

107TH CONGRESS
2D SESSION

S. 2729

To amend title XVIII of the Social Security Act to provide for a medicare voluntary prescription drug delivery program under the medicare program, to modernize the medicare program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JULY 15, 2002

Mr. GRASSLEY (for himself, Ms. SNOWE, Mr. JEFFORDS, Mr. BREAUX, Mr. HATCH, Ms. COLLINS, Ms. LANDRIEU, Mr. HUTCHINSON, and Mr. DOMENICI) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend title XVIII of the Social Security Act to provide for a medicare voluntary prescription drug delivery program under the medicare program, to modernize the medicare program, and for other purposes.

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

3 **SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECU-**
4 **RITY ACT; REFERENCES TO BIPA; TABLE OF**
5 **CONTENTS.**

6 (a) SHORT TITLE.—This Act may be cited as the
7 “21st Century Medicare Act”.

1 (b) AMENDMENTS TO SOCIAL SECURITY ACT.—Ex-
 2 cept as otherwise specifically provided, whenever in this
 3 Act an amendment is expressed in terms of an amendment
 4 to or repeal of a section or other provision, the reference
 5 shall be considered to be made to that section or other
 6 provision of the Social Security Act.

7 (c) BIPA; SECRETARY.—In this Act:

8 (1) BIPA.—The term “BIPA” means the
 9 Medicare, Medicaid, and SCHIP Benefits Improve-
 10 ment and Protection Act of 2000, as enacted into
 11 law by section 1(a)(6) of Public Law 106–554.

12 (2) SECRETARY.—The term “Secretary” means
 13 the Secretary of Health and Human Services.

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

Sec. 1. Short title; amendments to Social Security Act; references to BIPA;
 table of contents.

TITLE I—MEDICARE VOLUNTARY PRESCRIPTION DRUG
 DELIVERY PROGRAM

Sec. 101. Medicare voluntary prescription drug delivery program.

“PART D—VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

“Sec. 1860D. Definitions; treatment of references to provisions in
 Medicare+Choice program.

“Subpart 1—Establishment of Voluntary Prescription Drug Delivery Program

“Sec. 1860D–1. Establishment of voluntary prescription drug delivery pro-
 gram.

“Sec. 1860D–2. Enrollment under program.

“Sec. 1860D–3. Election of a Medicare Prescription Drug plan.

“Sec. 1860D–4. Providing information to beneficiaries.

“Sec. 1860D–5. Beneficiary protections.

“Sec. 1860D–6. Prescription drug benefits.

“Sec. 1860D–7. Requirements for entities offering Medicare Prescription
 Drug plans; establishment of standards.

“Subpart 2—Prescription Drug Delivery System

- “Sec. 1860D–10. Establishment of service areas.
- “Sec. 1860D–11. Publication of risk adjusters.
- “Sec. 1860D–12. Submission of bids for proposed Medicare Prescription Drug plans.
- “Sec. 1860D–13. Approval of proposed Medicare Prescription Drug plans.
- “Sec. 1860D–14. Computation of monthly standard coverage premiums.
- “Sec. 1860D–15. Computation of monthly national average premium.
- “Sec. 1860D–16. Payments to eligible entities offering Medicare Prescription Drug plans.
- “Sec. 1860D–17. Computation of beneficiary obligation.
- “Sec. 1860D–18. Collection of beneficiary obligation.
- “Sec. 1860D–19. Premium and cost-sharing subsidies for low-income individuals.
- “Sec. 1860D–20. Reinsurance payments for qualified prescription drug coverage.

“Subpart 3—Medicare Competitive Agency; Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund

- “Sec. 1860D–25. Establishment of Medicare Competitive Agency.
- “Sec. 1860D–26. Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.”.
- Sec. 102. Study and report on permitting part B only individuals to enroll in medicare voluntary prescription drug delivery program.
- Sec. 103. Additional requirements for annual financial report and oversight on medicare program.
- Sec. 104. Reference to medigap provisions.
- Sec. 105. Medicaid amendments.
- Sec. 106. Expansion of membership and duties of Medicare Payment Advisory Commission (MedPAC).
- Sec. 107. Miscellaneous administrative provisions.

TITLE II—OPTION FOR ENHANCED MEDICARE BENEFITS

- Sec. 201. Option for enhanced medicare benefits.

“PART E—ENHANCED MEDICARE BENEFITS

- “Sec. 1860E–1. Entitlement to elect to receive enhanced medicare benefits.
- “Sec. 1860E–2. Scope of enhanced medicare benefits.
- “Sec. 1860E–3. Payment of benefits.
- “Sec. 1860E–4. Eligible beneficiaries; election of enhanced medicare benefits; termination of election.
- “Sec. 1860E–5. Premium adjustments; late election penalty.”.
- Sec. 202. Rules relating to medigap policies that provide prescription drug coverage; establishment of enhanced medicare fee-for-service medigap policies.

TITLE III—MEDICARE+CHOICE COMPETITION

- Sec. 301. Annual calculation of benchmark amounts based on floor rates and local fee-for-service rates.
- Sec. 302. Application of comprehensive risk adjustment methodology.

- Sec. 303. Annual announcement of benchmark amounts and other payment factors.
- Sec. 304. Submission of bids by Medicare+Choice organizations.
- Sec. 305. Adjustment of plan bids; comparison of adjusted bid to benchmark; payment amount.
- Sec. 306. Determination of premium reductions, reduced cost-sharing, additional benefits, and beneficiary premiums.
- Sec. 307. Eligibility, election, and enrollment in competitive Medicare+Choice plans.
- Sec. 308. Benefits and beneficiary protections under competitive Medicare+Choice plans.
- Sec. 309. Payments to Medicare+Choice organizations for enhanced medicare benefits under part E based on risk-adjusted bids.
- Sec. 310. Separate payments to Medicare+Choice organizations for part D benefits.
- Sec. 311. Administration by the Medicare Competitive Agency.
- Sec. 312. Continued calculation of annual Medicare+Choice capitation rates.
- Sec. 313. Five-year extension of medicare cost contracts.
- Sec. 314. Effective date.

1 **TITLE I—MEDICARE VOLUNTARY**
 2 **PRESCRIPTION DRUG DELIV-**
 3 **ERY PROGRAM**

4 **SEC. 101. MEDICARE VOLUNTARY PRESCRIPTION DRUG DE-**
 5 **LIVERY PROGRAM.**

6 (a) ESTABLISHMENT.—Title XVIII (42 U.S.C. 1395
 7 et seq.) is amended by redesignating part D as part F
 8 and by inserting after part C the following new part:

9 “PART D—VOLUNTARY PRESCRIPTION DRUG DELIVERY
 10 PROGRAM

11 “DEFINITIONS; TREATMENT OF REFERENCES TO
 12 PROVISIONS IN MEDICARE+CHOICE PROGRAM

13 “SEC. 1860D. (a) DEFINITIONS.—In this part:

14 “(1) ADMINISTRATOR.—The term ‘Adminis-
 15 trator’ means the Administrator of the Medicare

1 Competitive Agency as established under section
2 1860D-25.

3 “(2) COVERED DRUG.—

4 “(A) IN GENERAL.—Except as provided in
5 subparagraph (B), the term ‘covered drug’
6 means—

7 “(i) a drug that may be dispensed
8 only upon a prescription and that is de-
9 scribed in clause (i) or (ii) of subparagraph
10 (A) of section 1927(k)(2); or

11 “(ii) a biological product or insulin de-
12 scribed in subparagraph (B) or (C) of such
13 section;

14 and such term includes a vaccine licensed under
15 section 351 of the Public Health Service Act
16 and any use of a covered outpatient drug for a
17 medically accepted indication (as defined in sec-
18 tion 1927(k)(6)).

19 “(B) EXCLUSIONS.—

20 “(i) IN GENERAL.—The term ‘covered
21 drug’ does not include drugs or classes of
22 drugs, or their medical uses, which may be
23 excluded from coverage or otherwise re-
24 stricted under section 1927(d)(2), other
25 than subparagraph (E) thereof (relating to

1 smoking cessation agents), or under sec-
2 tion 1927(d)(3).

3 “(ii) AVOIDANCE OF DUPLICATE COV-
4 ERAGE.—A drug prescribed for an indi-
5 vidual that would otherwise be a covered
6 drug under this part shall not be so con-
7 sidered if payment for such drug is avail-
8 able under part A or B (or under part E
9 for an eligible beneficiary who elects to re-
10 ceive enhanced medicare benefits under
11 that part), but shall be so considered if
12 such payment is not available because ben-
13 efits under part A or B (or part E, as ap-
14 plicable) have been exhausted.

15 “(3) ELIGIBLE BENEFICIARY.—The term ‘eligi-
16 ble beneficiary’ means an individual that is entitled
17 to benefits under part A and enrolled under part B.

18 “(4) ELIGIBLE ENTITY.—The term ‘eligible en-
19 tity’ means any risk-bearing entity that the Adminis-
20 trator determines to be appropriate to provide eligi-
21 ble beneficiaries with the benefits under a Medicare
22 Prescription Drug plan, including—

23 “(A) a pharmaceutical benefit management
24 company;

1 “(B) a wholesale or retail pharmacist deliv-
2 ery system;

3 “(C) an insurer (including an insurer that
4 offers medicare supplemental policies under sec-
5 tion 1882);

6 “(D) another entity; or

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

9 “(5) INITIAL COVERAGE LIMIT.—The term ‘ini-
10 tial coverage limit’ means the limit as established
11 under section 1860D–6(e)(3), or, in the case of cov-
12 erage that is not standard coverage, the comparable
13 limit (if any) established under the coverage.

14 “(6) MEDICARE+CHOICE ORGANIZATION;
15 MEDICARE+CHOICE PLAN.—The terms
16 ‘Medicare+Choice organization’ and
17 ‘Medicare+Choice plan’ have the meanings given
18 such terms in subsections (a)(1) and (b)(1), respec-
19 tively, of section 1859 (relating to definitions relat-
20 ing to Medicare+Choice organizations).

21 “(7) MEDICARE PRESCRIPTION DRUG PLAN.—
22 The term ‘Medicare Prescription Drug plan’ means
23 prescription drug coverage that is offered under a
24 policy, contract, or plan—

1 “(A) by an eligible entity pursuant to, and
2 in accordance with, a contract between the Ad-
3 ministrators and the entity under section
4 1860D-7(b); and

5 “(B) that has been approved under section
6 1860D-13.

7 “(8) PRESCRIPTION DRUG ACCOUNT.—The
8 term ‘Prescription Drug Account’ means the Pre-
9 scription Drug Account (as established under section
10 1860D-26) in the Federal Supplementary Medical
11 Insurance Trust Fund under section 1841.

12 “(9) QUALIFIED PRESCRIPTION DRUG COV-
13 ERAGE.—The term ‘qualified prescription drug cov-
14 erage’ means the coverage described in section
15 1860D-6(a)(1).

16 “(10) STANDARD COVERAGE.—The term
17 ‘standard coverage’ means the coverage described in
18 section 1860D-6(c).

19 “(b) APPLICATION OF MEDICARE+CHOICE PROVI-
20 SIONS UNDER THIS PART.—For purposes of applying pro-
21 visions of part C under this part with respect to a Medi-
22 care Prescription Drug plan and an eligible entity, unless
23 otherwise provided in this part such provisions shall be
24 applied as if—

1 “(1) any reference to a Medicare+Choice plan
2 included a reference to a Medicare Prescription
3 Drug plan;

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

6 “(3) any reference to a contract under section
7 1857 included a reference to a contract under sec-
8 tion 1860D-7(b); and

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

11 “Subpart 1—Establishment of Voluntary Prescription
12 Drug Delivery Program

13 “ESTABLISHMENT OF VOLUNTARY PRESCRIPTION DRUG
14 DELIVERY PROGRAM

15 “SEC. 1860D-1. (a) PROVISION OF BENEFIT.—

16 “(1) IN GENERAL.—The Administrator shall
17 provide for and administer a voluntary prescription
18 drug delivery program under which each eligible ben-
19 eficiary enrolled under this part shall be provided
20 with access to qualified prescription drug coverage
21 as follows:

22 “(A) MEDICARE+CHOICE PLAN.—An eligi-
23 ble beneficiary who is enrolled under this part
24 and enrolled in a Medicare+Choice plan offered
25 by a Medicare+Choice organization shall re-

1 ceive coverage of benefits under this part
2 through such plan if such plan provides quali-
3 fied prescription drug coverage.

4 “(B) MEDICARE PRESCRIPTION DRUG
5 PLAN.—An eligible beneficiary who is enrolled
6 under this part but is not enrolled in a
7 Medicare+Choice plan that provides qualified
8 prescription drug coverage shall receive cov-
9 erage of benefits under this part through enroll-
10 ment in a Medicare Prescription Drug plan that
11 is offered in the geographic area in which the
12 beneficiary resides.

13 “(2) VOLUNTARY NATURE OF PROGRAM.—
14 Nothing in this part shall be construed as requiring
15 an eligible beneficiary to enroll in the program under
16 this part.

17 “(3) SCOPE OF BENEFITS.—The program es-
18 tablished under this part shall provide for coverage
19 of all therapeutic classes of covered drugs.

20 “(4) PROGRAM TO BEGIN IN 2005.—The Admin-
21 istrator shall establish the program under this part
22 in a manner so that benefits are first provided for
23 months beginning with January 2005.

24 “(b) ACCESS TO ALTERNATIVE PRESCRIPTION DRUG
25 COVERAGE.—In the case of an eligible beneficiary who has

1 creditable prescription drug coverage (as defined in section
2 1860D–2(b)(1)(F)), such beneficiary—

3 “(1) may continue to receive such coverage and
4 not enroll under this part; and

5 “(2) pursuant to section 1860D–2(b)(1)(C), is
6 permitted to subsequently enroll under this part
7 without any penalty and obtain access to qualified
8 prescription drug coverage in the manner described
9 in subsection (a) if the beneficiary involuntarily loses
10 such coverage.

11 “(c) FINANCING.—The costs of providing benefits
12 under this part shall be payable from the Prescription
13 Drug Account.

14 “ENROLLMENT UNDER PROGRAM

15 “SEC. 1860D–2. (a) ESTABLISHMENT OF ENROLL-
16 MENT PROCESS.—

17 “(1) PROCESS SIMILAR TO PART B ENROLL-
18 MENT.—The Administrator shall establish a process
19 through which an eligible beneficiary (including an
20 eligible beneficiary enrolled in a Medicare+Choice
21 plan offered by a Medicare+Choice organization)
22 may make an election to enroll under this part. Such
23 process shall be similar to the process for enrollment
24 in part B under section 1837, including the deeming
25 provisions of such section.

1 “(2) CONDITION OF ENROLLMENT.—An eligible
2 beneficiary must be enrolled under this part in order
3 to be eligible to receive access to qualified prescrip-
4 tion drug coverage.

5 “(b) SPECIAL ENROLLMENT PROCEDURES.—

6 “(1) LATE ENROLLMENT PENALTY.—

7 “(A) INCREASE IN PREMIUM.—Subject to
8 the succeeding provisions of this paragraph, in
9 the case of an eligible beneficiary whose cov-
10 erage period under this part began pursuant to
11 an enrollment after the beneficiary’s initial en-
12 rollment period under part B (determined pur-
13 suant to section 1837(d)) and not pursuant to
14 the open enrollment period described in para-
15 graph (2), the Administrator shall establish
16 procedures for increasing the amount of the
17 monthly beneficiary obligation under section
18 1860D–17 applicable to such beneficiary by an
19 amount that the Administrator determines is
20 actuarially sound for each full 12-month period
21 (in the same continuous period of eligibility) in
22 which the eligible beneficiary could have been
23 enrolled under this part but was not so en-
24 rolled.

1 “(B) PERIODS TAKEN INTO ACCOUNT.—

2 For purposes of calculating any 12-month pe-
3 riod under subparagraph (A), there shall be
4 taken into account—

5 “(i) the months which elapsed be-
6 tween the close of the eligible beneficiary’s
7 initial enrollment period and the close of
8 the enrollment period in which the bene-
9 ficiary enrolled; and

10 “(ii) in the case of an eligible bene-
11 ficiary who reenrolls under this part, the
12 months which elapsed between the date of
13 termination of a previous coverage period
14 and the close of the enrollment period in
15 which the beneficiary reenrolled.

16 “(C) PERIODS NOT TAKEN INTO AC-
17 COUNT.—

18 “(i) IN GENERAL.—For purposes of
19 calculating any 12-month period under
20 subparagraph (A), subject to clauses (ii)
21 and (iii), there shall not be taken into ac-
22 count months for which the eligible bene-
23 ficiary can demonstrate that the bene-
24 ficiary had creditable prescription drug
25 coverage (as defined in subparagraph (F)).

1 “(ii) BENEFICIARY MUST INVOLUN-
2 TARILY LOSE COVERAGE.—Clause (i) shall
3 only apply with respect to coverage—

4 “(I) in the case of coverage de-
5 scribed in clause (ii) of subparagraph
6 (F), if the plan terminates, ceases to
7 provide, or reduces the value of the
8 prescription drug coverage under such
9 plan to below the actuarial value of
10 standard coverage (as determined
11 under section 1860D–6(f));

12 “(II) in the case of coverage de-
13 scribed in clause (i), (iii), or (iv) of
14 subparagraph (F), if the beneficiary
15 loses eligibility for such coverage; or

16 “(III) in the case of a beneficiary
17 with coverage described in clause (v)
18 of subparagraph (F), if the issuer of
19 the policy terminates coverage under
20 the policy.

21 “(iii) PARTIAL CREDIT FOR CERTAIN
22 MEDIGAP COVERAGE.—In the case of a
23 beneficiary that had creditable prescription
24 drug coverage described in subparagraph
25 (F)(v) that does not provide coverage of

1 the cost of prescription drugs the actuarial
2 value of which (as defined by the Adminis-
3 trator) to the beneficiary equals or exceeds
4 the actuarial value of standard coverage
5 (as determined under section 1860D–6(f)),
6 the Administrator shall determine a per-
7 centage of the period in which the bene-
8 ficiary had such creditable prescription
9 drug coverage that will be taken into ac-
10 count under subparagraph (B) (and not
11 considered to be such creditable prescrip-
12 tion drug coverage under clause (i)).

13 “(D) PERIODS TREATED SEPARATELY.—
14 Any increase in an eligible beneficiary’s monthly
15 beneficiary obligation under subparagraph (A)
16 with respect to a particular continuous period
17 of eligibility shall not be applicable with respect
18 to any other continuous period of eligibility
19 which the beneficiary may have.

20 “(E) CONTINUOUS PERIOD OF ELIGI-
21 BILITY.—

22 “(i) IN GENERAL.—Subject to clause
23 (ii), for purposes of this paragraph, an eli-
24 gible beneficiary’s ‘continuous period of eli-
25 gibility’ is the period that begins with the

1 first day on which the beneficiary is eligi-
2 ble to enroll under section 1836 and ends
3 with the beneficiary's death.

4 “(ii) SEPARATE PERIOD.—Any period
5 during all of which an eligible beneficiary
6 satisfied paragraph (1) of section 1836
7 and which terminated in or before the
8 month preceding the month in which the
9 beneficiary attained age 65 shall be a sepa-
10 rate ‘continuous period of eligibility’ with
11 respect to the beneficiary (and each such
12 period which terminates shall be deemed
13 not to have existed for purposes of subse-
14 quently applying this paragraph).

15 “(F) CREDITABLE PRESCRIPTION DRUG
16 COVERAGE DEFINED.—For purposes of this
17 part, the term ‘creditable prescription drug cov-
18 erage’ means any of the following:

19 “(i) MEDICAID PRESCRIPTION DRUG
20 COVERAGE.—Prescription drug coverage
21 under a medicaid plan under title XIX, in-
22 cluding through the Program of All-inclu-
23 sive Care for the Elderly (PACE) under
24 section 1934, through a social health main-
25 tenance organization (referred to in section

1 4104(c) of the Balanced Budget Act of
2 1997), and through a Medicare+Choice
3 project that demonstrates the application
4 of capitation payment rates for frail elderly
5 medicare beneficiaries through the use of
6 a interdisciplinary team and through the
7 provision of primary care services to such
8 beneficiaries by means of such a team at
9 the nursing facility involved, but only if the
10 coverage provides coverage of the cost of
11 prescription drugs the actuarial value of
12 which (as defined by the Administrator) to
13 the beneficiary equals or exceeds the actu-
14 arial value of standard coverage (as deter-
15 mined under section 1860D–6(f)).

16 “(ii) PRESCRIPTION DRUG COVERAGE
17 UNDER A GROUP HEALTH PLAN.—Any out-
18 patient prescription drug coverage under a
19 group health plan, including a health bene-
20 fits plan under the Federal Employees
21 Health Benefit Program under chapter 89
22 of title 5, United States Code, and a quali-
23 fied retiree prescription drug plan (as de-
24 fined in section 1860D–20(f)(1)), but only
25 if the coverage provides coverage of the

1 cost of prescription drugs the actuarial
2 value of which (as defined by the Adminis-
3 trator) to the beneficiary equals or exceeds
4 the actuarial value of standard coverage
5 (as determined under section 1860D–6(f)).

