ii) for 2004 and each subsequent year, at plan option, the reductions and benefits described in section 1854(i)(2)(A).''.

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

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

(e) CONFORMING AMENDMENTS.—

(1) PREMIUM REDUCTIONS UNDER PART B.—

(A) AMOUNT OF PREMIUMS.—Section 1839(a)(2) of the Social Security Act (42 U.S.C. 1395r(a)(2)), as amended by section 606(a)(2)(B)(i) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554), is amended by striking ''and to reflect 80 percent of any reduction elected under section 1854(f)(1)(E)'' and inserting ''and to comply with section 1854(i)(2)(A) (including an adjustment to reflect 80 percent of any reduction elected under section 1854(f)(1)(E)).''.

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

flect 80 percent of any reduction elected under section 1854(f)(1)(E)'' and inserting ''determined under section 1854(i)(2)(A)(i) (including an adjustment to reflect 80 percent of any reduction elected under section 1854(f)(1)(E))''.

(2) CONTINUATION OF ENROLLMENT PERMITTED.—Section 1851(b)(1)(B) of the Social Security Act (42 U.S.C. 1395w–21(b)(1)(B)) is amended by striking ''section 1852(a)(1)(A)'' and inserting ''section 1852(a)(1)''.

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

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

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

(A) in the heading, by striking ''BUDGET NEUTRALITY'';

(B) by striking ''adjust the payment rates'' and all that follows through ''that would have been made'' and inserting ''adjust the benchmark amounts otherwise established under this section for Medicare+Choice payment areas in the State in a manner so that the weighted average of the benchmark amounts under this section in the State equals the weighted average of benchmark amounts that would have been applicable''.

(6) MEDICARE+CHOICE MONTHLY BASIC BENEFICIARY PREMIUM.—Section 1854(b)(2)(A) of the Social Security Act (42 U.S.C. 1395w–24(b)(2)(A)) is amended by striking ''the amount authorized to be charged'' and all that follows and inserting ''the amount required to be charged for the plan.''.

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

''(3) COMMISSIONER.—The term 'Commissioner' means the Commissioner of the Competitive

Medicare Agency appointed under section 2202(a)(1).''.

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

''(9) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—For purposes of determining the blended capitation rate under subparagraph (A) of paragraph (1) and the minimum percentage increase under subparagraph (C) of such paragraph for a year, the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in such rate the Commissioner's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Veterans Affairs or the Department of Defense.''.

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

TITLE IV—MEDICARE BENEFICIARY OUTREACH AND EDUCATION

SEC. 401. MEDICARE CONSUMER COALITIONS.

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

''PART C—MEDICARE CONSUMER COALITIONS

''ESTABLISHMENT OF MEDICARE CONSUMER COALITIONS

''SEC. 2281. (a) ESTABLISHMENT OF MEDICARE CONSUMER COALITIONS.—The Commissioner of the Competitive Medicare Agency (in this part referred to as the 'Commissioner') may establish Medicare Consumer Coalitions (as defined in subsection (b)) to conduct information programs described in subsection (e).

''(b) MEDICARE CONSUMER COALITION DEFINED.—In this section, the term 'Medicare Consumer Coalition' means an entity that is a nonprofit organization operated under the direction of a board of directors that is primarily composed of eligible beneficiaries.

''(c) REQUEST FOR PROPOSALS; SELECTION OF MEDICARE CONSUMER COALITIONS.—If the Commissioner elects to establish Medicare Consumer Coalitions under subsection (a), the Commissioner shall—

''(1) develop and disseminate a request for proposals to establish Medicare Consumer Coalitions in such areas as the Commissioner determines appropriate to assist in conducting the information programs described in subsection (a); and

''(2) select a proposal to establish a Medicare Consumer Coalition to conduct the information programs in each such area.

''(d) PAYMENT TO MEDICARE CONSUMER COALITIONS.—The Commissioner shall pay to each Medicare Consumer Coalition for which a proposal has been selected under subsection (c)(2) an amount equal to the sum of any costs incurred—

''(1) in conducting the information programs under subsection (e); and

''(2) in the hiring of staff to conduct the information programs under such subsection.

''(e) INFORMATION PROGRAMS.—The information programs described in this subsection are those activities that are the responsibilities of the Commissioner under clause (iii) of section 2202(a)(4) (relating to dissemination of information), clause (iv) of such section (relating to dissemination of appeals rights information), and clause (v) of such section (relating to beneficiary education programs). If the Commissioner selects a Medicare Consumer

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

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

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

''(B) QUALITY AND PERFORMANCE.—The quality and performance of each plan and program.

''(C) BENEFICIARY COSTS.—The costs to eligible beneficiaries enrolled under each plan and program.

''(D) CONSUMER SATISFACTION SURVEYS.—The results of consumer satisfaction surveys regarding each plan and program.

''(E) ADDITIONAL INFORMATION.—Such additional information as the Commissioner may prescribe.

''(2) INFORMATION STANDARDS.—If the Commissioner establishes Medicare Consumer Coalitions, the Commissioner shall develop standards to ensure that the information provided to eligible beneficiaries

under the information programs is complete, accurate, and uniform.

''(3) REVIEW OF INFORMATION.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Commissioner may prescribe the procedures and conditions under which a Medicare Consumer Coalition may disseminate information to eligible beneficiaries to ensure the coordination of Federal, State, and local outreach efforts to eligible beneficiaries.

''(B) DEADLINE.—Any information proposed to be furnished to eligible beneficiaries under this section shall be submitted to the Commissioner not later than 45 days before the date on which the information is to be disseminated to such beneficiaries.

''(4) CONSULTATION.—In order to conduct the information programs under subsection (a), Medicare Consumer Coalitions may consult with the Administrator of the Health Care Financing Administration, entities that offer Medicare+Choice plans, Medicare Prescription Plus plans, and public and private purchasers of health care benefits.

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

later than December 31, 2004, the Commissioner shall submit to the appropriate committees of Congress a report on the performance of any Medicare Consumer Coalitions, including an assessment of the effectiveness of the outreach efforts conducted under this section.

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

''(h) EFFECTIVE DATE.—If the Commissioner establishes Medicare Consumer Coalitions, the Commissioner should establish such Coalitions under this section in a manner that ensures that the information programs conducted by Medicare Consumer Coalitions begin not later than January 1, 2004.''.

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