6 “(iii) STATE PHARMACEUTICAL AS-
7 SISTANCE PROGRAM.—Coverage of pre-
8 scription drugs under a State pharma-
9 ceutical assistance program, but only if the
10 coverage provides coverage of the cost of
11 prescription drugs the actuarial value of
12 which (as defined by the Administrator) to
13 the beneficiary equals or exceeds the actu-
14 arial value of standard coverage (as deter-
15 mined under section 1860D–6(f)).

16 “(iv) VETERANS’ COVERAGE OF PRE-
17 SCRIPTON DRUGS.—Coverage of prescrip-
18 tion drugs for veterans, and survivors and
19 dependents of veterans, under chapter 17
20 of title 38, United States Code, but only if
21 the coverage provides coverage of the cost
22 of prescription drugs the actuarial value of
23 which (as defined by the Administrator) to
24 the beneficiary equals or exceeds the actu-

1 arial value of standard coverage (as deter-
2 mined under section 1860D-6(f)).

3 “(v) PRESCRIPTION DRUG COVERAGE
4 UNDER MEDIGAP POLICIES.—Subject to
5 subparagraph (C)(iii), coverage under a
6 medicare supplemental policy under section
7 1882 that provides benefits for prescrip-
8 tion drugs (whether or not such coverage
9 conforms to the standards for packages of
10 benefits under section 1882(p)(1)).

11 “(2) OPEN ENROLLMENT PERIOD FOR CUR-
12 RENT BENEFICIARIES IN WHICH LATE ENROLLMENT
13 PROCEDURES DO NOT APPLY.—In the case of an in-
14 dividual who is an eligible beneficiary as of January
15 1, 2005, the Administrator shall establish proce-
16 dures under which such beneficiary may enroll under
17 this part during the open enrollment period without
18 the application of the late enrollment procedures es-
19 tablished under paragraph (1)(A). For purposes of
20 the preceding sentence, the open enrollment period
21 shall be the 7-month period that begins on April 1,
22 2004, and ends on November 30, 2004.

23 “(3) SPECIAL ENROLLMENT PERIOD FOR BENE-
24 FICIARIES WHO INVOLUNTARILY LOSE CREDITABLE
25 PRESCRIPTION DRUG COVERAGE.—

1 “(A) ESTABLISHMENT.—The Adminis-
2 trator shall establish a special open enrollment
3 period (as described in subparagraph (B)) for
4 an eligible beneficiary that loses creditable pre-
5 scription drug coverage.

6 “(B) SPECIAL OPEN ENROLLMENT PE-
7 RIOD.—The special open enrollment period de-
8 scribed in this subparagraph is the 63-day pe-
9 riod that begins—

10 “(i) in the case of a beneficiary with
11 coverage described in clause (ii) of para-
12 graph (1)(F), the date on which the plan
13 terminates, ceases to provide, or substan-
14 tially reduces (as defined by the Adminis-
15 trator) the value of the prescription drug
16 coverage under such plan;

17 “(ii) in the case of a beneficiary with
18 coverage described in clause (i), (iii), or
19 (iv) of paragraph (1)(F), the date on which
20 the beneficiary loses eligibility for such
21 coverage; or

22 “(iii) in the case of a beneficiary with
23 coverage described in clause (v) of para-
24 graph (1)(F), the date on which the issuer

1 of the policy terminates coverage under the
2 policy.

3 “(c) PERIOD OF COVERAGE.—

4 “(1) IN GENERAL.—Except as provided in para-
5 graph (2) and subject to paragraph (3), an eligible
6 beneficiary’s coverage under the program under this
7 part shall be effective for the period provided in sec-
8 tion 1838, as if that section applied to the program
9 under this part.

10 “(2) OPEN AND SPECIAL ENROLLMENT.—

11 “(A) OPEN ENROLLMENT.—An eligible
12 beneficiary who enrolls under the program
13 under this part pursuant to subsection (b)(2)
14 shall be entitled to the benefits under this part
15 beginning on January 1, 2005.

16 “(B) SPECIAL ENROLLMENT.—Subject to
17 paragraph (3), an eligible beneficiary who en-
18 rolls under the program under this part pursu-
19 ant to subsection (b)(3) shall be entitled to the
20 benefits under this part beginning on the first
21 day of the month following the month in which
22 such enrollment occurs.

23 “(3) LIMITATION.—Coverage under this part
24 shall not begin prior to January 1, 2005.

25 “(d) TERMINATION.—

1 “(1) IN GENERAL.—The causes of termination
2 specified in section 1838 shall apply to this part in
3 the same manner as such causes apply to part B.

4 “(2) COVERAGE TERMINATED BY TERMINATION
5 OF COVERAGE UNDER PARTS A OR B.—

6 “(A) IN GENERAL.—In addition to the
7 causes of termination specified in paragraph
8 (1), the Administrator shall terminate an indi-
9 vidual’s coverage under this part if the indi-
10 vidual is no longer enrolled in both parts A and
11 B.

12 “(B) EFFECTIVE DATE.—The termination
13 described in subparagraph (A) shall be effective
14 on the effective date of termination of coverage
15 under part A or (if earlier) under part B.

16 “(3) PROCEDURES REGARDING TERMINATION
17 OF A BENEFICIARY UNDER A PLAN.—The Adminis-
18 trator shall establish procedures for determining the
19 status of an eligible beneficiary’s enrollment under
20 this part if the beneficiary’s enrollment in a Medi-
21 care Prescription Drug plan offered by an eligible
22 entity under this part is terminated by the entity for
23 cause (pursuant to procedures established by the
24 Administrator under section 1860D–3(a)(1)).

25 “ELECTION OF A MEDICARE PRESCRIPTION DRUG PLAN

26 “SEC. 1860D–3. (a) IN GENERAL.—

1 “(1) PROCESS.—

2 “(A) ELECTION.—

3 “(i) IN GENERAL.—The Administrator
4 shall establish a process through which an
5 eligible beneficiary who is enrolled under
6 this part but not enrolled in a
7 Medicare+Choice plan offered by a
8 Medicare+Choice organization that pro-
9 vides qualified prescription drug
10 coverage—

11 “(I) shall make an election to en-
12 roll in any Medicare Prescription
13 Drug plan that is offered by an eligi-
14 ble entity and that serves the geo-
15 graphic area in which the beneficiary
16 resides; and

17 “(II) may make an annual elec-
18 tion to change the election under this
19 clause.

20 “(ii) CLARIFICATION REGARDING EN-
21 ROLLMENT.—The process established
22 under clause (i) shall include, in the case
23 of an eligible beneficiary who is enrolled
24 under this part but who has failed to make
25 an election of a Medicare Prescription

1 Drug plan in an area, for the enrollment
2 in the Medicare Prescription Drug plan
3 with the lowest monthly premium that is
4 available in the area.

5 “(B) REQUIREMENTS FOR PROCESS.—In
6 establishing the process under subparagraph
7 (A), the Administrator shall—

8 “(i) use rules similar to the rules for
9 enrollment, disenrollment, and termination
10 of enrollment with a Medicare+Choice
11 plan under section 1851, including—

12 “(I) the establishment of special
13 election periods under subsection
14 (e)(4) of such section; and

15 “(II) the application of the guar-
16 anteed issue and renewal provisions of
17 section 1851(g) (other than clause (i)
18 and the second sentence of clause (ii)
19 of paragraph (3)(C), relating to de-
20 fault enrollment); and

21 “(ii) coordinate enrollments,
22 disenrollments, and terminations of enroll-
23 ment under part C with enrollments,
24 disenrollments, and terminations of enroll-
25 ment under this part.

1 “(2) FIRST ENROLLMENT PERIOD FOR PLAN
2 ENROLLMENT.—The process developed under para-
3 graph (1) shall ensure that eligible beneficiaries who
4 enroll under this part during the open enrollment
5 period under section 1860D–2(b)(2) are permitted
6 to elect an eligible entity prior to January 1, 2005,
7 in order to ensure that coverage under this part is
8 effective as of such date.

9 “(b) ENROLLMENT IN A MEDICARE+CHOICE
10 PLAN.—

11 “(1) IN GENERAL.—An eligible beneficiary who
12 is enrolled under this part and enrolled in a
13 Medicare+Choice plan offered by a
14 Medicare+Choice organization that provides quali-
15 fied prescription drug coverage shall receive access
16 to such coverage under this part through such plan.

17 “(2) RULES.—Enrollment in a
18 Medicare+Choice plan is subject to the rules for en-
19 rollment in such plan under section 1851.

20 “PROVIDING INFORMATION TO BENEFICIARIES

21 “SEC. 1860D–4. (a) ACTIVITIES.—

22 “(1) IN GENERAL.—The Administrator shall
23 conduct activities that are designed to broadly dis-
24 seminate information to eligible beneficiaries (and
25 prospective eligible beneficiaries) regarding the cov-
26 erage provided under this part.

1 “(2) SPECIAL RULE FOR FIRST ENROLLMENT
2 UNDER THE PROGRAM.—The activities described in
3 paragraph (1) shall ensure that eligible beneficiaries
4 are provided with such information at least 30 days
5 prior to the first enrollment period described in sec-
6 tion 1860D–3(a)(2).

7 “(b) REQUIREMENTS.—

8 “(1) IN GENERAL.—The activities described in
9 subsection (a) shall—

10 “(A) be similar to the activities performed
11 by the Administrator under section 1851(d);

12 “(B) be coordinated with the activities per-
13 formed by—

14 “(i) the Administrator under such sec-
15 tion; and

16 “(ii) the Secretary under section
17 1804; and

18 “(C) provide for the dissemination of infor-
19 mation comparing the plans offered by eligible
20 entities under this part that are available to eli-
21 gible beneficiaries residing in an area.

22 “(2) COMPARATIVE INFORMATION.—The com-
23 parative information described in paragraph (1)(C)
24 shall include a comparison of the following:

1 “(A) BENEFITS.—The benefits provided
2 under the plan and the formularies and appeals
3 processes under the plan.

4 “(B) QUALITY AND PERFORMANCE.—To
5 the extent available, the quality and perform-
6 ance of the eligible entity offering the plan.

7 “(C) BENEFICIARY COST-SHARING.—The
8 cost-sharing required of eligible beneficiaries
9 under the plan.

10 “(D) CONSUMER SATISFACTION SUR-
11 VEYS.—To the extent available, the results of
12 consumer satisfaction surveys regarding the
13 plan and the eligible entity offering such plan.

14 “(E) ADDITIONAL INFORMATION.—Such
15 additional information as the Administrator
16 may prescribe.

17 “BENEFICIARY PROTECTIONS

18 “SEC. 1860D-5. (a) DISSEMINATION OF INFORMA-
19 TION.—

20 “(1) GENERAL INFORMATION.—An eligible enti-
21 ty offering a Medicare Prescription Drug plan shall
22 disclose, in a clear, accurate, and standardized form
23 to each enrollee at the time of enrollment and at
24 least annually thereafter, the information described
25 in section 1852(c)(1) relating to such plan. Such in-
26 formation includes the following:

1 “(A) Access to covered drugs, including ac-
2 cess through pharmacy networks.

3 “(B) How any formulary used by the enti-
4 ty functions.

5 “(C) Copayments, coinsurance, and de-
6 ductible requirements.

7 “(D) Grievance and appeals procedures.

8 “(2) DISCLOSURE UPON REQUEST OF GENERAL
9 COVERAGE, UTILIZATION, AND GRIEVANCE INFORMA-
10 TION.—Upon request of an individual eligible to en-
11 roll in a Medicare Prescription Drug plan, the eligi-
12 ble entity offering such plan shall provide the infor-
13 mation described in section 1852(c)(2) to such indi-
14 vidual.

15 “(3) RESPONSE TO BENEFICIARY QUESTIONS.—
16 An eligible entity offering a Medicare Prescription
17 Drug plan shall have a mechanism for providing spe-
18 cific information to enrollees upon request, including
19 information on the coverage of specific drugs and
20 changes in its formulary on a timely basis.

21 “(4) CLAIMS INFORMATION.—An eligible entity
22 offering a Medicare Prescription Drug plan must
23 furnish to enrolled individuals in a form easily un-
24 derstandable to such individuals an explanation of
25 benefits (in accordance with section 1806(a) or in a

1 comparable manner) and a notice of the benefits in
2 relation to initial coverage limit and annual out-of-
3 pocket limit for the current year, whenever prescrip-
4 tion drug benefits are provided under this part (ex-
5 cept that such notice need not be provided more
6 often than monthly).

7 “(5) APPROVAL OF MARKETING MATERIAL AND
8 APPLICATION FORMS.—The provisions of section
9 1851(h) shall apply to marketing material and appli-
10 cation forms under this part in the same manner as
11 such provisions apply to marketing material and ap-
12 plication forms under part C.

13 “(b) ACCESS TO COVERED DRUGS.—

14 “(1) ACCESS TO NEGOTIATED PRICES FOR PRE-
15 SCRIPTION DRUGS.—An eligible entity offering a
16 Medicare Prescription Drug plan shall issue such a
17 card (or other technology) that may be used by an
18 enrolled beneficiary to assure access to negotiated
19 prices under section 1860D–6(e) for the purchase of
20 prescription drugs for which coverage is not other-
21 wise provided under the Medicare Prescription Drug
22 plan.

23 “(2) ASSURING PHARMACY ACCESS.—

24 “(A) IN GENERAL.—An eligible entity of-
25 fering a Medicare Prescription Drug plan shall

1 secure the participation in its network of a suf-
2 ficient number of pharmacies that dispense
3 (other than by mail order) drugs directly to pa-
4 tients to ensure convenient access (as deter-
5 mined by the Administrator and including ade-
6 quate emergency access) for enrolled bene-
7 ficiaries, in accordance with standards estab-
8 lished under section 1860D-7(f) that ensure
9 such convenient access. Such standards shall
10 take into account reasonable distances to phar-
11 macy services in both urban and rural areas.

12 “(B) USE OF POINT-OF-SERVICE SYS-
13 TEM.—An eligible entity offering a Medicare
14 Prescription Drug plan shall establish an op-
15 tional point-of-service method of operation
16 under which—

17 “(i) the plan provides access to any or
18 all pharmacies that are not participating
19 pharmacies in its network; and

20 “(ii) the plan may charge beneficiaries
21 through adjustments in copayments any
22 additional costs associated with the point-
23 of-service option.

1 The additional copayments so charged shall not
2 count toward the application of section 1860D–
3 6(c).

4 “(3) REQUIREMENTS ON DEVELOPMENT AND
5 APPLICATION OF FORMULARIES.—If an eligible enti-
6 ty offering a Medicare Prescription Drug plan uses
7 a formulary, the following requirements must be
8 met:

9 “(A) PHARMACY AND THERAPEUTIC (P&T)
10 COMMITTEE.—The eligible entity must establish
11 a pharmacy and therapeutic committee that de-
12 velops and reviews the formulary. Such com-
13 mittee shall include at least one practicing phy-
14 sician and at least one practicing pharmacist
15 both with expertise in the care of elderly or dis-
16 abled persons and a majority of its members
17 shall consist of individuals who are a practicing
18 physician or a practicing pharmacist (or both).

19 “(B) FORMULARY DEVELOPMENT.—In de-
20 veloping and reviewing the formulary, the com-
21 mittee shall base clinical decisions on the
22 strength of scientific evidence and standards of
23 practice, including assessing peer-reviewed med-
24 ical literature, such as randomized clinical
25 trials, pharmacoeconomic studies, outcomes re-

1 search data, and such other information as the
2 committee determines to be appropriate.

3 “(C) INCLUSION OF DRUGS IN ALL THERA-
4 PEUTIC CATEGORIES.—The formulary must in-
5 clude drugs within each therapeutic category
6 and class of covered outpatient drugs (although
7 not necessarily for all drugs within such cat-
8 egories and classes).

9 “(D) PROVIDER EDUCATION.—The com-
10 mittee shall establish policies and procedures to
11 educate and inform health care providers con-
12 cerning the formulary.

13 “(E) NOTICE BEFORE REMOVING DRUGS
14 FROM FORMULARY.—Any removal of a drug
15 from a formulary shall take effect only after ap-
16 propriate notice is made available to bene-
17 ficiaries and physicians.

18 “(F) APPEALS AND EXCEPTIONS TO APPLI-
19 CATION.—The eligible entity must have, as part
20 of the appeals process under subsection (e)(3),
21 a process for timely appeals for denials of cov-
22 erage based on such application of the for-
23 mulary.

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

4 “(1) IN GENERAL.—An eligible entity shall have
5 in place the following with respect to covered drugs:

6 “(A) A cost-effective drug utilization man-
7 agement program, including incentives to re-
8 duce costs when appropriate.

9 “(B) Quality assurance measures to reduce
10 medical errors and adverse drug interactions,
11 which—

12 “(i) shall include a medication therapy
13 management program described in para-
14 graph (2); and

15 “(ii) may include beneficiary edu-
16 cation programs, counseling, medication
17 refill reminders, and special packaging.

18 “(C) A program to control fraud, abuse,
19 and waste.

20 “(2) MEDICATION THERAPY MANAGEMENT PRO-
21 GRAM.—

22 “(A) IN GENERAL.—A medication therapy
23 management program described in this para-
24 graph is a program of drug therapy manage-
25 ment and medication administration that is de-

1 signed to assure, with respect to beneficiaries
2 with chronic diseases (such as diabetes, asthma,
3 hypertension, and congestive heart failure) or
4 multiple prescriptions, that covered outpatient
5 drugs under the prescription drug plan are ap-
6 propriately used to achieve therapeutic goals
7 and reduce the risk of adverse events, including
8 adverse drug interactions.

9 “(B) ELEMENTS.—Such program may
10 include—

11 “(i) enhanced beneficiary under-
12 standing of such appropriate use through
13 beneficiary education, counseling, and
14 other appropriate means;

15 “(ii) increased beneficiary adherence
16 with prescription medication regimens
17 through medication refill reminders, special
18 packaging, and other appropriate means;
19 and

20 “(iii) detection of patterns of overuse
21 and underuse of prescription drugs.

22 “(C) DEVELOPMENT OF PROGRAM IN CO-
23 OPERATION WITH LICENSED PHARMACISTS.—
24 The program shall be developed in cooperation

1 with licensed and practicing pharmacists and
2 physicians.

3 “(D) CONSIDERATIONS IN PHARMACY
4 FEES.—The eligible entity offering a Medicare
5 Prescription Drug plan shall take into account,
6 in establishing fees for pharmacists and others
7 providing services under the medication therapy
8 management program, the resources and time
9 used in implementing the program.

10 “(3) PUBLIC DISCLOSURE OF PHARMACEUTICAL
11 PRICES FOR EQUIVALENT DRUGS.—The eligible enti-
12 ty offering a Medicare Prescription Drug plan shall
13 provide that each pharmacy or other dispenser that
14 arranges for the dispensing of a covered drug shall
15 inform the beneficiary at the time of purchase of the
16 drug of any differential between the price of the pre-
17 scribed drug to the enrollee and the price of the low-
18 est cost generic drug covered under the plan that is
19 therapeutically equivalent and bioequivalent.

20 “(d) GRIEVANCE MECHANISM.—An eligible entity
21 shall provide meaningful procedures for hearing and re-
22 solving grievances between the eligible entity (including
23 any entity or individual through which the eligible entity
24 provides covered benefits) and enrollees in a Medicare Pre-

1 scription Drug plan offered by the eligible entity in accord-
2 ance with section 1852(f).

3 “(e) COVERAGE DETERMINATIONS, RECONSIDER-
4 ATIONS, AND APPEALS.—

5 “(1) IN GENERAL.—An eligible entity shall
6 meet the requirements of section 1852(g) with re-
7 spect to covered benefits under the Medicare Pre-
8 scription Drug plan it offers under this part in the
9 same manner as such requirements apply to a
10 Medicare+Choice organization with respect to bene-
11 fits it offers under a Medicare+Choice plan under
12 part C.

13 “(2) REQUEST FOR REVIEW OF TIERED FOR-
14 MULARY DETERMINATIONS.—In the case of a Medi-
15 care Prescription Drug plan offered by an eligible
16 entity that provides for tiered cost-sharing for cov-
17 ered drugs included within a formulary and provides
18 lower cost-sharing for preferred drugs included with-
19 in the formulary, an individual who is enrolled in the
20 plan may request coverage of a nonpreferred drug
21 under the terms applicable for preferred drugs if the
22 prescribing physician determines that the preferred
23 drug for treatment of the same condition is not as
24 effective for the individual or has adverse effects for
25 the individual.

1 “(3) APPEALS OF FORMULARY DETERMINA-
2 TIONS.—

3 “(A) IN GENERAL.—Subject to subpara-
4 graph (B), consistent with the requirements of
5 section 1852(g), an eligible entity shall establish
6 a process for individuals to appeal formulary
7 determinations.

8 “(B) FORMULARY DETERMINATIONS.—An
9 individual who is enrolled in a Medicare Pre-
10 scription Drug plan offered by an eligible entity
11 may appeal to obtain coverage for a covered
12 drug that is not on a formulary of the eligible
13 entity if the prescribing physician determines
14 that the formulary drug for treatment of the
15 same condition is not as effective for the indi-
16 vidual or has adverse effects for the individual.

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

23 “(g) UNIFORM PREMIUM.—An eligible entity shall
24 ensure that the monthly premium for a Medicare Prescrip-

1 tion Drug plan charged under this part is the same for
 2 all eligible beneficiaries enrolled in the plan.

3 “PRESCRIPTION DRUG BENEFITS

4 “SEC. 1860D–6. (a) REQUIREMENTS.—

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

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

12 “(B) ACTUARIALLY EQUIVALENT COV-
 13 ERAGE WITH ACCESS TO NEGOTIATED
 14 PRICES.—Coverage of covered drugs which
 15 meets the alternative coverage requirements of
 16 subsection (d) and access to negotiated prices
 17 under subsection (e), but only if it is approved
 18 by the Administrator, as provided under sub-
 19 section (d).

20 “(2) PERMITTING ADDITIONAL PRESCRIPTION
 21 DRUG COVERAGE.—

22 “(A) IN GENERAL.—Subject to subpara-
 23 graph (B) and section 1860D–13(c)(2), nothing
 24 in this part shall be construed as preventing
 25 qualified prescription drug coverage from in-

1 including coverage of covered drugs that exceeds
2 the coverage required under paragraph (1).

3 “(B) REQUIREMENT.—An eligible entity
4 may not offer a Medicare Prescription Drug
5 plan that provides additional benefits pursuant
6 to subparagraph (A) in an area unless the eligi-
7 ble entity offering such plan also offers a Medi-
8 care Prescription Drug plan in the area that
9 only provides the coverage of prescription drugs
10 that is required under subsection (a)(1).

11 “(3) COST CONTROL MECHANISMS.—In pro-
12 viding qualified prescription drug coverage, the enti-
13 ty offering the Medicare Prescription Drug plan or
14 the Medicare+Choice plan may use cost control
15 mechanisms that are customarily used in employer-
16 sponsored health care plans that offer coverage for
17 prescription drugs, including the use of formularies,
18 tiered copayments, selective contracting with pro-
19 viders of prescription drugs, and mail order phar-
20 macies.

21 “(b) APPLICATION OF SECONDARY PAYOR PROVI-
22 SIONS.—The provisions of section 1852(a)(4) shall apply
23 under this part in the same manner as they apply under
24 part C.

1 “(c) STANDARD COVERAGE.—For purposes of this
2 part and part C, the term ‘standard coverage’ means cov-
3 erage of covered drugs that meets the following require-
4 ments:

5 “(1) DEDUCTIBLE.—

6 “(A) IN GENERAL.—The coverage has an
7 annual deductible—

8 “(i) for 2005, that is equal to \$250;

9 or

10 “(ii) for a subsequent year, that is
11 equal to the amount specified under this
12 paragraph for the previous year increased
13 by the percentage specified in paragraph
14 (5) for the year involved.

15 “(B) ROUNDING.—Any amount determined
16 under subparagraph (A)(ii) that is not a mul-
17 tiple of \$1 shall be rounded to the nearest mul-
18 tiple of \$1.

19 “(2) LIMITS ON COST-SHARING.—The coverage
20 has cost-sharing (for costs above the annual deduct-
21 ible specified in paragraph (1) and up to the initial
22 coverage limit under paragraph (3)) that is equal to
23 50 percent or that is actuarially consistent (using
24 processes established under subsection (f)) with an

1 average expected payment of 50 percent of such
2 costs.

3 “(3) INITIAL COVERAGE LIMIT.—

4 “(A) IN GENERAL.—Subject to paragraph
5 (4), the coverage has an initial coverage limit
6 on the maximum costs that may be recognized
7 for payment purposes (above the annual deduct-
8 ible)—

9 “(i) for 2005, that is equal to \$3,450;

10 or

11 “(ii) for a subsequent year, that is
12 equal to the amount specified in this para-
13 graph for the previous year, increased by
14 the annual percentage increase described
15 in paragraph (5) for the year involved.

16 “(B) ROUNDING.—Any amount determined
17 under subparagraph (A)(ii) that is not a mul-
18 tiple of \$1 shall be rounded to the nearest mul-
19 tiple of \$1.

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

22 “(A) IN GENERAL.—Notwithstanding para-
23 graph (3), the coverage provides benefits with
24 cost-sharing that is equal to 10 percent after
25 the individual has incurred costs (as described

1 in subparagraph (C)) for covered drugs in a
2 year equal to the annual out-of-pocket limit
3 specified in subparagraph (B).

4 “(B) ANNUAL OUT-OF-POCKET LIMIT.—

5 “(i) IN GENERAL.—For purposes of
6 this part, the ‘annual out-of-pocket limit’
7 specified in this subparagraph—

8 “(I) for 2005, is equal to \$3,700;

9 or

10 “(II) for a subsequent year, is
11 equal to the amount specified in the
12 subparagraph for the previous year,
13 increased by the annual percentage in-
14 crease described in paragraph (5) for
15 the year involved.

16 “(ii) ROUNDING.—Any amount deter-
17 mined under clause (i)(II) that is not a
18 multiple of \$1 shall be rounded to the
19 nearest multiple of \$1.

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

22 “(i) incurred costs shall only include
23 costs incurred for the annual deductible
24 (described in paragraph (1)), cost-sharing
25 (described in paragraph (2)), and amounts

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

4 “(ii) such costs shall be treated as in-
5 curred only if they are paid by the indi-
6 vidual (or by another individual, such as a
7 family member, on behalf of the indi-
8 vidual), under section 1860D–19, or under
9 title XIX and the individual (or other indi-
10 vidual) is not reimbursed through insur-
11 ance or otherwise, a group health plan, or
12 other third-party payment arrangement for
13 such costs.

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

22 “(d) ALTERNATIVE COVERAGE REQUIREMENTS.—A
23 Medicare Prescription Drug plan or Medicare+Choice
24 plan may provide a different prescription drug benefit de-
25 sign from the standard coverage described in subsection

1 (c) so long as the Administrator determines (based on an
2 actuarial analysis by the Administrator) that the following
3 requirements are met and the plan applies for, and re-
4 ceives, the approval of the Administrator for such benefit
5 design:

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

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

13 “(B) ASSURING EQUIVALENT UNSUB-
14 SIDIZED VALUE OF COVERAGE.—The unsub-
15 sidized value of the coverage is at least equal to
16 the unsubsidized value of standard coverage.
17 For purposes of this subparagraph, the unsub-
18 sidized value of coverage is the amount by
19 which the actuarial value of the coverage (as
20 determined under subsection (f)) exceeds the
21 actuarial value of the amounts associated with
22 the application of section 1860D–17(c) and re-
23 insurance payments under section 1860D–20
24 with respect to such coverage.

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

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

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

19 “(e) ACCESS TO NEGOTIATED PRICES.—

20 “(1) ACCESS.—

21 “(A) IN GENERAL.—Under qualified pre-
22 scription drug coverage offered by an eligible
23 entity or a Medicare+Choice organization, the
24 entity or organization shall provide beneficiaries
25 with access to negotiated prices (including ap-

1 plicable discounts) used for payment for covered
2 drugs, regardless of the fact that no benefits
3 may be payable under the coverage with respect
4 to such drugs because of the application of the
5 deductible, any cost-sharing, or an initial cov-
6 erage limit (described in subsection (c)(3)).

7 “(B) MEDICAID RELATED PROVISIONS.—
8 Insofar as a State elects to provide medical as-
9 sistance under title XIX for a drug based on
10 the prices negotiated under a Medicare Pre-
11 scription Drug plan under this part, the re-
12 quirements of section 1927 shall not apply to
13 such drugs. The prices negotiated under a
14 Medicare Prescription Drug plan with respect
15 to covered drugs, under a Medicare+Choice
16 plan with respect to such drugs, or under a
17 qualified retiree prescription drug plan (as de-
18 fined in section 1860D–20(f)(1)) with respect
19 to such drugs, on behalf of eligible beneficiaries,
20 shall (notwithstanding any other provision of
21 law) not be taken into account for the purposes
22 of establishing the best price under section
23 1927(c)(1)(C).

24 “(2) CARDS OR OTHER TECHNOLOGY.—In pro-
25 viding the access under paragraph (1), the eligible

1 entity or Medicare+Choice organization shall issue
2 a card or use other technology pursuant to section
3 1860D–5(b)(1).

4 “(f) ACTUARIAL VALUATION; DETERMINATION OF
5 ANNUAL PERCENTAGE INCREASES.—

6 “(1) PROCESSES.—For purposes of this section,
7 the Administrator shall establish processes and
8 methods—

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

11 “(i) an actuarial valuation of standard
12 coverage and of the reinsurance payments
13 under section 1860D–20;

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

16 “(iii) applying the same methodology
17 for determinations of alternative coverage
18 under subsection (d) as is used with re-
19 spect to determinations of standard cov-
20 erage under subsection (c); and

21 “(B) for determining annual percentage in-
22 creases described in subsection (c)(5).

23 “(2) USE OF OUTSIDE ACTUARIES.—Under the
24 processes under paragraph (1)(A), eligible entities
25 and Medicare+Choice organizations may use actu-

1 arial opinions certified by independent, qualified ac-
 2 tuaries to establish actuarial values, but the Admin-
 3 istrator shall determine whether such actuarial val-
 4 ues meet the requirements under subsection (c)(1).

5 “REQUIREMENTS FOR ENTITIES OFFERING MEDICARE
 6 PRESCRIPTION DRUG PLANS; ESTABLISHMENT OF
 7 STANDARDS

8 “SEC. 1860D–7. (a) GENERAL REQUIREMENTS.—An
 9 eligible entity offering a Medicare Prescription Drug plan
 10 shall meet the following requirements:

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

16 “(2) ASSUMPTION OF FINANCIAL RISK.—

17 “(A) IN GENERAL.—Subject to subpara-
 18 graph (B) and section 1860D–20, the entity as-
 19 sumes financial risk on a prospective basis for
 20 the benefits that it offers under a Medicare
 21 Prescription Drug plan and that is not covered
 22 under such section or section 1860D–16.

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

1 “(3) SOLVENCY FOR UNLICENSED ENTITIES.—

2 In the case of an eligible entity that is not described
3 in paragraph (1) and for which a waiver has been
4 approved under subsection (c), such entity shall
5 meet solvency standards established by the Adminis-
6 trator under subsection (d).

7 “(b) CONTRACT REQUIREMENTS.—The Adminis-
8 trator shall not permit an eligible beneficiary to elect a
9 Medicare Prescription Drug plan offered by an eligible en-
10 tity under this part, and the entity shall not be eligible
11 for payments under section 1860D–16 or 1860D–20, un-
12 less the Administrator has entered into a contract under
13 this subsection with the entity with respect to the offering
14 of such plan. Such a contract with an entity may cover
15 more than 1 Medicare Prescription Drug plan. Such con-
16 tract shall provide that the entity agrees to comply with
17 the applicable requirements and standards of this part and
18 the terms and conditions of payment as provided for in
19 this part.

20 “(c) WAIVER OF CERTAIN REQUIREMENTS IN ORDER
21 TO ENSURE BENEFICIARY CHOICE.—

22 “(1) IN GENERAL.—In the case of an eligible
23 entity that seeks to offer a Medicare Prescription
24 Drug plan in a State, the Administrator shall waive
25 the requirement of subsection (a)(1) that the entity

1 be licensed in that State if the Administrator deter-
2 mines, based on the application and other evidence
3 presented to the Administrator, that any of the
4 grounds for approval of the application described in
5 paragraph (2) have been met.

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

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

17 “(4) REFERENCES TO CERTAIN PROVISIONS.—
18 For purposes of this subsection, in applying the pro-
19 visions of section 1855(a)(2) under this subsection
20 to Medicare Prescription Drug plans and eligible
21 entities—

22 “(A) any reference to a waiver application
23 under section 1855 shall be treated as a ref-
24 erence to a waiver application under paragraph
25 (1); and

1 “(B) any reference to solvency standards
2 were treated as a reference to solvency stand-
3 ards established under subsection (d).

4 “(d) SOLVENCY STANDARDS FOR NON-LICENSED
5 ENTITIES.—

6 “(1) ESTABLISHMENT AND PUBLICATION.—The
7 Administrator, in consultation with the National As-
8 sociation of Insurance Commissioners, shall establish
9 and publish, by not later than January 1, 2004, fi-
10 nancial solvency and capital adequacy standards for
11 entities described in paragraph (2).

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

21 “(e) LICENSURE DOES NOT SUBSTITUTE FOR OR
22 CONSTITUTE CERTIFICATION.—The fact that an entity is
23 licensed in accordance with subsection (a)(1) or has a
24 waiver application approved under subsection (c) does not

1 deem the eligible entity to meet other requirements im-
2 posed under this part for an eligible entity.

3 “(f) OTHER STANDARDS.—The Administrator shall
4 establish by regulation other standards (not described in
5 subsection (d)) for eligible entities and Medicare Prescrip-
6 tion Drug plans consistent with, and to carry out, this
7 part. The Administrator shall publish such regulations by
8 January 1, 2004.

9 “(g) PERIODIC REVIEW AND REVISION OF STAND-
10 ARDS.—The Administrator shall periodically review the
11 standards established under this section and, based on
12 such review, may revise such standards if the Adminis-
13 trator determines such revision to be appropriate.

14 “(h) RELATION TO STATE LAWS.—

15 “(1) IN GENERAL.—The standards established
16 under this part shall supersede any State law or reg-
17 ulation (including standards described in paragraph
18 (2)) with respect to Medicare Prescription Drug
19 plans which are offered by eligible entities under this
20 part—

21 “(A) to the extent such law or regulation
22 is inconsistent with such standards; and

23 “(B) in the same manner as such laws and
24 regulations are superseded under section
25 1856(b)(3).

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

4 “(A) Benefit requirements.

5 “(B) Requirements relating to inclusion or
 6 treatment of providers.

7 “(C) Coverage determinations (including
 8 related appeals and grievance processes).

9 “(3) PROHIBITION OF STATE IMPOSITION OF
 10 PREMIUM TAXES.—No State may impose a premium
 11 tax or similar tax with respect to—

12 “(A) premiums paid to the Administrator
 13 for Medicare Prescription Drug plans under
 14 this part; or

15 “(B) any payments made by the Adminis-
 16 trator under this part to an eligible entity offer-
 17 ing such a plan.

18 “Subpart 2—Prescription Drug Delivery System

19 “ESTABLISHMENT OF SERVICE AREAS

20 “SEC. 1860D–10. (a) ESTABLISHMENT.—

21 “(1) INITIAL ESTABLISHMENT.—Not later than
 22 April 15, 2004, the Administrator shall establish
 23 and publish the service areas in which Medicare Pre-
 24 scription Drug plans may offer benefits under this
 25 part.

1 “(2) PERIODIC REVIEW AND REVISION OF
2 SERVICE AREAS.—The Administrator shall periodically review the service areas applicable under this
3 section and, based on such review, may revise such
4 service areas if the Administrator determines such
5 revision to be appropriate.
6

7 “(b) REQUIREMENTS FOR ESTABLISHMENT OF
8 SERVICE AREAS.—

9 “(1) IN GENERAL.—The Administrator shall establish the service areas under subsection (a) in a
10 manner that—
11

12 “(A) maximizes the availability of Medicare Prescription Drug plans to eligible beneficiaries; and
13
14

15 “(B) minimizes the ability of eligible entities offering such plans to favorably select eligible beneficiaries.
16
17

18 “(2) SERVICE AREA MAY NOT BE SMALLER THAN A STATE.—A service area established under
19 subsection (a) may not be smaller than a State.
20

21 “PUBLICATION OF RISK ADJUSTERS

22 “SEC. 1860D–11. (a) PUBLICATION.—Not later than
23 April 15 of each year (beginning in 2004), the Administrator shall publish the risk adjusters established under
24 subsection (b) to be used in computing—
25

1 “(1) under section 1860D–16(a) the amount of
2 payment to Medicare Prescription Drug plans in the
3 subsequent year; and

4 “(2) under section 1853(k)(2) the amount of
5 payment to Medicare+Choice organizations that
6 offer qualified prescription drug coverage in the sub-
7 sequent year.

8 “(b) ESTABLISHMENT OF RISK ADJUSTERS.—

9 “(1) IN GENERAL.—Subject to paragraph (2),
10 the Administrator shall establish an appropriate
11 methodology for adjusting the amount of payment to
12 Medicare Prescription Drug plans computed under
13 section 1860D–16(a) to take into account, in a
14 budget neutral manner, variation in costs based on
15 the differences in actuarial risk of different enrollees
16 being served.

17 “(2) CONSIDERATIONS.—In establishing the
18 methodology under paragraph (1), the Administrator
19 may take into account the similar methodologies
20 used under section 1853(a)(3) to adjust payments to
21 Medicare+Choice organizations (with respect to en-
22 hanced medicare benefits under part E).

23 “SUBMISSION OF BIDS FOR PROPOSED MEDICARE
24 PRESCRIPTION DRUG PLANS

25 “SEC. 1860D–12. (a) IN GENERAL.—Each eligible
26 entity that intends to offer a Medicare Prescription Drug

1 plan in a year (beginning with 2005) shall submit to the
2 Administrator, at such time and in such manner as the
3 Administrator may specify, such information as the Ad-
4 ministrator may require, including the information de-
5 scribed in subsection (b).

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

9 “(1) A description of the benefits under the
10 plan (as required under section 1860D–6).

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

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

16 “(A) the actuarial basis for such premium;
17 and

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

21 “(C) the reduction in such bid and pre-
22 mium resulting from the payments associated
23 with section 1860D–16(c) and payments pro-
24 vided under section 1860D–20.

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

1 “(5) Such other information as the Adminis-
2 trator may require to carry out this part.

3 “(c) OPTIONS REGARDING SERVICE AREAS.—

4 “(1) IN GENERAL.—The service area of a Medi-
5 care Prescription Drug plan shall be either—

6 “(A) the entire area of 1 of the service
7 areas established by the Administrator under
8 section 1860D–10; or

9 “(B) the entire area covered by the medi-
10 care program.

11 “(2) RULE OF CONSTRUCTION.—Nothing in
12 this part shall be construed as prohibiting an eligible
13 entity from submitting separate bids in multiple
14 service areas as long as each bid is for a single serv-
15 ice area.

16 “APPROVAL OF PROPOSED MEDICARE PRESCRIPTION
17 DRUG PLANS

18 “SEC. 1860D–13. (a) IN GENERAL.—The Adminis-
19 trator shall review the information filed under section
20 1860D–12 and shall approve or disapprove the Medicare
21 Prescription Drug plan. The Administrator may not ap-
22 prove a plan if—

23 “(1) the plan and the entity offering the plan
24 comply with the requirements under this part; and

25 “(2) the premium accurately reflects both (A)
26 the actuarial value of the benefits provided, and (B)

1 the payments associated with the application of
2 186D–16(c) and the payments under section
3 1860D–20 for the standard benefit.

4 “(b) NEGOTIATION.—In exercising the authority
5 under subsection (a), the Administrator shall have the
6 same authority to negotiate the terms and conditions of
7 the premiums submitted and other terms and conditions
8 of proposed plans as the Director of the Office of Per-
9 sonnel Management has with respect to health benefits
10 plans under chapter 89 of title 5, United States Code.

11 “(c) SPECIAL RULES FOR APPROVAL.—The Adminis-
12 trator may approve a Medicare Prescription Drug plan
13 submitted under section 1860D–12 only if the benefits
14 under such plan—

15 “(1) include the required benefits under section
16 1860D–6(a)(1); and

17 “(2) are not designed in such a manner that
18 the Administrator finds is likely to result in favor-
19 able selection of eligible beneficiaries.

20 “(d) ASSURING ACCESS.—

21 “(1) NUMBER OF CONTRACTS.—The Adminis-
22 trator shall, consistent with the requirements of this
23 part and the goal of containing costs under this title,
24 approve at least 2 contracts to offer a Medicare Pre-
25 scription Drug plan in an area.

1 “(2) GUARANTEEING ACCESS TO COVERAGE.—

2 In order to assure access under paragraph (1) in an
3 area and consistent with paragraph (3), the Admin-
4 istrator may provide financial incentives (including
5 partial underwriting of risk) for an eligible entity to
6 offer a Medicare Prescription Drug plan in that
7 area, but only so long as (and to the extent) nec-
8 essary to assure the access guaranteed under para-
9 graph (1) in that area.

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

13 “(A) shall not provide for the full under-
14 writing of financial risk for any eligible entity;

15 “(B) shall not provide for any under-
16 writing of financial risk for a public eligible en-
17 tity with respect to the offering of a nationwide
18 prescription drug plan; and

19 “(C) shall seek to maximize the assump-
20 tion of financial risk by an eligible entity.

21 “(4) REPORTS.—The Administrator shall, in
22 each annual report to Congress under section
23 1860D–25(c)(1)(D), include information on the ex-
24 ercise of authority under this subsection. The Ad-
25 ministrator also shall include such recommendations

1 as may be appropriate to limit the exercise of such
2 authority, including minimizing the assumption of fi-
3 nancial risk.

4 “(e) ANNUAL CONTRACTS.—A contract approved
5 under this part shall be for a 1-year period.

6 “COMPUTATION OF MONTHLY STANDARD COVERAGE

7 PREMIUMS

8 “SEC. 1860D–14. (a) IN GENERAL.—For each year
9 (beginning with 2005), the Administrator shall compute
10 a monthly standard coverage premium for each Medicare
11 Prescription Drug plan approved under section 1860D–
12 13.

13 “(b) REQUIREMENTS.—The monthly standard cov-
14 erage premium for a Medicare Prescription Drug plan for
15 a year shall be equal to—

16 “(1) in the case of a plan offered by an eligible
17 entity that provides standard coverage or an actuari-
18 ally equivalent coverage and does not provide addi-
19 tional prescription drug coverage pursuant to section
20 1860D–6(a)(2), the monthly premium approved for
21 the plan under section 1860D–13 for the year; and

22 “(2) in the case of a plan offered by an eligible
23 entity that provides additional prescription drug cov-
24 erage pursuant to section 1860D–6(a)(2)—

1 “(A) an amount that reflects only the actu-
 2 arial value of the standard coverage offered
 3 under the plan; or

4 “(B) if determined appropriate by the Ad-
 5 ministrator, the monthly premium approved
 6 under section 1860D–13 for the year for the
 7 Medicare Prescription Drug plan that (as re-
 8 quired under subparagraph (B) of such sec-
 9 tion)—

10 “(i) is offered by such entity in the
 11 same area as the plan; and

12 “(ii) does not provide additional pre-
 13 scription drug coverage pursuant to such
 14 section.

15 “COMPUTATION OF MONTHLY NATIONAL AVERAGE

16 PREMIUM

17 “SEC. 1860D–15. (a) COMPUTATION.—

18 “(1) IN GENERAL.—For each year (beginning
 19 with 2005) the Administrator shall compute a
 20 monthly national average premium equal to the aver-
 21 age of the monthly standard coverage premium for
 22 each Medicare Prescription Drug plan (as computed
 23 under section 1860D–14).

24 “(2) WEIGHTED AVERAGE.—The monthly na-
 25 tional average premium computed under paragraph
 26 (1) shall be a weighted average, with the weight for

1 each plan being equal to the average number of
2 beneficiaries enrolled under such plan in the pre-
3 vious year.

4 “(b) SPECIAL RULE FOR 2005.—For purposes of ap-
5 plying this section for 2005, the Administrator shall estab-
6 lish procedures for determining the weighted average
7 under subsection (a)(2) for 2004.

8 “PAYMENTS TO ELIGIBLE ENTITIES OFFERING MEDICARE
9 PRESCRIPTION DRUG PLANS

10 “SEC. 1860D–16. (a) PAYMENT OF PREMIUMS.—For
11 each year (beginning with 2005), the Administrator shall
12 pay to each entity offering a Medicare Prescription Drug
13 plan in which an eligible beneficiary is enrolled an amount
14 equal to the full amount of the monthly premium approved
15 for the plan under section 1860D–13 on behalf of each
16 eligible beneficiary enrolled in such plan for the year, as
17 adjusted using the risk adjusters that apply to the stand-
18 ard coverage published under section 1860D–11.

19 “(b) PAYMENT TERMS.—Payment under this section
20 to an entity offering a Medicare Prescription Drug plan
21 shall be made in a manner determined by the Adminis-
22 trator and based upon the manner in which payments are
23 made under section 1853(a) (relating to payments to
24 Medicare+Choice organizations).

25 “(c) PAYMENTS TO MEDICARE+CHOICE PLANS.—
26 For provisions related to payments to Medicare+Choice

1 organizations offering Medicare+Choice plans that pro-
2 vide qualified prescription drug coverage, see section
3 1853(k)(2).

4 “(d) SECONDARY PAYER PROVISIONS.—The provi-
5 sions of section 1862(b) shall apply to the benefits pro-
6 vided under this part.

7 “COMPUTATION OF BENEFICIARY OBLIGATION

8 “SEC. 1860D–17. (a) BENEFICIARIES ENROLLED IN
9 A MEDICARE PRESCRIPTION DRUG PLAN.—In the case of
10 an eligible beneficiary enrolled under this part and in a
11 Medicare Prescription Drug plan, the monthly beneficiary
12 obligation for enrollment in such plan in a year shall be
13 determined as follows:

14 “(1) MEDICARE PRESCRIPTION DRUG PLAN
15 PREMIUMS EQUAL TO THE MONTHLY NATIONAL AV-
16 ERAGE.—If the amount of the monthly premium ap-
17 proved by the Administrator under section 1860D–
18 13 for a Medicare Prescription Drug plan for the
19 year is equal to the monthly national average pre-
20 mium (as computed under section 1860D–15) for
21 the year, the monthly obligation of the eligible bene-
22 ficiary in that year shall be an amount equal to the
23 applicable percent (as defined in subsection (c)) of
24 the amount of the monthly national average pre-
25 mium.

1 “(2) MEDICARE PRESCRIPTION DRUG PLAN
2 PREMIUMS THAT ARE LESS THAN THE MONTHLY NA-
3 TIONAL AVERAGE.—If the amount of the monthly
4 premium approved by the Administrator under sec-
5 tion 1860D–13 for the Medicare Prescription Drug
6 plan for the year is less than the monthly national
7 average premium (as computed under section
8 1860D–15) for the year, the monthly obligation of
9 the eligible beneficiary in that year shall be an
10 amount equal to—

11 “(A) the applicable percent of the amount
12 of the monthly national average premium;
13 minus

14 “(B) the amount by which the monthly na-
15 tional average premium exceeds the amount of
16 the premium approved by the Administrator for
17 the plan.

18 “(3) MEDICARE PRESCRIPTION DRUG PLAN
19 PREMIUMS THAT ARE GREATER THAN THE MONTH-
20 LY NATIONAL AVERAGE.—If the amount of the
21 monthly premium approved by the Administrator
22 under section 1860D–13 for a Medicare Prescription
23 Drug plan for the year exceeds the monthly national
24 average premium (as computed under section
25 1860D–15) for the year, the monthly obligation of

1 the eligible beneficiary in that year shall be an
2 amount equal to the sum of—

3 “(A) the applicable percent of the amount
4 of the monthly national average premium; plus

5 “(B) the amount by which the premium
6 approved by the Administrator for the plan ex-
7 ceeds the amount of the monthly national aver-
8 age premium.

9 “(b) BENEFICIARIES ENROLLED IN A
10 MEDICARE+CHOICE PLAN.—In the case of an eligible
11 beneficiary that is receiving qualified prescription drug
12 coverage under a Medicare+Choice plan, the monthly obli-
13 gation for such coverage shall be determined pursuant to
14 section 1853(k)(3).

15 “(c) APPLICABLE PERCENT DEFINED.—For pur-
16 poses of this section, except as provided in section 1860D-
17 19 (relating to premium subsidies for low-income individ-
18 uals), the term ‘applicable percent’ means 55 percent.

19 “COLLECTION OF BENEFICIARY OBLIGATION

20 “SEC. 1860D-18. (a) COLLECTION OF AMOUNT IN
21 SAME MANNER AS PART B PREMIUM.—The amount of
22 the monthly beneficiary obligation (determined under sec-
23 tion 1860D-17) applicable to an eligible beneficiary under
24 this part (after application of any increase under section
25 1860D-2(b)(1)(A)) shall be collected and credited to the
26 Prescription Drug Account in the same manner as the

1 monthly premium determined under section 1839 is col-
 2 lected and credited to the Federal Supplementary Medical
 3 Insurance Trust Fund under section 1840.

4 “(b) INFORMATION NECESSARY FOR COLLECTION.—
 5 In order to carry out subsection (a), the Administrator
 6 shall transmit to the Commissioner of Social Security—

7 “(1) at the beginning of each year, the name,
 8 social security account number, and annual bene-
 9 ficiary obligation owed by each individual enrolled in
 10 a Medicare Prescription Drug plan for each month
 11 during the year; and

12 “(2) periodically throughout the year, informa-
 13 tion to update the information previously trans-
 14 mitted under this paragraph for the year.

15 “(c) COLLECTION FOR BENEFICIARIES RECEIVING
 16 QUALIFIED PRESCRIPTION DRUG COVERAGE UNDER A
 17 MEDICARE+CHOICE PLAN.—For provisions related to the
 18 collection of the monthly beneficiary obligation for quali-
 19 fied prescription drug coverage under a Medicare+Choice
 20 plan, see section 1853(k)(4).

21 “PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-
 22 INCOME INDIVIDUALS

23 “SEC. 1860D–19. (a) IN GENERAL.—

24 “(1) FULL PREMIUM SUBSIDY AND REDUCTION
 25 OF COST-SHARING FOR INDIVIDUALS WITH INCOME
 26 BELOW 135 PERCENT OF FEDERAL POVERTY LINE.—

1 In the case of a subsidy-eligible individual (as de-
2 fined in paragraph (3)) who is determined to have
3 income that does not exceed 135 percent of the Fed-
4 eral poverty line—

5 “(A) section 1860D–17 shall be applied—

6 “(i) in subsection (c), by substituting
7 ‘0 percent’ for ‘55 percent’; and

8 “(ii) in subparagraphs (A) and (B) of
9 subsection (a)(3), by substituting “the
10 amount of the premium for the Medicare
11 Prescription Drug plan with the lowest
12 monthly premium in the area that the ben-
13 eficiary resides” for “the amount of the
14 monthly national average premium”, but
15 only if there is no Medicare Prescription
16 Drug plan offered in the area in which the
17 individual resides that has a monthly pre-
18 mium for the year that is equal to or less
19 than the monthly national average pre-
20 mium (as computed under section 1860D–
21 15) for the year;

22 “(B) the annual deductible applicable
23 under section 1860D–6(c)(1) in a year shall be
24 reduced to an amount equal to 5 percent of the

1 annual deductible otherwise applicable under
2 such section for that year;

3 “(C) section 1860D–6(c)(2) shall be ap-
4 plied by substituting ‘2.5 percent’ for ‘50 per-
5 cent’ each place it appears;

6 “(D) such individual shall be responsible
7 for cost-sharing for the cost of any covered
8 drug provided in the year (after the individual
9 has reached such initial coverage limit and be-
10 fore the individual has reached the limitation
11 under section 1860D–6(c)(4)(A)), that is equal
12 to 50 percent; and

13 “(E) section 1860D–6(c)(4)(A) shall be
14 applied by substituting ‘0 percent’ for ‘10 per-
15 cent’.

16 In no case may the application of subparagraph (A)
17 result in a monthly beneficiary obligation that is
18 below zero.

19 “(2) SLIDING SCALE PREMIUM SUBSIDY AND
20 REDUCTION OF COST-SHARING FOR INDIVIDUALS
21 WITH INCOME BETWEEN 135 AND 150 PERCENT OF
22 FEDERAL POVERTY LINE.—

23 “(A) IN GENERAL.—In the case of a sub-
24 sidy-eligible individual who is determined to
25 have income that exceeds 135 percent, but is

1 less than 150 percent, of the Federal poverty
2 line—

3 “(i) section 1860D–17 shall be
4 applied—

5 “(I) in subsection (c), by sub-
6 stituting ‘subsidy percent’ for ‘55 per-
7 cent’; and

8 “(II) in subparagraphs (A) and
9 (B) of subsection (a)(3), by sub-
10 stituting “the amount of the premium
11 for the Medicare Prescription Drug
12 plan with the lowest monthly premium
13 in the area that the beneficiary re-
14 sides” for “the amount of the monthly
15 national average premium”, but only
16 if there is no Medicare Prescription
17 Drug plan offered in the area in
18 which the individual resides that has a
19 monthly premium for the year that is
20 equal to or less than the monthly na-
21 tional average premium (as computed
22 under section 1860D–15) for the
23 year; and

24 “(ii) such individual shall be respon-
25 sible for cost-sharing for the cost of any

1 covered drug provided in the year (after
 2 the individual has reached such initial cov-
 3 erage limit and before the individual has
 4 reached the limitation under section
 5 1860D–6(c)(4)(A)), that is equal to 50
 6 percent.

7 In no case may the application of clause (i) re-
 8 sult in a monthly beneficiary obligation that is
 9 below zero.

10 “(B) SUBSIDY PERCENT DEFINED.—For
 11 purposes of subparagraph (A)(i), the term ‘sub-
 12 sidy percent’ means a percent determined on a
 13 linear sliding scale ranging from 0 percent for
 14 individuals with incomes at 135 percent of such
 15 level to 55 percent for individuals with incomes
 16 at 150 percent of such level.

17 “(3) DETERMINATION OF ELIGIBILITY.—

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

22 “(i) is enrolled under this part, in-
 23 cluding an individual receiving qualified
 24 prescription drug coverage under a
 25 Medicare+Choice plan;

1 “(ii) has income that is less than 150
2 percent of the Federal poverty line; and

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

5 “(B) DETERMINATIONS.—The determina-
6 tion of whether an individual residing in a State
7 is a subsidy-eligible individual and the amount
8 of such individual’s income shall be determined
9 under the State medicaid plan for the State
10 under section 1935(a). In the case of a State
11 that does not operate such a medicaid plan (ei-
12 ther under title XIX or under a statewide waiv-
13 er granted under section 1115), such deter-
14 mination shall be made under arrangements
15 made by the Administrator.

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

18 “(i) income shall be determined in the
19 manner described in section
20 1905(p)(1)(B); and

21 “(ii) the term ‘Federal poverty line’
22 means the official poverty line (as defined
23 by the Office of Management and Budget,
24 and revised annually in accordance with
25 section 673(2) of the Omnibus Budget

1 Reconciliation Act of 1981) applicable to a
2 family of the size involved.

3 “(D) TREATMENT OF TERRITORIAL RESI-
4 DENTS.—In the case of an individual who is not
5 a resident of the 50 States or the District of
6 Columbia, the individual is not eligible to be a
7 subsidy-eligible individual but may be eligible
8 for financial assistance with prescription drug
9 expenses under section 1935(e).

10 “(b) RULES IN APPLYING COST-SHARING SUB-
11 SIDIES.—

12 “(1) ADDITIONAL BENEFITS.—In applying sub-
13 paragraphs (B) and (C) of subsection (a)(1) and
14 clauses (ii) and (iii) of subsection (a)(2)(A), nothing
15 in this part shall be construed as preventing an eligi-
16 ble entity offering a Medicare Prescription Drug
17 plan or a Medicare+Choice organization offering a
18 Medicare+Choice plan in which qualified drug cov-
19 erage is provided from waiving or reducing the
20 amount of the deductible or other cost-sharing oth-
21 erwise applicable pursuant to section 1860D-
22 6(a)(2).

23 “(2) LIMITATION ON CHARGES.—In the case of
24 an individual receiving cost-sharing subsidies under
25 subparagraphs (B) and (C) of subsection (a)(1) or

1 under clauses (ii) and (iii) of subsection (a)(2)(A),
2 the eligible entity offering a Medicare Prescription
3 Drug plan or the Medicare+Choice organization of-
4 fering a Medicare+Choice plan in which qualified
5 drug coverage is provided may not charge more than
6 the deductible or other cost-sharing required pursu-
7 ant to such subsection.

8 “(c) ADMINISTRATION OF SUBSIDY PROGRAM.—The
9 Administrator shall provide a process whereby, in the case
10 of an individual eligible for a cost-sharing under subpara-
11 graphs (B) and (C) of subsection (a)(1) or under clauses
12 (ii) and (iii) of subsection (a)(2)(A) and who is enrolled
13 in a Medicare Prescription Drug plan or is enrolled in a
14 Medicare+Choice plan under which qualified prescription
15 drug coverage is provided—

16 “(1) the Administrator provides for a notifica-
17 tion of the eligible entity or Medicare+Choice orga-
18 nization involved that the individual is eligible for a
19 cost-sharing subsidy and the amount of the subsidy
20 under such subsection;

21 “(2) the entity or organization involved reduces
22 the cost-sharing otherwise imposed by the amount of
23 the applicable subsidy and submits to the Adminis-
24 trator information on the amount of such reduction;
25 and

1 “(3) the Administrator periodically and on a
2 timely basis reimburses the entity or organization
3 for the amount of such reductions.

4 The reimbursement under paragraph (3) may be com-
5 puted on a capitated basis, taking into account the actu-
6 arial value of the subsidies and with appropriate adjust-
7 ments to reflect differences in the risks actually involved.

8 “(d) RELATION TO MEDICAID PROGRAM.—

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

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

16 “REINSURANCE PAYMENTS FOR QUALIFIED
17 PRESCRIPTION DRUG COVERAGE

18 “SEC. 1860D–20. (a) REINSURANCE PAYMENTS.—

19 “(1) IN GENERAL.—The Administrator shall
20 provide in accordance with this section for payment
21 to a qualifying entity (as defined in subsection (b))
22 of the reinsurance payment amount (as defined in
23 subsection (c)), which in the aggregate is 30 percent
24 of the total payments made by a qualifying entity
25 for standard coverage under the respective plan, for
26 excess costs incurred in providing qualified prescrip-

1 tion drug coverage for qualifying covered individuals
2 (as defined in subsection (g)(1)).

3 “(2) BUDGET AUTHORITY.—This section con-
4 stitutes budget authority in advance of appropria-
5 tions Acts and represents the obligation of the Ad-
6 ministrator to provide for the payment of amounts
7 provided under this section.

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

13 “(1) An eligible entity offering a Medicare Pre-
14 scription Drug plan under this part.

15 “(2) A Medicare+Choice organization that pro-
16 vides qualified prescription drug coverage under a
17 Medicare+Choice plan under part C.

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

20 “(c) REINSURANCE PAYMENT AMOUNT.—

21 “(1) IN GENERAL.—Subject to subsection
22 (d)(2), the reinsurance payment amount under this
23 subsection for a qualifying covered individual for a
24 coverage year (as defined in subsection (g)(2)) is
25 equal to the sum of the following:

1 “(A) For the portion of the individual’s
2 gross covered drug costs (as defined in para-
3 graph (3)) for the year that exceeds the amount
4 specified in paragraph (2), but does not exceed
5 the initial coverage limit, an amount equal to
6 50 percent of the allowable costs (as defined in
7 paragraph (3)) attributable to such gross cov-
8 ered drug costs.

9 “(B) For the portion of the individual’s
10 gross covered drug costs for the year that ex-
11 ceeds the annual out-of-pocket threshold speci-
12 fied in section 1860D–6(c)(4)(B), an amount
13 equal to 80 percent of the allowable costs at-
14 tributable to such gross covered drug costs.

15 “(2) AMOUNT SPECIFIED.—The amount speci-
16 fied under this paragraph—

17 “(A) for 2005, is equal to \$2,000; and

18 “(B) for a subsequent year, is equal to the
19 amount specified in this paragraph for the pre-
20 vious year, increased by the annual percentage
21 increase described in section 1860D–6(c)(5).

22 “(3) ALLOWABLE COSTS.—For purposes of this
23 section, the term ‘allowable costs’ means, with re-
24 spect to gross covered drug costs (as defined in
25 paragraph (4)) under a plan described in subsection

1 (b) offered by a qualifying entity, the part of such
2 costs that are actually paid (net of average percent-
3 age rebates) under the plan, but in no case more
4 than the part of such costs that would have been
5 paid under the plan if the prescription drug coverage
6 under the plan were standard coverage.

7 “(4) GROSS COVERED DRUG COSTS.—For pur-
8 poses of this section, the term ‘gross covered drug
9 costs’ means, with respect to an enrollee with a
10 qualifying entity under a plan described in sub-
11 section (b) during a coverage year, the costs in-
12 curred under the plan (including costs attributable
13 to administrative costs) for covered drugs dispensed
14 during the year, including costs relating to the de-
15 ductible, whether paid by the enrollee or under the
16 plan, regardless of whether the coverage under the
17 plan exceeds standard coverage and regardless of
18 when the payment for such drugs is made.

19 “(d) ADJUSTMENT OF REINSURANCE PAYMENTS TO
20 ASSURE 30 PERCENT LEVEL OF PAYMENT.—

21 “(1) ESTIMATION OF PAYMENTS.—The Admin-
22 istrator shall estimate—

23 “(A) the total payments to be made (with-
24 out regard to this subsection) during a year
25 under subsections (a) and (c); and

1 “(B) the total payments to be made by
2 qualifying entities for standard coverage under
3 plans described in subsection (b) during the
4 year.

5 “(2) ADJUSTMENT.—The Administrator shall
6 proportionally adjust the payments made under sub-
7 sections (a) and (c) for a coverage year in such man-
8 ner so that the total of the payments made under
9 such subsections for the year is equal to 30 percent
10 of the total payments described in subparagraph
11 (A)(ii).

12 “(e) PAYMENT METHODS.—

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

21 “(2) SOURCE OF PAYMENTS.—Payments under
22 this section shall be made from the Prescription
23 Drug Account.

24 “(f) QUALIFIED RETIREE PRESCRIPTION DRUG
25 PLAN DEFINED.—

1 “(1) IN GENERAL.—For purposes of this sec-
2 tion, the term ‘qualified retiree prescription drug
3 plan’ means employment-based retiree health cov-
4 erage (as defined in paragraph (3)(A)) if, with re-
5 spect to a qualifying covered individual who is cov-
6 ered under the plan, the following requirements are
7 met:

8 “(A) ASSURANCE.—The sponsor of the
9 plan shall annually attest, and provide such as-
10 surances as the Administrator may require,
11 that the coverage meets or exceeds the require-
12 ments for qualified prescription drug coverage.

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

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

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

1 “(B) was eligible for, but was not enrolled
2 in, the program under this part.

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

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

11 “(B) SPONSOR.—The term ‘sponsor’
12 means a plan sponsor, as defined in section
13 3(16)(B) of the Employee Retirement Income
14 Security Act of 1974.

15 “(g) GENERAL DEFINITIONS.—For purposes of this
16 section:

17 “(1) QUALIFYING COVERED INDIVIDUAL.—The
18 term ‘qualifying covered individual’ means an indi-
19 vidual who—

20 “(A) is enrolled in this part and in a Medi-
21 care Prescription Drug plan;

22 “(B) is enrolled in this part and in a
23 Medicare+Choice plan that provides qualified
24 prescription drug coverage; or

1 “(C) is eligible for, but not enrolled in, the
2 program under this part, and is covered under
3 a qualified retiree prescription drug plan.

4 “(2) COVERAGE YEAR.—The term ‘coverage
5 year’ means a calendar year in which covered drugs
6 are dispensed if a claim for payment is made under
7 the plan for such drugs, regardless of when the
8 claim is paid.

9 “Subpart 3—Medicare Competitive Agency; Prescription
10 Drug Account in the Federal Supplementary Med-
11 ical Insurance Trust Fund

12 “ESTABLISHMENT OF MEDICARE COMPETITIVE AGENCY

13 “SEC. 1860D–25. (a) ESTABLISHMENT.—By not
14 later than March 1, 2003, the Secretary shall establish
15 within the Department of Health and Human Services an
16 agency to be known as the Medicare Competitive Agency.

17 “(b) ADMINISTRATOR AND DEPUTY ADMINIS-
18 TRATOR.—

19 “(1) ADMINISTRATOR.—

20 “(A) IN GENERAL.—The Medicare Com-
21 petitive Agency shall be headed by an Adminis-
22 trator (in this section referred to as the ‘Ad-
23 ministrators’) who shall be appointed by the
24 President, by and with the advice and consent

1 of the Senate. The Administrator shall report
2 directly to the Secretary.

3 “(B) COMPENSATION.—The Administrator
4 shall be paid at the rate of basic pay payable
5 for level III of the Executive Schedule under
6 section 5314 of title 5, United States Code.

7 “(C) TERM OF OFFICE.—The Adminis-
8 trator shall be appointed for a term of 5 years.
9 In any case in which a successor does not take
10 office at the end of an Administrator’s term of
11 office, that Administrator may continue in of-
12 fice until the entry upon office of such a suc-
13 cessor. An Administrator appointed to a term of
14 office after the commencement of such term
15 may serve under such appointment only for the
16 remainder of such term.

17 “(D) GENERAL AUTHORITY.—The Admin-
18 istrator shall be responsible for the exercise of
19 all powers and the discharge of all duties of the
20 Administration, and shall have authority and
21 control over all personnel and activities thereof.

22 “(E) RULEMAKING AUTHORITY.—The Ad-
23 ministrator may prescribe such rules and regu-
24 lations as the Administrator determines nec-
25 essary or appropriate to carry out the functions

1 of the Administration. The regulations pre-
2 scribed by the Administrator shall be subject to
3 the rulemaking procedures established under
4 section 553 of title 5, United States Code.

5 “(F) AUTHORITY TO ESTABLISH ORGANI-
6 ZATIONAL UNITS.—The Administrator may es-
7 tablish, alter, consolidate, or discontinue such
8 organizational units or components within the
9 Administration as the Administrator considers
10 necessary or appropriate, except that this sub-
11 paragraph shall not apply with respect to any
12 unit, component, or provision provided for by
13 this section.

14 “(G) AUTHORITY TO DELEGATE.—The Ad-
15 ministrator may assign duties, and delegate, or
16 authorize successive redelegations of, authority
17 to act and to render decisions, to such officers
18 and employees of the Administration as the Ad-
19 ministrator may find necessary. Within the lim-
20 itations of such delegations, redelegations, or
21 assignments, all official acts and decisions of
22 such officers and employees shall have the same
23 force and effect as though performed or ren-
24 dered by the Administrator.

25 “(2) DEPUTY ADMINISTRATOR.—

1 “(A) IN GENERAL.—There shall be a Dep-
2 puty Administrator of the Medicare Competitive
3 Agency who shall be appointed by the Presi-
4 dent, by and with the advice and consent of the
5 Senate.

6 “(B) COMPENSATION.—The Deputy Ad-
7 ministrators shall be paid at the rate of basic
8 pay payable for level IV of the Executive Sched-
9 ule under section 5315 of title 5, United States
10 Code.

11 “(C) TERM OF OFFICE.—The Deputy Ad-
12 ministrators shall be appointed for a term of 5
13 years. In any case in which a successor does not
14 take office at the end of a Deputy Administra-
15 tor’s term of office, such Deputy Administrator
16 may continue in office until the entry upon of-
17 fice of such a successor. A Deputy Adminis-
18 trator appointed to a term of office after the
19 commencement of such term may serve under
20 such appointment only for the remainder of
21 such term.

22 “(D) DUTIES.—The Deputy Administrator
23 shall perform such duties and exercise such
24 powers as the Administrator shall from time to
25 time assign or delegate. The Deputy Adminis-

1 trator shall be Acting Administrator of the Ad-
2 ministration during the absence or disability of
3 the Administrator and, unless the President
4 designates another officer of the Government as
5 Acting Administrator, in the event of a vacancy
6 in the office of the Administrator.

7 “(3) SECRETARIAL COORDINATION OF PROGRAM
8 ADMINISTRATION.—The Secretary shall ensure ap-
9 propriate coordination between the Administrator
10 and the Administrator of the Centers for Medicare
11 & Medicaid Services in carrying out the programs
12 under this title.

13 “(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

14 “(1) DUTIES.—

15 “(A) GENERAL DUTIES.—The Adminis-
16 trator shall carry out parts C and D,
17 including—

18 “(i) negotiating, entering into, and en-
19 forcing, contracts with plans for the offer-
20 ing of Medicare+Choice plans under part
21 C, including the offering of qualified pre-
22 scription drug coverage under such plans;
23 and

24 “(ii) negotiating, entering into, and
25 enforcing, contracts with eligible entities

1 for the offering of Medicare Prescription
2 Drug plans under part D.

3 “(B) OTHER DUTIES.—The Administrator
4 shall carry out any duty provided for under
5 part C or D, including demonstration projects
6 carried out in part or in whole under such
7 parts, the programs of all-inclusive care for the
8 elderly (PACE program) under section 1894,
9 the social health maintenance organization
10 (SHMO) demonstration projects (referred to in
11 section 4104(c) of the Balanced Budget Act of
12 1997), and through a Medicare+Choice project
13 that demonstrates the application of capitation
14 payment rates for frail elderly medicare bene-
15 ficiaries through the use of an interdisciplinary
16 team and through the provision of primary care
17 services to such beneficiaries by means of such
18 a team at the nursing facility involved.

19 “(C) NONINTERFERENCE.—In carrying
20 out its duties with respect to the provision of
21 qualified prescription drug coverage to bene-
22 ficiaries under this title, the Administrator may
23 not—

1 “(i) require a particular formulary or
2 institute a price structure for the reim-
3 bursement of covered drugs;

4 “(ii) interfere in any way with nego-
5 tiations between eligible entities and
6 Medicare+Choice organizations and drug
7 manufacturers, wholesalers, or other sup-
8 pliers of covered drugs; and

9 “(iii) otherwise interfere with the
10 competitive nature of providing such quali-
11 fied prescription drug coverage through
12 such entities and organizations.

13 “(D) ANNUAL REPORTS.—Not later than
14 March 31 of each year, the Administrator shall
15 submit to Congress and the President a report
16 on the administration of the voluntary prescrip-
17 tion drug delivery program under this part dur-
18 ing the previous fiscal year.

19 “(2) STAFF.—

20 “(A) IN GENERAL.—The Administrator,
21 with the approval of the Secretary, may employ,
22 without regard to chapter 31 of title 5, United
23 States Code, other than sections 3110 and
24 3112, such officers and employees as are nec-
25 essary to administer the activities to be carried

1 out through the Medicare Competitive Agency.
2 The Administrator shall employ staff with ap-
3 propriate and necessary expertise in negotiating
4 contracts in the private sector.

5 “(B) FLEXIBILITY WITH RESPECT TO COM-
6 PENSATION.—

7 “(i) IN GENERAL.—The staff of the
8 Medicare Competitive Agency shall, subject
9 to clause (ii), be paid without regard to the
10 provisions of chapter 51 (other than sec-
11 tion 5101) and chapter 53 (other than sec-
12 tion 5301) of such title (relating to classi-
13 fication and schedule pay rates).

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

20 “(C) LIMITATION ON FULL-TIME EQUIVA-
21 LENT STAFFING FOR CURRENT CMS FUNCTIONS
22 BEING TRANSFERRED.—The Administrator may
23 not employ under this paragraph a number of
24 full-time equivalent employees, to carry out
25 functions that were previously conducted by the

1 Centers for Medicare & Medicaid Services and
2 that are conducted by the Administrator by rea-
3 son of this section, that exceeds the number of
4 such full-time equivalent employees authorized
5 to be employed by the Centers for Medicare &
6 Medicaid Services to conduct such functions as
7 of the date of enactment of this Act.

8 “(3) REDELEGATION OF CERTAIN FUNCTIONS
9 OF THE CENTERS FOR MEDICARE AND MEDICAID
10 SERVICES.—

11 “(A) IN GENERAL.—The Secretary, the
12 Administrator, and the Administrator of the
13 Centers for Medicare & Medicaid Services shall
14 establish an appropriate transition of responsi-
15 bility in order to redelegate the administration
16 of part C from the Secretary and the Adminis-
17 trator of the Centers for Medicare & Medicaid
18 Services to the Administrator as is appropriate
19 to carry out the purposes of this section.

20 “(B) TRANSFER OF DATA AND INFORMA-
21 TION.—The Secretary shall ensure that the Ad-
22 ministrator of the Centers for Medicare & Med-
23 icaid Services transfers to the Administrator
24 such information and data in the possession of
25 the Administrator of the Centers for Medicare

1 & Medicaid Services as the Administrator re-
2 quires to carry out the duties described in para-
3 graph (1).

4 “(C) CONSTRUCTION.—Insofar as a re-
5 sponsibility of the Secretary or the Adminis-
6 trator of the Centers for Medicare & Medicaid
7 Services is redelegated to the Administrator
8 under this section, any reference to the Sec-
9 retary or the Administrator of the Centers for
10 Medicare & Medicaid Services in this title or
11 title XI with respect to such responsibility is
12 deemed to be a reference to the Administrator.

13 “(d) OFFICE OF BENEFICIARY ASSISTANCE.—

14 “(1) ESTABLISHMENT.—The Secretary shall es-
15 tablish within the Medicare Competitive Agency an
16 Office of Beneficiary Assistance to carry out func-
17 tions relating to medicare beneficiaries under this
18 title, including making determinations of eligibility
19 of individuals for benefits under this title, providing
20 for enrollment of medicare beneficiaries under this
21 title, and the functions described in paragraph (2).
22 The Office shall be a separate operating division
23 within the Administration.

24 “(2) DISSEMINATION OF INFORMATION ON
25 BENEFITS AND APPEALS RIGHTS.—

1 “(A) DISSEMINATION OF BENEFITS INFOR-
2 MATION.—The Office of Beneficiary Assistance
3 shall disseminate to medicare beneficiaries, by
4 mail, by posting on the Internet site of the
5 Medicare Competitive Agency, and through the
6 toll-free telephone number provided for under
7 section 1804(b), information with respect to the
8 following:

9 “(i) Benefits, and limitations on pay-
10 ment (including cost-sharing, stop-loss pro-
11 visions, and formulary restrictions) under
12 parts C and D.

13 “(ii) Benefits, and limitations on pay-
14 ment under parts A, B, and E, including
15 information on medicare supplemental poli-
16 cies under section 1882.

17 Such information shall be presented in a man-
18 ner so that medicare beneficiaries may compare
19 benefits under parts A, B, D, and E, and medi-
20 care supplemental policies with benefits under
21 Medicare+Choice plans under part C.

22 “(B) DISSEMINATION OF APPEALS RIGHTS
23 INFORMATION.—The Office of Beneficiary As-
24 sistance shall disseminate to medicare bene-
25 ficiaries in the manner provided under subpara-

1 graph (A) a description of procedural rights (in-
2 cluding grievance and appeals procedures) of
3 beneficiaries under the original medicare fee-
4 for-service program under parts A and B (in-
5 cluding beneficiaries who elect to receive en-
6 hanced medicare benefits under part E), the
7 Medicare+Choice program under part C, and
8 the voluntary prescription drug delivery pro-
9 gram under part D.

10 “(3) MEDICARE OMBUDSMAN.—

11 “(A) IN GENERAL.—Within the Office of
12 Beneficiary Assistance, there shall be a Medi-
13 care Ombudsman, appointed by the Secretary
14 from among individuals with expertise and ex-
15 perience in the fields of health care and advo-
16 cacy, to carry out the duties described in sub-
17 paragraph (B).

18 “(B) DUTIES.—The Medicare Ombudsman
19 shall—

20 “(i) receive complaints, grievances,
21 and requests for information submitted by
22 a medicare beneficiary, with respect to any
23 aspect of the medicare program;

1 “(ii) provide assistance with respect to
2 complaints, grievances, and requests re-
3 ferred to in clause (i), including—

4 “(I) assistance in collecting rel-
5 evant information for such bene-
6 ficiaries, to seek an appeal of a deci-
7 sion or determination made by a fiscal
8 intermediary, carrier,
9 Medicare+Choice organization, an eli-
10 gible entity under part D, or the Sec-
11 retary; and

12 “(II) assistance to such bene-
13 ficiaries with any problems arising
14 from disenrollment from a
15 Medicare+Choice plan under part C
16 or a prescription drug plan under part
17 D; and

18 “(iii) submit annual reports to Con-
19 gress, the Secretary, and the Medicare
20 Competitive Policy Advisory Board describ-
21 ing the activities of the Office, and includ-
22 ing such recommendations for improve-
23 ment in the administration of this title as
24 the Ombudsman determines appropriate.

1 “(C) COORDINATION WITH STATE OM-
2 BUDSMAN PROGRAMS AND CONSUMER ORGANI-
3 ZATIONS.—The Medicare Ombudsman shall, to
4 the extent appropriate, coordinate with State
5 medical Ombudsman programs, and with State-
6 and community-based consumer organizations,
7 to—

8 “(i) provide information about the
9 medicare program; and

10 “(ii) conduct outreach to educate
11 medicare beneficiaries with respect to man-
12 ners in which problems under the medicare
13 program may be resolved or avoided.

14 “(e) MEDICARE COMPETITIVE POLICY ADVISORY
15 BOARD.—

16 “(1) ESTABLISHMENT.—There is established
17 within the Medicare Competitive Agency the Medi-
18 care Competitive Policy Advisory Board (in this sec-
19 tion referred to as the ‘Board’). The Board shall ad-
20 vise, consult with, and make recommendations to the
21 Administrator with respect to the administration of
22 parts C and D, including the review of payment poli-
23 cies under such parts.

24 “(2) REPORTS.—

1 “(A) IN GENERAL.—With respect to mat-
2 ters of the administration of parts C and D, the
3 Board shall submit to Congress and to the Ad-
4 ministrators such reports as the Board deter-
5 mines appropriate. Each such report may con-
6 tain such recommendations as the Board deter-
7 mines appropriate for legislative or administra-
8 tive changes to improve the administration of
9 such parts, including the stability and solvency
10 of the programs under such parts and the top-
11 ics described in subparagraph (B). Each such
12 report shall be published in the Federal Reg-
13 ister.

14 “(B) TOPICS DESCRIBED.—Reports re-
15 quired under subparagraph (A) may include the
16 following topics:

17 “(i) FOSTERING COMPETITION.—Rec-
18 ommendations or proposals to increase
19 competition under parts C and D for serv-
20 ices furnished to medicare beneficiaries.

21 “(ii) EDUCATION AND ENROLL-
22 MENT.—Recommendations for the im-
23 provement of efforts to provide medicare
24 beneficiaries information and education on
25 the program under this title, and specifi-

1 cally parts C and D, and the program for
2 enrollment under the title.

3 “(iii) QUALITY.—Recommendations
4 on ways to improve the quality of benefits
5 provided under plans under parts C and D.

6 “(iv) DISEASE MANAGEMENT PRO-
7 GRAMS.—Recommendations on the incor-
8 poration of disease management programs
9 under parts C and D.

10 “(v) RURAL ACCESS.—Recommendations
11 to improve competition and access to
12 plans under parts C and D in rural areas.

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

21 “(3) DUTY OF ADMINISTRATOR.—With respect
22 to any report submitted by the Board under para-
23 graph (2)(A), not later than 90 days after the report
24 is submitted, the Administrator shall submit to Con-
25 gress and the President an analysis of recommenda-

1 tions made by the Board in such report. Each such
2 analysis shall be published in the Federal Register.

3 “(4) MEMBERSHIP.—

4 “(A) APPOINTMENT.—Subject to the suc-
5 ceeding provisions of this paragraph, the Board
6 shall consist of 7 members to be appointed as
7 follows:

8 “(i) Three members shall be ap-
9 pointed by the President.

10 “(ii) Two members shall be appointed
11 by the Speaker of the House of Represent-
12 atives, with the advice of the chairman and
13 the ranking minority member of the Com-
14 mittees on Ways and Means and on En-
15 ergy and Commerce of the House of Rep-
16 resentatives.

17 “(iii) Two members shall be appointed
18 by the President pro tempore of the Senate
19 with the advice of the chairman and the
20 ranking minority member of the Com-
21 mittee on Finance of the Senate.

22 “(B) QUALIFICATIONS.—The members
23 shall be chosen on the basis of their integrity,
24 impartiality, and good judgment, and shall be
25 individuals who are, by reason of their edu-

1 cation and experience in health care benefits
2 management, exceptionally qualified to perform
3 the duties of members of the Board.

4 “(C) PROHIBITION ON INCLUSION OF FED-
5 ERAL EMPLOYEES.—No officer or employee of
6 the United States may serve as a member of
7 the Board.

8 “(5) COMPENSATION.—Members of the Board
9 shall receive, for each day (including travel time)
10 they are engaged in the performance of the functions
11 of the Board, compensation at rates not to exceed
12 the daily equivalent to the annual rate in effect for
13 level IV of the Executive Schedule under section
14 5315 of title 5, United States Code.

15 “(6) TERMS OF OFFICE.—

16 “(A) IN GENERAL.—The term of office of
17 members of the Board shall be 3 years.

18 “(B) TERMS OF INITIAL APPOINTEES.—As
19 designated by the President at the time of ap-
20 pointment, of the members first appointed—

21 “(i) one shall be appointed for a term
22 of 1 year;

23 “(ii) three shall be appointed for
24 terms of 2 years; and

1 “(iii) three shall be appointed for
2 terms of 3 years.

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

6 “(D) VACANCY.—Any member appointed
7 to fill a vacancy occurring before the expiration
8 of the term for which the member’s predecessor
9 was appointed shall be appointed only for the
10 remainder of that term. A member may serve
11 after the expiration of that member’s term until
12 a successor has taken office. A vacancy in the
13 Board shall be filled in the manner in which the
14 original appointment was made.

15 “(7) CHAIR.—The Chair of the Board shall be
16 elected by the members. The term of office of the
17 Chair shall be 3 years.

18 “(8) MEETINGS.—The Board shall meet at the
19 call of the Chair, but in no event less than 3 times
20 during each fiscal year.

21 “(9) DIRECTOR AND STAFF.—

22 “(A) APPOINTMENT OF DIRECTOR.—The
23 Board shall have a Director who shall be ap-
24 pointed by the Chair.

1 “(B) IN GENERAL.—With the approval of
2 the Board, the Director may appoint, without
3 regard to chapter 31 of title 5, United States
4 Code, such additional personnel as the Director
5 considers appropriate.

6 “(C) FLEXIBILITY WITH RESPECT TO COM-
7 PENSATION.—

8 “(i) IN GENERAL.—The Director and
9 staff of the Board shall, subject to clause
10 (ii), be paid without regard to the provi-
11 sions of chapter 51 and chapter 53 of such
12 title (relating to classification and schedule
13 pay rates).

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

20 “(D) ASSISTANCE FROM THE ADMINIS-
21 TRATOR.—The Administrator shall make avail-
22 able to the Board such information and other
23 assistance as it may require to carry out its
24 functions.

1 “(10) CONTRACT AUTHORITY.—The Board may
 2 contract with and compensate government and pri-
 3 vate agencies or persons to carry out its duties
 4 under this subsection, without regard to section
 5 3709 of the Revised Statutes (41 U.S.C. 5).

6 “(f) FUNDING.—There is authorized to be appro-
 7 priated, in appropriate part from the Federal Hospital In-
 8 surance Trust Fund and from the Federal Supplementary
 9 Medical Insurance Trust Fund (including the Prescription
 10 Drug Account), such sums as are necessary to carry out
 11 this section.

12 “PRESCRIPTION DRUG ACCOUNT IN THE FEDERAL
 13 SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

14 “SEC. 1860D–26. (a) ESTABLISHMENT.—

15 “(1) IN GENERAL.—There is created within the
 16 Federal Supplementary Medical Insurance Trust
 17 Fund established by section 1841 an account to be
 18 known as the ‘Prescription Drug Account’ (in this
 19 section referred to as the ‘Account’).

20 “(2) FUNDS.—The Account shall consist of
 21 such gifts and bequests as may be made as provided
 22 in section 201(i)(1), and such amounts as may be
 23 deposited in, or appropriated to, the Account as pro-
 24 vided in this part.

25 “(3) SEPARATE FROM REST OF TRUST FUND.—
 26 Funds provided under this part to the Account shall

1 be kept separate from all other funds within the
2 Federal Supplementary Medical Insurance Trust
3 Fund.

4 “(b) PAYMENTS FROM ACCOUNT.—

5 “(1) IN GENERAL.—The Managing Trustee
6 shall pay from time to time from the Account such
7 amounts as the Secretary certifies are necessary to
8 make payments to operate the program under this
9 part, including payments to eligible entities under
10 section 1860D–16, payments under 1860D–19 for
11 low-income subsidy payments for cost-sharing, rein-
12 surance payments under section 1860D–20, and
13 payments with respect to administrative expenses
14 under this part in accordance with section 201(g).

15 “(2) TRANSFER TO PARTS A AND B TRUST
16 FUNDS FOR MEDICARE+CHOICE PAYMENTS.—The
17 Managing Trustee shall establish procedures for the
18 transfer of funds from the Account, in an amount
19 determined appropriate by the Secretary, to the Fed-
20 eral Hospital Insurance Trust Fund and the Federal
21 Supplementary Medical Insurance Trust Fund in
22 order to reimburse such trust funds for payments to
23 Medicare+Choice organizations for the provision of
24 qualified prescription drug coverage pursuant to sec-
25 tion 1853(k).

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

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

13 “(c) DEPOSITS INTO ACCOUNT.—

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

20 “(2) APPROPRIATIONS TO COVER BENEFITS
21 AND ADMINISTRATIVE COSTS.—There are appro-
22 priated to the Account in a fiscal year, out of any
23 moneys in the Treasury not otherwise appropriated,
24 an amount equal to the amount by which—

1 “(A) the payments and transfers made
2 from the Account under subsection (b) in the
3 year; exceed

4 “(B) the premiums collected under section
5 1860D–18 and 1853(k)(4) (for beneficiaries re-
6 ceiving qualified prescription drug coverage
7 under a Medicare+Choice plan).”.

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

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

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

14 (B) by inserting before the period the fol-
15 lowing: “, and such amounts as may be depos-
16 ited in, or appropriated to, the Prescription
17 Drug Account established by section 1860D–
18 26”;

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

24 (3) in subsection (h), by inserting after
25 “1840(d)” the following: “and section 1860D–18 (in

1 which case the payments shall be made from the
 2 Prescription Drug Account in the Trust Fund)”;
 3 and

4 (4) in subsection (i), by inserting after “section
 5 1840(b)(1)” the following: “, section 1860D–18 (in
 6 which case the payments shall be made from the
 7 Prescription Drug Account in the Trust Fund),”.

8 (c) CONFORMING REFERENCES TO PREVIOUS PART
 9 D.—Any reference in law (in effect before the date of en-
 10 actment of this Act) to part D of title XVIII of the Social
 11 Security Act is deemed a reference to part F of such title
 12 (as in effect after such date).

13 **SEC. 102. STUDY AND REPORT ON PERMITTING PART B**
 14 **ONLY INDIVIDUALS TO ENROLL IN MEDICARE**
 15 **VOLUNTARY PRESCRIPTION DRUG DELIVERY**
 16 **PROGRAM.**

17 (a) STUDY.—The Administrator of the Medicare
 18 Competitive Agency (as established under section 1860D–
 19 25 of the Social Security Act (as added by section 301(a)))
 20 shall conduct a study on the need for rules relating to per-
 21 mitting individuals who are enrolled under part B of title
 22 XVIII of the Social Security Act but are not entitled to
 23 benefits under part A of such title to buy into the medicare
 24 voluntary prescription drug delivery program under part
 25 D of such title (as so added).

1 (b) REPORT.—Not later than January 1, 2004, the
2 Administrator of the Medicare Competitive Agency shall
3 submit a report to Congress on the study conducted under
4 subsection (a), together with any recommendations for leg-
5 islation that the Administrator determines to be appro-
6 priate as a result of such study.

7 **SEC. 103. ADDITIONAL REQUIREMENTS FOR ANNUAL FI-**
8 **NANCIAL REPORT AND OVERSIGHT ON MEDI-**
9 **CARE PROGRAM.**

10 (a) IN GENERAL.—Section 1817 (42 U.S.C. 1395i)
11 is amended by adding at the end the following new sub-
12 section:

13 “(1) COMBINED REPORT ON OPERATION AND STATUS
14 OF THE TRUST FUND AND THE FEDERAL SUPPLE-
15 MENTARY MEDICAL INSURANCE TRUST FUND (INCLUD-
16 ING THE PRESCRIPTION DRUG ACCOUNT).—In addition
17 to the duty of the Board of Trustees to report to Congress
18 under subsection (b), on the date the Board submits the
19 report required under subsection (b)(2), the Board shall
20 submit to Congress a report on the operation and status
21 of the Trust Fund and the Federal Supplementary Med-
22 ical Insurance Trust Fund established under section 1841,
23 including the Prescription Drug Account within such
24 Trust Fund, (in this subsection referred to as the ‘Trust

1 Funds'). Such report shall include the following informa-
2 tion:

3 “(1) OVERALL SPENDING FROM THE GENERAL
4 FUND OF THE TREASURY.—A statement of total
5 amounts obligated during the preceding fiscal year
6 from the General Revenues of the Treasury to the
7 Trust Funds, separately stated in terms of the total
8 amount and in terms of the percentage such amount
9 bears to all other amounts obligated from such Gen-
10 eral Revenues during such fiscal year, for each of
11 the following amounts:

12 “(A) MEDICARE BENEFITS.—The amount
13 expended for payment of benefits covered under
14 this title.

15 “(B) ADMINISTRATIVE AND OTHER EX-
16 PENSES.—The amount expended for payments
17 not related to the benefits described in subpara-
18 graph (A).

19 “(2) HISTORICAL OVERVIEW OF SPENDING.—
20 From the date of the inception of the program of in-
21 surance under this title through the fiscal year in-
22 volved, a statement of the total amounts referred to
23 in paragraph (1), separately stated for the amounts
24 described in subparagraphs (A) and (B) of such
25 paragraph.

1 “(3) 10-YEAR AND 50-YEAR PROJECTIONS.—An
2 estimate of total amounts referred to in paragraph
3 (1), separately stated for the amounts described in
4 subparagraphs (A) and (B) of such paragraph, re-
5 quired to be obligated for payment for benefits cov-
6 ered under this title for each of the 10 fiscal years
7 succeeding the fiscal year involved and for the 50-
8 year period beginning with the succeeding fiscal
9 year.

10 “(4) RELATION TO OTHER MEASURES OF
11 GROWTH.—A comparison of the rate of growth of
12 the total amounts referred to in paragraph (1), sepa-
13 rately stated for the amounts described in subpara-
14 graphs (A) and (B) of such paragraph, to the rate
15 of growth for the same period in—

16 “(A) the gross domestic product;

17 “(B) health insurance costs in the private
18 sector;

19 “(C) employment-based health insurance
20 costs in the public and private sectors; and

21 “(D) other areas as determined appro-
22 priate by the Board of Trustees.”.

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

1 (c) CONGRESSIONAL HEARINGS.—It is the sense of
 2 Congress that the committees of jurisdiction of Congress
 3 shall hold hearings on the reports submitted under section
 4 1817(l) of the Social Security Act (as added by subsection
 5 (a)).

6 **SEC. 104. REFERENCE TO MEDIGAP PROVISIONS.**

7 For provisions related to medicare supplemental poli-
 8 cies under section 1882 of the Social Security Act (42
 9 U.S.C. 1395ss), see section 202.

10 **SEC. 105. MEDICAID AMENDMENTS.**

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

13 (1) REQUIREMENT.—Section 1902 (42 U.S.C.
 14 1396a) is amended—

15 (A) in subsection (a)—

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

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

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

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

1 (2) NEW SECTION.—Title XIX (42 U.S.C. 1396
2 et seq.) is amended—

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

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

7 “SPECIAL PROVISIONS RELATING TO MEDICARE
8 PRESCRIPTION DRUG BENEFIT

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

14 “(1) make determinations of eligibility for pre-
15 mium and cost-sharing subsidies under (and in ac-
16 cordance with) section 1860D–19;

17 “(2) inform the Administrator of the Medicare
18 Competitive Agency of such determinations in cases
19 in which such eligibility is established; and

20 “(3) otherwise provide such Administrator with
21 such information as may be required to carry out
22 part D of title XVIII (including section 1860D–19).

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

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

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

7 “(A) For expenditures attributable to costs
8 incurred during 2005, the otherwise applicable
9 Federal matching rate shall be increased by 20
10 percent of the percentage otherwise payable
11 (but for this subsection) by the State.

12 “(B) For expenditures attributable to costs
13 incurred during 2006, the otherwise applicable
14 Federal matching rate shall be increased by 40
15 percent of the percentage otherwise payable
16 (but for this subsection) by the State.

17 “(C) For expenditures attributable to costs
18 incurred during 2007, the otherwise applicable
19 Federal matching rate shall be increased by 60
20 percent of the percentage otherwise payable
21 (but for this subsection) by the State.

22 “(D) For expenditures attributable to costs
23 incurred during 2008, the otherwise applicable
24 Federal matching rate shall be increased by 80

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

3 “(E) For expenditures attributable to costs
4 incurred after 2008, the otherwise applicable
5 Federal matching rate shall be increased to 100
6 percent.

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

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

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

20 (2) AMOUNT DESCRIBED.—Section 1935, as
21 added by subsection (a)(2), is amended by adding at
22 the end the following new subsection:

23 “(c) FEDERAL ASSUMPTION OF MEDICAID PRE-
24 SCRIPTION DRUG COSTS FOR DUALY-ELIGIBLE BENE-
25 FIARIES.—

1 “(1) IN GENERAL.—For purposes of section
2 1903(a)(1), for a State for a calendar quarter in a
3 year (beginning with 2005) the amount computed
4 under this subsection is equal to the product of the
5 following:

6 “(A) STANDARD PRESCRIPTION DRUG COV-
7 ERAGE UNDER MEDICARE.—With respect to in-
8 dividuals who are residents of the State and are
9 entitled to benefits with respect to prescribed
10 drugs under the State plan under this title (in-
11 cluding such a plan operating under a waiver
12 under section 1115)—

13 “(i) the total amount of payments
14 made (or not collected from the individ-
15 uals) in the quarter under section 1860D-
16 19 (relating to premium and cost-sharing
17 prescription drug subsidies for low-income
18 medicare beneficiaries) that are attrib-
19 utable to such individuals; and

20 “(ii) the actuarial value of standard
21 coverage (as determined under section
22 1860D-6(f)) provided for all such individ-
23 uals.

24 “(B) STATE MATCHING RATE.—A propor-
25 tion computed by subtracting from 100 percent

1 the Federal medical assistance percentage (as
2 defined in section 1905(b)) applicable to the
3 State and the quarter.

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

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

10 “(A) 2005 is 90 percent;

11 “(B) 2006 is 80 percent;

12 “(C) 2007 is 70 percent;

13 “(D) 2008 is 60 percent; or

14 “(E) a year after 2008 is 50 percent.”.

15 (c) MEDICAID PROVIDING WRAP-AROUND BENE-
16 FITS.—Section 1935, as added by subsection (a)(2) and
17 amended by subsection (b)(2), is amended by adding at
18 the end the following new subsection:

19 “(d) ADDITIONAL PROVISIONS.—

20 “(1) MEDICAID AS SECONDARY PAYOR.—In the
21 case of an individual who is enrolled under part D
22 of title XVIII and entitled to medical assistance for
23 prescribed drugs under this title, medical assistance
24 shall continue to be provided under this title for pre-
25 scribed drugs to the extent payment is not made

1 under the Medicare Prescription Drug plan or the
 2 Medicare+Choice plan selected by the individual to
 3 receive part D benefits.

4 “(2) CONDITION.—A State may require, as a
 5 condition for the receipt of medical assistance under
 6 this title with respect to prescription drug benefits
 7 for an individual eligible to enroll in part D, that the
 8 individual elect to enroll under such part.”.

9 (d) TREATMENT OF TERRITORIES.—

10 (1) IN GENERAL.—Section 1935, as added by
 11 subsection (a)(2) and amended by subsections (b)(2)
 12 and (c), is amended—

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

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

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

20 “(e) TREATMENT OF TERRITORIES.—

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

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

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

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

11 “(A) provides medical assistance with re-
12 spect to the provision of covered drugs (as de-
13 fined in section 1860D(a)(2)) to low-income
14 medicare beneficiaries; and

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

19 “(3) INCREASED AMOUNT.—

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

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

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

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

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

9 “(ii) a subsequent year, is equal to the
10 aggregate amount specified in this sub-
11 paragraph for the previous year increased
12 by the annual percentage increase specified
13 in section 1860D–6(c)(5) for the year in-
14 volved.

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

19 (2) CONFORMING AMENDMENT.—Section
20 1108(f) (42 U.S.C. 1308(f)) is amended by inserting
21 “and section 1935(e)(1)(B)” after “Subject to sub-
22 section (g)”.

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

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

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

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

7 “(V) any prices charged which
8 are negotiated under a Medicare Pre-
9 scription Drug plan under part D of
10 title XVIII with respect to covered
11 drugs, under a Medicare+Choice plan
12 under part C of such title with respect
13 to such drugs, or under a qualified re-
14 tiree prescription drug plan (as de-
15 fined in section 1860D–20(f)(1)) with
16 respect to such drugs, on behalf of eli-
17 gible beneficiaries (as defined in sec-
18 tion 1860D(a)(3)).”.

19 **SEC. 106. EXPANSION OF MEMBERSHIP AND DUTIES OF**
20 **MEDICARE PAYMENT ADVISORY COMMISSION**
21 **(MEDPAC).**

22 (a) EXPANSION OF MEMBERSHIP.—

23 (1) IN GENERAL.—Section 1805(c) (42 U.S.C.
24 1395b–6(c)) is amended—

1 (A) in paragraph (1), by striking “17” and
2 inserting “19”; and

3 (B) in paragraph (2)(B), by inserting “ex-
4 perts in the area of pharmacology and prescrip-
5 tion drug benefit programs,” after “other
6 health professionals,”.

7 (2) INITIAL TERMS OF ADDITIONAL MEM-
8 BERS.—

9 (A) IN GENERAL.—For purposes of stag-
10 gering the initial terms of members of the
11 Medicare Payment Advisory Commission under
12 section 1805(c)(3) of the Social Security Act
13 (42 U.S.C. 1395b–6(c)(3)), the initial terms of
14 the 2 additional members of the Commission
15 provided for by the amendment under para-
16 graph (1)(A) are as follows:

17 (i) One member shall be appointed for
18 1 year.

19 (ii) One member shall be appointed
20 for 2 years.

21 (B) COMMENCEMENT OF TERMS.—Such
22 terms shall begin on January 1, 2004.

23 (b) EXPANSION OF DUTIES.—Section 1805(b)(2) (42
24 U.S.C. 1395b–6(b)(2)) is amended by adding at the end
25 the following new subparagraph:

1 “(D) VOLUNTARY PRESCRIPTION DRUG
2 DELIVERY PROGRAM.—Specifically, the Com-
3 mission shall review, with respect to the vol-
4 untary prescription drug delivery program
5 under part D, competition among eligible enti-
6 ties offering Medicare Prescription Drug plans
7 and beneficiary access to such plans and cov-
8 ered drugs, particularly in rural areas.”.

9 **SEC. 107. MISCELLANEOUS ADMINISTRATIVE PROVISIONS.**

10 (a) ADMINISTRATOR AS MEMBER OF THE BOARD OF
11 TRUSTEES OF THE MEDICARE TRUST FUNDS.—Sections
12 1817(b) and 1841(b) (42 U.S.C. 1395i(b), 1395t(b)) are
13 each amended by striking “and the Secretary of Health
14 and Human Services, all ex officio,” and inserting “the
15 Secretary of Health and Human Services, and the Admin-
16 istrator of the Medicare Competitive Agency, all ex offi-
17 cio,”.

18 (b) INCREASE IN GRADE TO EXECUTIVE LEVEL III
19 FOR THE ADMINISTRATOR OF THE CENTERS FOR MEDI-
20 CARE & MEDICAID SERVICES.—

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

24 “Administrator of the Centers for Medicare &
25 Medicaid Services.”.

1 (2) CONFORMING AMENDMENT.—Section 5315
 2 of such title is amended by striking “Administrator
 3 of the Health Care Financing Administration.”.

4 (3) EFFECTIVE DATE.—The amendments made
 5 by this subsection take effect on March 1, 2003.

6 **TITLE II—OPTION FOR EN-**
 7 **HANCED MEDICARE BENE-**
 8 **FITS**

9 **SEC. 201. OPTION FOR ENHANCED MEDICARE BENEFITS.**

10 (a) ESTABLISHMENT.—Title XVIII (42 U.S.C. 1395
 11 et seq.), as amended by section 101, is amended by insert-
 12 ing after part D the following new part:

13 “PART E—ENHANCED MEDICARE BENEFITS

14 “ENTITLEMENT TO ELECT TO RECEIVE ENHANCED

15 MEDICARE BENEFITS

16 “SEC. 1860E–1. (a) IN GENERAL.—The Secretary
 17 shall establish procedures under which each eligible bene-
 18 ficiary shall be entitled to elect to receive enhanced medi-
 19 care benefits under this part instead of the benefits under
 20 parts A and B.

21 “(b) ENHANCED MEDICARE BENEFITS TO BE
 22 AVAILABLE IN 2005.—The Secretary shall establish the
 23 procedures under subsection (a) in a manner such that
 24 enhanced medicare benefits are first provided for months
 25 beginning with January 2005.

1 “(c) PRESERVATION OF ORIGINAL MEDICARE FEE-
 2 FOR-SERVICE BENEFITS.—Nothing in this part shall be
 3 construed to limit the right of an individual who is entitled
 4 to benefits under part A or enrolled under part B to re-
 5 ceive benefits under such part if an election to receive en-
 6 hanced medicare benefits under this part is not in effect
 7 with respect to such individual.

8 “SCOPE OF ENHANCED MEDICARE BENEFITS

9 “SEC. 1860E-2. (a) IN GENERAL.—Except for the
 10 modifications described in the succeeding provisions of this
 11 section, enhanced medicare benefits shall be identical to
 12 the benefits that are available under parts A and B.

13 “(b) UNIFIED DEDUCTIBLE.—

14 “(1) IN GENERAL.—In the case of an eligible
 15 beneficiary who has elected to receive enhanced
 16 medicare benefits under this part—

17 “(A) the amount otherwise payable under
 18 part A and the total amount of expenses in-
 19 curred by an eligible beneficiary during a year
 20 which would (except for this section) constitute
 21 incurred expenses from which benefits payable
 22 under section 1833(a) are determinable, shall
 23 be reduced under sections 1813(b) and 1833(b)
 24 by the amount of the unified deductible under
 25 paragraph (2); and

1 “(B) the eligible beneficiary shall be re-
2 sponsible for the payment of such amount.

3 “(2) AMOUNT OF UNIFIED DEDUCTIBLE.—

4 “(A) IN GENERAL.—The amount of the
5 unified deductible under this subsection shall
6 be—

7 “(i) for 2005, \$300; or

8 “(ii) for a subsequent year, the
9 amount specified in this subparagraph for
10 the preceding year increased by the per-
11 centage increase in the per capita actuarial
12 value of benefits under parts A and B for
13 such subsequent year.

14 “(B) ROUNDING.—If any amount deter-
15 mined under subparagraph (A) is not a multiple
16 of \$1, such amount shall be rounded to the
17 nearest multiple of \$1.

18 “(3) APPLICATION.—The unified deductible
19 under this subsection for a year shall be applied—

20 “(A) with respect to benefits under part A,
21 on the basis of the amount that is payable for
22 such benefits without regard to any other co-
23 payments or coinsurance and before the appli-
24 cation of any such copayments or coinsurance;

1 “(B) with respect to benefits under part B,
2 on the basis of the total amount of the expenses
3 incurred by an eligible beneficiary during a year
4 which would, except for the application of the
5 deductible, constitute incurred expenses from
6 which benefits payable under section 1833(a)
7 are determinable, without regard to any other
8 copayments or coinsurance and before the ap-
9 plication of any such copayments or coinsur-
10 ance; and

11 “(C) instead of the deductibles described in
12 sections 1813(b) and 1833(b).

13 “(c) SERIOUS ILLNESS PROTECTION.—

14 “(1) IN GENERAL.—In the case of an eligible
15 beneficiary who has elected to receive enhanced
16 medicare benefits under this part, if the amount of
17 the out-of-pocket cost-sharing of such beneficiary for
18 a calendar year equals or exceeds the serious illness
19 protection threshold for that year—

20 “(A) the beneficiary shall not be respon-
21 sible for additional out-of-pocket cost-sharing
22 incurred during that year; and

23 “(B) the Secretary shall establish proce-
24 dures under which the Secretary shall pay on
25 behalf of the beneficiary the amount of the ad-

1 ditional out-of-pocket cost-sharing described in
 2 subparagraph (A) from the Federal Hospital
 3 Insurance Trust Fund and the Federal Supple-
 4 mentary Medical Insurance Trust Fund, in
 5 such proportion as the Secretary determines ap-
 6 propriate.

7 “(2) SERIOUS ILLNESS PROTECTION THRESH-
 8 OLD.—

9 “(A) IN GENERAL.—The amount of the se-
 10 rious illness protection threshold under this
 11 subsection shall be—

12 “(i) for 2005, \$6,000; or

13 “(ii) for a subsequent year, the
 14 amount specified in this subparagraph for
 15 the preceding year increased by the per-
 16 centage increase in the per capita actuarial
 17 value of benefits under parts A and B for
 18 such subsequent year.

19 “(B) ROUNDING.—If any amount deter-
 20 mined under subparagraph (A) is not a multiple
 21 of \$1, such amount shall be rounded to the
 22 nearest multiple of \$1.

23 “(3) OUT-OF-POCKET COST-SHARING DE-
 24 FINED.—In this subsection, the term ‘out-of-pocket
 25 cost-sharing’ means, with respect to an eligible bene-

1 beneficiary, the amount of costs incurred by the bene-
2 ficiary that are attributable to deductibles, coinsur-
3 ance, and copayments imposed under part A or B
4 (as modified by this part), without regard to wheth-
5 er the beneficiary or another person, including a
6 State program or other third-party coverage, has
7 paid for such costs.

8 “(d) ENHANCED HOSPITAL BENEFITS.—

9 “(1) ELIMINATION OF DURATIONAL LIMITS ON
10 INPATIENT HOSPITAL SERVICES.—In the case of an
11 eligible beneficiary who has elected to receive en-
12 hanced medicare benefits under this part—

13 “(A) there shall be no spell of illness limit
14 or lifetime limit on inpatient hospital services
15 under subsections (a)(1) and (b)(1) of section
16 1812 during the period in which the election of
17 the beneficiary to receive enhanced medicare
18 benefits under this part is in effect; and

19 “(B) section 1812(c) shall not be applied
20 during such period.

21 “(2) REVISION OF INPATIENT HOSPITAL COIN-
22 SURANCE.—

23 “(A) IN GENERAL.—In the case of an eligi-
24 ble beneficiary who has elected to receive en-
25 hanced medicare benefits under this part, after

1 the application of the unified deductible under
2 subsection (b), instead of imposing any coinsur-
3 ance under the second sentence of section
4 1813(a)(1), the amount payable under part A
5 for inpatient hospital services or inpatient crit-
6 ical access hospital services furnished to the eli-
7 gible beneficiary during any year, shall be re-
8 duced by the amount of the inpatient hospital
9 copayment specified in subparagraph (B) for
10 each period of hospitalization and the bene-
11 ficiary shall be responsible for payment of such
12 amount for each such period.

13 “(B) AMOUNT OF INPATIENT HOSPITAL
14 COPAYMENT.—

15 “(i) IN GENERAL.—The amount of
16 the inpatient hospital copayment under
17 this paragraph shall be—

18 “(I) for 2005, \$400; or

19 “(II) for a subsequent year, the
20 amount specified in this clause for the
21 preceding year increased by the per-
22 centage increase in the per capita ac-
23 tual value of benefits under parts A
24 and B for such subsequent year.

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

5 “(C) PERIOD OF HOSPITALIZATION DE-
6 FINED.—In this subsection, the term ‘period of
7 hospitalization’ means the period that begins on
8 the date that the eligible beneficiary is admitted
9 to the hospital and ends on the date on which
10 the beneficiary has not been hospitalized for a
11 72-hour period.

12 “(D) COLLECTION OF COPAYMENTS.—For
13 purposes of section 1866(a)(2)(A), hospitals
14 shall substitute the imposition of the inpatient
15 hospital copayment under this paragraph for
16 the hospital coinsurance described in the second
17 sentence of section 1813(a)(1).

18 “(e) ELIMINATION OF COST-SHARING FOR PREVEN-
19 TIVE HEALTH CARE ITEMS AND SERVICES.—

20 “(1) IN GENERAL.—In the case of an eligible
21 beneficiary who has elected to receive enhanced
22 medicare benefits under this part, the unified de-
23 ductible under subsection (b) and deductibles and
24 the coinsurance otherwise applicable under sub-
25 sections (a) and (b) of section 1833 shall not be ap-

1 plied with respect to expenses incurred for any pre-
2 ventive health care items and services (and no
3 charges may be imposed under section 1866(a)(2)
4 where such deductibles and coinsurance are not im-
5 posed).

6 “(2) PREVENTIVE HEALTH CARE ITEMS AND
7 SERVICES DEFINED.—In this subsection, the term
8 ‘preventive health care items and services’ means
9 any of the following health care items and services:

10 “(A) Screening mammography under sec-
11 tion 1861(s)(13).

12 “(B) Screening pap smear and screening
13 pelvic examinations under section 1861(s)(14).

14 “(C) Bone mass measurement under sec-
15 tion 1861(s)(15).

16 “(D) Prostate cancer screening tests under
17 section 1861(s)(2)(P).

18 “(E) Colorectal cancer screening under
19 section 1861(s)(2)(R).

20 “(F) Blood testing strips, lancets, and
21 blood glucose monitors for individuals with dia-
22 betes under section 1861(n).

23 “(G) Diabetes outpatient self-management
24 training services under section 1861(s)(2)(S).

1 “(H) Pneumococcal, influenza, and hepa-
2 titis B vaccines and administration under sec-
3 tion 1861(s)(10).

4 “(I) Screening for glaucoma under section
5 1861(s)(2)(U).

6 “(J) Medical nutrition therapy services
7 under section 1861(s)(2)(V).

8 “(f) SIMPLIFICATION OF COST-SHARING.—In the
9 case of an eligible beneficiary who has elected to receive
10 enhanced medicare benefits under this part, the following
11 cost-sharing rules shall apply:

12 “(1) MODIFICATION OF SKILLED NURSING FA-
13 CILITY COST-SHARING.—Instead of the coinsurance
14 established under section 1813(b) for extended care
15 services, under section 1888(e)—

16 “(A) the payment amount under para-
17 graph (1)(B) of such section shall be equal to
18 the amount otherwise provided minus the
19 amount described in subparagraph (B); and

20 “(B) the eligible beneficiary shall be re-
21 sponsible for a copayment amount for each of
22 the 100 days of care for which payment is made
23 on behalf of an eligible beneficiary under that
24 section equal to—

25 “(i) for 2005, \$60; and

1 “(ii) for a subsequent year, the
2 amount specified in this subparagraph for
3 the preceding year increased by the per-
4 centage increase in the per capita actuarial
5 value of benefits under parts A and B for
6 such subsequent year.

7 If any amount determined under this subpara-
8 graph is not a multiple of \$1, such amount
9 shall be rounded to the nearest multiple of \$1.

10 “(2) APPLICATION OF HOME HEALTH SERVICE
11 COINSURANCE.—

12 “(A) IN GENERAL.—The amount of the
13 payment otherwise made under section 1895 for
14 home health services (other than such services
15 for which payment is made under section
16 1834(a)) shall be reduced by the amount de-
17 scribed in clause (ii).

18 “(B) COPAYMENT AMOUNT.—

19 “(i) IN GENERAL.—Subject to clause
20 (ii), the eligible beneficiary shall be respon-
21 sible for a copayment amount for each of
22 the first 5 visits during an episode of care
23 for which payment is made on behalf of an
24 eligible beneficiary under section 1895
25 equal to—

1 “(I) for 2005, \$10; and

2 “(II) for a subsequent year, the
3 amount specified in this clause for the
4 preceding year increased by the per-
5 centage increase in the per capita ac-
6 tuarial value of benefits under parts A
7 and B for such subsequent year.

8 If any amount determined under this
9 clause is not a multiple of \$1, such amount
10 shall be rounded to the nearest multiple of
11 \$1.

12 “(ii) ANNUAL LIMIT.—For each year
13 in which an election to receive enhanced
14 medicare benefits under this part is in ef-
15 fect, the eligible beneficiary shall not be re-
16 sponsible for the payment of any copay-
17 ment amount under this subparagraph
18 after the date on which the amount of pay-
19 ments made as a result of the application
20 of this paragraph equals \$300.

21 “(3) BLOOD DEDUCTIBLE.—The Secretary
22 shall not apply the deductible under sections
23 1813(a)(2) and 1833(b) for blood or blood cells fur-
24 nished to an eligible beneficiary during the period in

1 which an election of the beneficiary to receive en-
2 hanced medicare benefits under this part is in effect.

3 “PAYMENT OF BENEFITS

4 “SEC. 1860E–3. Payment for enhanced medicare
5 benefits on behalf of an eligible beneficiary who has elected
6 to receive such benefits under this part shall be made in
7 the same manner as payment for such benefits would have
8 been made under parts A and B, subject to the modifica-
9 tions described in section 1860E–2, from the Federal Hos-
10 pital Insurance Trust Fund and the Federal Supple-
11 mentary Medical Insurance Trust Fund, in such propor-
12 tion as the Secretary determines appropriate.

13 “ELIGIBLE BENEFICIARIES; ELECTION OF ENHANCED
14 MEDICARE BENEFITS; TERMINATION OF ELECTION

15 “SEC. 1860E–4. (a) ELIGIBLE BENEFICIARY DE-
16 FINED.—For purposes of this part, the term ‘eligible bene-
17 ficiary’ has the meaning given that term in section
18 1860D(a)(3).

19 “(b) ELECTION OF ENHANCED MEDICARE BENE-
20 FITS.—

21 “(1) ELECTION BY INDIVIDUALS WHO BECOME
22 ELIGIBLE BENEFICIARIES AFTER JANUARY 1, 2005.—

23 “(A) INITIAL ELECTION.—Any individual
24 whose initial election period begins after Sep-
25 tember 30, 2004, shall be deemed to have elect-
26 ed to receive enhanced medicare benefits under

1 this part as of the date on which such indi-
2 vidual first becomes entitled to benefits under
3 part A or eligible to enroll for benefits under
4 part B, whichever is later, unless that indi-
5 vidual affirmatively elects (in such form and
6 manner as the Secretary may specify) to receive
7 benefits under parts A and B.

8 “(B) INITIAL ELECTION PERIOD.—For
9 purposes of this paragraph, the term ‘initial
10 election period’ means, with respect to an indi-
11 vidual, the period that begins on the first day
12 of the third month before the month in which
13 such individual first becomes entitled to benefits
14 under part A or eligible to enroll for benefits
15 under part B, whichever is later, and ends 7
16 months later.

17 “(C) EFFECT OF ELECTION.—If an indi-
18 vidual makes an election under subparagraph
19 (A) and such individual is not entitled to bene-
20 fits under part A or enrolled for benefits under
21 part B at the time of such election, such indi-
22 vidual shall be deemed—

23 “(i) to have elected to enroll for bene-
24 fits under such part under section 1818 or
25 1837 (as appropriate) if such individual is

1 eligible to enroll for benefits under such
2 section, as of the date of such election; or

3 “(ii) if such individual is not eligible
4 to enroll for benefits under section 1818 or
5 1837, to have elected to enroll under part
6 B as of the first date on which the indi-
7 vidual is eligible to enroll under such part.

8 “(2) SPECIAL ELECTION PERIODS.—The Sec-
9 retary shall establish special election periods for in-
10 dividuals under this part who have elected not to
11 make an election (or to be deemed to have made
12 such an election) under this part that are similar to
13 the special enrollment periods under section 1837(i)
14 for individuals described in such section.

15 “(3) TRANSITIONAL ELECTION FOR INDIVID-
16 UALS WHO BECOME ELIGIBLE BENEFICIARIES ON OR
17 BEFORE JANUARY 1, 2005.—

18 “(A) IN GENERAL.—In the case of an indi-
19 vidual who is an eligible beneficiary as of Janu-
20 ary 1, 2005, the Secretary shall establish proce-
21 dures under which such beneficiary may affirm-
22 atively elect to receive enhanced medicare bene-
23 fits under this part during the 7-month period
24 that begins on April 1, 2004, and ends on No-

1 vember 30, 2004, for such election to take ef-
2 fect on January 1, 2005.

3 “(B) EFFECT OF MEDICARE+CHOICE EN-
4 ROLLMENT.—If an eligible beneficiary enrolls in
5 a Medicare+Choice plan under part C during
6 November 2004, such individual shall be
7 deemed to have elected to receive enhanced
8 medicare benefits under subparagraph (A).

9 “(4) CHANGES IN ELECTION.—

10 “(A) IN GENERAL.—An individual who has
11 elected (or is deemed to have elected) to receive
12 enhanced medicare benefits under this part
13 under paragraph (1), (2), or (3) may change
14 such election during an annual, coordinated
15 election period and such election shall take ef-
16 fect on January 1 of the subsequent year. In no
17 case shall such a change of election take effect
18 on a date other than on January 1 of a year
19 (unless the election is automatic pursuant to a
20 termination resulting from a loss or termination
21 of coverage under part A or part B).

22 “(B) ANNUAL, COORDINATED ELECTION
23 PERIOD.—For purposes of this section, the
24 term ‘annual, coordinated election period’
25 means, with respect to a calendar year (begin-

1 ning with 2005), the month of November pre-
2 ceding such year.

3 “(5) PROCEDURES.—The Secretary shall estab-
4 lish procedures for the termination and reinstatement
5 of an election under this section.

6 “(c) COVERAGE TERMINATED BY TERMINATION OF
7 COVERAGE UNDER PART A OR B.—

8 “(1) IN GENERAL.—The Secretary shall termi-
9 nate an individual’s coverage under this part if the
10 individual is no longer enrolled in both parts A and
11 B.

12 “(2) EFFECTIVE DATE.—The termination de-
13 scribed in subparagraph (A) shall be effective on the
14 effective date of termination of coverage under part
15 A or (if earlier) under part B.

16 “PREMIUM ADJUSTMENTS; LATE ELECTION PENALTY

17 “SEC. 1860E-5. (a) GENERAL RULE OF NO CHANGE
18 IN AMOUNT OF PREMIUMS.—Except as provided in this
19 section, an election to receive enhanced medicare benefits
20 under this part shall not affect the amount of any pre-
21 mium charged under part A or B.

22 “(b) LATE ELECTION PENALTY.—

23 “(1) IN GENERAL.—In the case of an eligible
24 beneficiary who does not elect to receive enhanced
25 medicare benefits under this part during an election
26 period described in paragraph (1), (2), or (3) of sec-

1 tion 1860E–4(b) of that beneficiary, reinstates such
2 an election under the procedures established under
3 paragraph (5) of such section, or otherwise does not
4 have such an election continuously in effect from the
5 first date on which such election could be in effect,
6 the premium otherwise imposed under part B (tak-
7 ing into account any late enrollment penalty under
8 section 1839(b)) shall be increased during the period
9 in which such individual has an election to receive
10 enhanced medicare benefits under this part in effect
11 by an amount that the Secretary determines is actu-
12 arially sound (based on the financial impact on the
13 program under this part of the late election of the
14 beneficiary or of the reinstatement of an election of
15 the beneficiary) for each full 12-month period (in
16 the same continuous period of eligibility) in which
17 the eligible beneficiary could have elected to receive
18 enhanced medicare benefits under this part but did
19 not elect to receive such benefits.

20 “(2) PROCEDURES.—In applying the late elec-
21 tion penalty under paragraph (1), the Secretary
22 shall establish procedures for applying the penalty
23 under this subsection that are similar to the proce-
24 dures for applying the late enrollment penalty under
25 section 1839(b).

1 “(c) LATE REVERSAL OF ELECTION PENALTY.—

2 “(1) IN GENERAL.—In the case of an eligible
3 beneficiary who has elected to receive enhanced
4 medicare benefits under this part and terminates
5 such election under the procedures established under
6 section 1860E-4(b)(5) on a date that is more than
7 1 year after the date on which such beneficiary first
8 elected to receive enhanced medicare benefits under
9 this part, the premium otherwise imposed under part
10 B (taking into account any late enrollment penalty
11 under section 1839(b)) shall be increased during the
12 period in which such individual is enrolled under
13 such part by an amount that the Secretary deter-
14 mines is actuarially sound based on the financial im-
15 pact on the program under this part of the reversal
16 of the election of the beneficiary.

17 “(2) PROCEDURES.—In applying the late rever-
18 sal of election penalty under paragraph (1), the Sec-
19 retary shall establish procedures for applying the
20 penalty under this subsection that are similar to the
21 procedures for applying the late enrollment penalty
22 under section 1839(b).”.

23 (b) PROVIDING INFORMATION TO BENEFICIARIES.—

24 During 2004, the Secretary shall provide for an extensive,
25 national educational and publicity campaign to inform eli-

1 gible beneficiaries (and prospective eligible beneficiaries)
2 regarding the enhanced medicare benefits to be made
3 available under part E of title XVIII of the Social Security
4 Act (as added by subsection (a)).

5 (c) CONFORMING ADJUSTMENTS TO PART A AND B
6 PREMIUMS.—

7 (1) EFFECT OF PART E ON PART A PREMIUM.—
8 Section 1818(d)(1) (42 U.S.C. 1395i–2(d)(1)) is
9 amended by adding at the end the following new
10 sentence: “In making the estimate under the pre-
11 vious sentence, the Secretary shall take into account
12 the effect of elections to receive enhanced medicare
13 benefits under part E on the amounts paid from
14 such Trust Fund.”.

15 (2) EFFECT OF PART E ON PART B PREMIUM.—
16 Section 1839(a) (42 U.S.C. 1395r(a)) is amended—

17 (A) in paragraph (1)—

18 (i) by inserting “(including eligible
19 beneficiaries who elect to receive enhanced
20 medicare benefits under part E)” after
21 “age 65 and over”; and

22 (ii) by inserting “(including eligible
23 beneficiaries who elect to receive enhanced
24 medicare benefits under part E)” after
25 “age 65 and older”;

1 (B) in paragraph (2), by inserting “, as
2 adjusted under section 1860E–5” before the pe-
3 riod at the end;

4 (C) in paragraph (3)—

5 (i) by inserting “(including eligible
6 beneficiaries who elect to receive enhanced
7 medicare benefits under part E)” after
8 “age 65 and over”; and

9 (ii) by inserting “(including eligible
10 beneficiaries who elect to receive enhanced
11 medicare benefits under part E)” after
12 “age 65 and older”; and

13 (D) in paragraph (4)—

14 (i) in the first sentence, by inserting
15 “(including eligible beneficiaries who elect
16 to receive enhanced medicare benefits
17 under part E)” after “under age 65”; and

18 (ii) in the second sentence, by striking
19 “under age 65 which” and inserting
20 “under age 65 (including eligible bene-
21 ficiaries who elect to receive enhanced
22 medicare benefits under part E)”.

23 (d) CLARIFICATION OF APPLICATION OF EXCLU-
24 SIONS FROM COVERAGE TO PART E.—Section 1862(a)
25 (42 U.S.C. 1395y(a)) is amended in the matter preceding

1 paragraph (1) by inserting “(including for enhanced medi-
2 care benefits under part E)” after “for items or services”.

3 **SEC. 202. RULES RELATING TO MEDIGAP POLICIES THAT**
4 **PROVIDE PRESCRIPTION DRUG COVERAGE;**
5 **ESTABLISHMENT OF ENHANCED MEDICARE**
6 **FEE-FOR-SERVICE MEDIGAP POLICIES.**

7 (a) RULES RELATING TO MEDIGAP POLICIES THAT
8 PROVIDE PRESCRIPTION DRUG COVERAGE.—Section
9 1882 (42 U.S.C. 1395ss) is amended by adding at the end
10 the following new subsection:

11 “(v) RULES RELATING TO MEDIGAP POLICIES THAT
12 PROVIDE PRESCRIPTION DRUG COVERAGE.—

13 “(1) PROHIBITION ON SALE, ISSUANCE, AND
14 RENEWAL OF POLICIES THAT PROVIDE PRESCRIP-
15 TION DRUG COVERAGE TO PART D ENROLLEES.—

16 “(A) IN GENERAL.—Notwithstanding any
17 other provision of law, on or after January 1,
18 2005, no medicare supplemental policy that
19 provides coverage of expenses for prescription
20 drugs may be sold, issued, or renewed under
21 this section to an individual who is enrolled
22 under part D.

23 “(B) PENALTIES.—The penalties described
24 in subsection (d)(3)(A)(ii) shall apply with re-
25 spect to a violation of subparagraph (A).

1 “(2) ISSUANCE OF SUBSTITUTE POLICIES IF
2 THE POLICYHOLDER OBTAINS PRESCRIPTION DRUG
3 COVERAGE UNDER PART D.—

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

6 “(i) may not deny or condition the
7 issuance or effectiveness of a medicare
8 supplemental policy that has a benefit
9 package classified as ‘A’, ‘B’, ‘C’, ‘D’, ‘E’,
10 ‘F’ (including the benefit package classi-
11 fied as ‘F’ with a high deductible feature,
12 as described in subsection (p)(11)), or ‘G’
13 (under the standards established under
14 subsection (p)(2)) and that is offered and
15 is available for issuance to new enrollees by
16 such issuer;

17 “(ii) may not discriminate in the prie-
18 ing of such policy, because of health sta-
19 tus, claims experience, receipt of health
20 care, or medical condition; and

21 “(iii) may not impose an exclusion of
22 benefits based on a pre-existing condition
23 under such policy,

24 in the case of an individual described in sub-
25 paragraph (B) who seeks to enroll under the

1 policy during the open enrollment period estab-
2 lished under section 1860D–2(b)(2) and who
3 submits evidence that they meet the require-
4 ments under subparagraph (B) along with the
5 application for such medicare supplemental pol-
6 icy.

7 “(B) INDIVIDUAL DESCRIBED.—An indi-
8 vidual described in this subparagraph is an in-
9 dividual who—

10 “(i) enrolls in the medicare prescrip-
11 tion drug delivery program under part D;
12 and

13 “(ii) at the time of such enrollment
14 was enrolled and terminates enrollment in
15 a medicare supplemental policy which has
16 a benefit package classified as ‘H’, ‘I’, or
17 ‘J’ (including the benefit package classified
18 as ‘J’ with a high deductible feature, as
19 described in section 1882(p)(11)) under
20 the standards referred to in subparagraph
21 (A)(i) or terminates enrollment in a policy
22 to which such standards do not apply but
23 which provides benefits for prescription
24 drugs.

1 “(C) ENFORCEMENT.—The provisions of
2 subparagraph (A) shall be enforced as though
3 they were included in subsection (s).

4 “(3) NOTICE REQUIRED TO BE PROVIDED TO
5 CURRENT POLICYHOLDERS WITH PRESCRIPTION
6 DRUG COVERAGE.—

7 “(A) IN GENERAL.—No medicare supple-
8 mental policy of an issuer shall be deemed to
9 meet the standards in subsection (c) unless the
10 issuer provides written notice during the 60-day
11 period immediately preceding the period estab-
12 lished for the open enrollment period estab-
13 lished under section 1860D–2(b)(2), to each in-
14 dividual who is a policyholder or certificate
15 holder of a medicare supplemental policy issued
16 by that issuer that provides some coverage of
17 expenses for prescription drugs (at the most re-
18 cent available address of that individual) of—

19 “(i) the ability to enroll in a new
20 medicare supplemental policy pursuant to
21 paragraph (2); and

22 “(ii) the fact that, so long as such in-
23 dividual retains coverage under such pol-
24 icy, the individual shall be ineligible for
25 coverage of prescription drugs under part

1 D and ineligible to elect to receive en-
 2 hanced medicare benefits under part E.

3 “(B) COORDINATION.—The notice pro-
 4 vided under subparagraph (A) shall be coordi-
 5 nated with the notice required under subsection
 6 (v)(4)(A)(i).

7 “(4) CLARIFICATION REGARDING ONE-TIME
 8 AVAILABILITY OF A GUARANTEED ISSUE POLICY FOR
 9 BENEFICIARIES WHO LOSE COVERAGE UNDER A
 10 MEDICARE+CHOICE PLAN OF JANUARY 1, 2005, BE-
 11 CAUSE THEY ELECT NOT TO RECEIVE ENHANCED
 12 PART E BENEFITS.—In the case of a beneficiary who
 13 is enrolled in a Medicare+Choice plan as of Decem-
 14 ber 31, 2004, will not be eligible to be enrolled
 15 under such plan as of January 1, 2005, because the
 16 beneficiary has elected not to receive enhanced medi-
 17 care benefits under part E—

18 “(A) such beneficiary shall be deemed to
 19 be described in subsection (s)(3)(B)(ii); and

20 “(B) for purposes of (s)(3)(E)(ii), the date
 21 of the termination of coverage shall be January
 22 1, 2005.”.

23 (b) ESTABLISHMENT OF ENHANCED MEDICARE
 24 FEE-FOR-SERVICE MEDIGAP POLICIES.—Section 1882
 25 (42 U.S.C. 1395ss), as amended by subsection (a), is

1 amended by adding at the end the following new sub-
2 section:

3 “(w) ENHANCED MEDICARE FEE-FOR-SERVICE SUP-
4 PLEMENTAL POLICIES.—

5 “(1) ADDITIONAL BENEFIT PACKAGES.—

6 “(A) ESTABLISHMENT.—

7 “(i) IN GENERAL.—In addition to the
8 benefit packages classified under the
9 standards established by subsection (p)(2),
10 there shall be established benefit packages
11 that may only be purchased by bene-
12 ficiaries who have elected to receive en-
13 hanced medicare benefits under part E
14 that—

15 “(I) complement but do not du-
16 plicate enhanced medicare benefits de-
17 scribed in section 1860E-2;

18 “(II) do not provide for coverage
19 of the unified deductible under section
20 1860E-2(b);

21 “(III) subject to clause (ii), do
22 not provide coverage for more than 50
23 percent of the amount of coinsurance
24 and copayments applicable under sec-
25 tion 1860E-2;

1 “(IV) do not provide for coverage
2 of expenses for prescription drugs;

3 “(V) provide a range of coverage
4 options for beneficiaries; and

5 “(VI) use uniform language, defi-
6 nitions, and format with respect to
7 the coverage provided under a policy.

8 “(ii) ONE PACKAGE REQUIRED TO
9 COVER ALL COST-SHARING.—

10 “(I) IN GENERAL.—One of the
11 benefit packages established under
12 clause (i) shall include coverage of all
13 coinsurance and copayments applica-
14 ble under section 1860E–2.

15 “(II) AVAILABILITY LIMITED TO
16 BENEFICIARIES THAT ENROLLED IN
17 PART E DURING CERTAIN PERIODS.—

18 The benefit package that includes the
19 coverage described in subclause (II)
20 shall only be made available to bene-
21 ficiaries who elect to receive enhanced
22 medicare benefits under part E during
23 the beneficiary’s initial election period
24 (as defined in paragraph (1)(B) of
25 section 1860D–4(b)), during a special

1 election period described in paragraph
2 (2) of such section, or during the
3 transitional election period under
4 paragraph (3) of such section.

5 “(B) MANNER OF ESTABLISHMENT.—The
6 benefit packages established under this section
7 shall be established in the manner described in
8 subparagraph (E) of subsection (p)(1), except
9 that for purposes of subparagraph (C) of such
10 subsection, the standards established under this
11 subsection shall take effect not later than Janu-
12 ary 1, 2005.

13 “(2) CONSTRUCTION OF BENEFITS IN OTHER
14 MEDICARE SUPPLEMENTAL POLICIES.—Nothing in
15 this subsection shall be construed to affect the ben-
16 efit packages classified as ‘A’ through ‘J’ under the
17 standards established by subsection (p)(2) (including
18 the benefit packages classified as ‘F’ and ‘J’ with a
19 high deductible feature, as described in subsection
20 (p)(11)).

21 “(3) GUARANTEED ISSUANCE AND RENEWAL
22 OF ENHANCED MEDICARE FEE-FOR-SERVICE SUP-
23 PLEMENTAL POLICIES.—The provisions of sub-
24 sections (q) and (s), including provisions of sub-
25 section (s)(3) (relating to special enrollment periods

1 in cases of termination or disenrollment), shall apply
2 to medicare supplemental policies established under
3 this subsection in a similar manner as such provi-
4 sions apply to medicare supplemental policies issued
5 under the standards established under subsection
6 (p).

7 “(4) OPPORTUNITY OF CURRENT POLICY-
8 HOLDERS TO PURCHASE ENHANCED MEDICARE FEE-
9 FOR-SERVICE SUPPLEMENTAL POLICIES.—

10 “(A) REQUIREMENTS FOR ISSUERS OF
11 POLICIES WITH RESPECT TO CURRENT POLICY-
12 HOLDERS.—No medicare supplemental policy of
13 an issuer with a benefit package that is estab-
14 lished under paragraph (1) shall be deemed to
15 meet the standards in subsection (c) unless the
16 issuer does all of the following:

17 “(i) NOTICE TO CURRENT POLICY-
18 HOLDERS.—Provide written notice during
19 the 60-day period immediately preceding
20 the period established under section
21 1860E-4(b)(1), to each individual who is a
22 policyholder or certificate holder of a medi-
23 care supplemental policy issued by that
24 issuer (at the most recent available address
25 of that individual) of the offer described in

1 clause (ii) and of the fact that, so long as
2 such individual retains coverage under
3 such policy, the individual shall be ineli-
4 gible to elect enhanced medicare benefits
5 under part E.

6 “(ii) OFFER FOR CURRENT POLICY-
7 HOLDERS.—Offer the policyholder or cer-
8 tificate holder under the terms described in
9 subparagraph (C), during at least the pe-
10 riod established under section 1860E-
11 4(b)(1), a medicare supplemental policy es-
12 tablished under paragraph (1) with the
13 benefit package that the Secretary deter-
14 mines is most comparable to the policy in
15 which the individual is enrolled with cov-
16 erage effective as of the effective date of
17 the election of the individual under part E.

18 “(iii) OFFER FOR INDIVIDUALS COV-
19 ERED UNDER POLICIES ISSUED BY OTHER
20 ISSUERS IF THAT ISSUER IS NOT GOING TO
21 OFFER ENHANCED MEDICARE FEE-FOR-
22 SERVICE SUPPLEMENTAL POLICIES.—Offer
23 an individual described in subparagraph
24 (B), under the terms described in subpara-
25 graph (C), and during at least the period

1 established under section 1860E–4(b)(1), a
2 medicare supplemental policy established
3 under paragraph (1) with the benefit pack-
4 age that the Secretary determines is most
5 comparable to the policy in which the indi-
6 vidual is enrolled with coverage effective as
7 of the effective date of the election of the
8 individual under part E.

9 The notice provided under clause (i) shall be co-
10 ordinated with the notice required under sub-
11 section (v)(3)(A).

12 “(B) INDIVIDUAL DESCRIBED.—An indi-
13 vidual described in this subparagraph is an in-
14 dividual who is a policyholder or certificate
15 holder of a medicare supplemental policy issued
16 by an issuer who is not going to offer a policy
17 with a benefit package established under para-
18 graph (1).

19 “(C) TERMS OF OFFER DESCRIBED.—The
20 terms described in this subparagraph are terms
21 which do not—

22 “(i) deny or condition the issuance or
23 effectiveness of a medicare supplemental
24 policy described in subparagraph (A)(ii)

1 that is offered and is available for issuance
 2 to new enrollees by such issuer;

3 “(ii) discriminate in the pricing of
 4 such policy because of health status, claims
 5 experience, receipt of health care, or med-
 6 ical condition; or

7 “(iii) impose an exclusion of benefits
 8 based on a preexisting condition under
 9 such policy.

10 “(5) PROHIBITION OF SALE OF ENHANCED
 11 POLICIES TO ORIGINAL MEDICARE FEE-FOR-SERVICE
 12 ENROLLEES; PROHIBITION OF SALE OF ORIGINAL
 13 POLICIES TO ENHANCED MEDICARE FEE-FOR-SERV-
 14 ICE ENROLLEES.—

15 “(A) PROHIBITION.—No person may sell,
 16 issue, or renew a medicare supplemental policy
 17 with—

18 “(i) a benefit package established
 19 under this subsection to an individual who
 20 has not elected to receive enhanced medi-
 21 care benefits under part E; or

22 “(ii) a benefit package classified as
 23 ‘A’ through ‘J’ under the standards estab-
 24 lished by subsection (p)(2) (including the
 25 benefit packages classified as ‘F’ and ‘J’

1 with a high deductible feature, as described
2 in subsection (p)(11)) to an individual who
3 has elected to receive enhanced medicare
4 benefits under part E.

5 “(B) PENALTY.—Any person who violates
6 the provisions of subparagraph (A) shall be
7 subject to a civil money penalty in an amount
8 that does not exceed \$25,000 (or \$15,000 in
9 the case of a seller who is not an issuer of a
10 policy) for each such violation. The provisions
11 of section 1128A (other than the first sentence
12 of subsection (a) and other than subsection (b))
13 shall apply to a civil money penalty under the
14 previous sentence in the same manner as such
15 provisions apply to a penalty or proceeding
16 under section 1128A(a).

17 “(6) OTHER PROHIBITIONS AND PENALTIES.—
18 Each penalty under this section shall apply with re-
19 spect to policies established under this subsection as
20 if such policies were issued under the standards es-
21 tablished under subsection (p), including the pen-
22 alties under subsections (a), (d), (p)(8), (p)(9),
23 (q)(5), (r)(6)(A), (s)(4), and (t)(2)(D).”.

1 **TITLE III—MEDICARE+CHOICE**
 2 **COMPETITION**

3 **SEC. 301. ANNUAL CALCULATION OF BENCHMARK**
 4 **AMOUNTS BASED ON FLOOR RATES AND**
 5 **LOCAL FEE-FOR-SERVICE RATES.**

6 (a) ANNUAL CALCULATION OF BENCHMARK
 7 AMOUNTS BASED ON FLOOR RATES AND LOCAL FEE-
 8 FOR-SERVICE RATES.—Section 1853(a) (42 U.S.C.
 9 1395w–23(a)) is amended by adding at the end the fol-
 10 lowing new paragraph:

11 “(4) ANNUAL CALCULATION OF BENCHMARK
 12 AMOUNTS.—For each year, the Secretary shall cal-
 13 culate a benchmark amount for each
 14 Medicare+Choice payment area for each month for
 15 such year with respect to coverage of enhanced
 16 medicare benefits under part E equal to the greatest
 17 of the following amounts:

18 “(A) MINIMUM AMOUNT.— $\frac{1}{12}$ of the an-
 19 nual Medicare+Choice capitation rate deter-
 20 mined under subsection (c)(1)(B) for the pay-
 21 ment area for the year; or

22 “(B) LOCAL FEE-FOR-SERVICE RATE.—
 23 The local fee-for-service rate for such area for
 24 the year (as calculated under paragraph (5)).”.

1 (b) ANNUAL CALCULATION OF LOCAL FEE-FOR-
2 SERVICE RATES.—Section 1853(a) (42 U.S.C. 1395w-
3 23(a)), as amended by subsection (a), is amended by add-
4 ing at the end the following new paragraph:

5 “(5) ANNUAL CALCULATION OF LOCAL FEE-
6 FOR-SERVICE RATES.—

7 “(A) IN GENERAL.—Subject to subpara-
8 graphs (B) and (C), the term ‘local fee-for-serv-
9 ice rate’ means the amount of payment for a
10 month in a Medicare+Choice payment area for
11 benefits under this title and associated claims
12 processing costs for an individual who has elect-
13 ed to receive enhanced medicare benefits under
14 part E (but, if the Medicare+Choice plan offers
15 prescription drug coverage, excluding any costs
16 associated with part D), and not enrolled in a
17 Medicare+Choice plan under this part. The
18 Secretary shall annually calculate such amount
19 in a manner similar to the manner in which the
20 Secretary calculated the adjusted average per
21 capita cost under section 1876, except that
22 such calculation shall include in such amount,
23 to the extent practicable, any amounts that
24 would have been paid under this title if individ-
25 uals entitled to benefits under this title had not

1 received services from facilities of the Depart-
2 ment of Veterans Affairs or the Department of
3 Defense.

4 “(B) REMOVAL OF MEDICAL EDUCATION
5 COSTS FROM CALCULATION OF LOCAL FEE-FOR-
6 SERVICE RATE.—

7 “(i) IN GENERAL.—In calculating the
8 local fee-for-service rate under subpara-
9 graph (A) for a year, the amount of pay-
10 ment described in such subparagraph shall
11 be adjusted to exclude from such payment
12 the payment adjustments described in
13 clause (ii).

14 “(ii) PAYMENT ADJUSTMENTS DE-
15 SCRIBED.—

16 “(I) IN GENERAL.—Subject to
17 subclause (II), the payment adjust-
18 ments described in this subparagraph
19 are payment adjustments that the
20 Secretary estimates were payable dur-
21 ing each month for direct graduate
22 medical education costs under section
23 1886(h).

24 “(II) TREATMENT OF PAYMENTS
25 COVERED UNDER STATE HOSPITAL

1 REIMBURSEMENT SYSTEM.—To the
2 extent that the Secretary estimates
3 that the amount of the local fee-for-
4 service rates reflects payments to hos-
5 pitals reimbursed under section
6 1814(b)(3), the Secretary shall esti-
7 mate a payment adjustment that is
8 comparable to the payment adjust-
9 ment that would have been made
10 under clause (i) if the hospitals had
11 not been reimbursed under such sec-
12 tion.

13 “(C) SPECIAL RULE FOR RURAL AREAS.—

14 “(i) IN GENERAL.—Subject to clause
15 (ii), in calculating the local fee-for-service
16 rates under subparagraph (A) for a year,
17 the Secretary shall calculate such costs for
18 rural areas (as defined in section
19 1886(d)(2)(D)) of a State as if each rural
20 area were part of a single
21 Medicare+Choice payment area.

22 “(ii) LIMITATION.—Payment amounts
23 determined under subparagraph (A) may
24 not be less than the amounts that would
25 have been paid if clause (i) did not apply.”.

1 (c) CPI INCREASES IN FLOOR PAYMENT RATES.—
2 Section 1853(c)(1)(B) (42 U.S.C. 1395w-23(c)(1)(B)) is
3 amended—

4 (1) in clause (iv), by striking “and each suc-
5 ceeding year,” and inserting “, 2003, and 2004,”;
6 and

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

9 “(v) For 2005 and each succeeding
10 year, the minimum amount specified in
11 this clause (or clause (iv)) for the pre-
12 ceding year increased by the percentage in-
13 crease in the Consumer Price Index for all
14 urban consumers (U.S. urban average) for
15 the 12-month period ending with June of
16 the previous year.”.

17 (d) FURNISHING OF CLAIMS DATA BY VA AND
18 DOD.—Upon the request of the Secretary of Health and
19 Human Services, the Secretary of Veterans Affairs and
20 the Secretary of Defense shall provide such claims data
21 as the Secretary of Health and Human Services may re-
22 quire to determine the amount that would have been paid
23 under the medicare program under title XVIII of the So-
24 cial Security Act if individuals entitled to benefits under
25 such program had not received services from facilities of

1 the Department of Veterans Affairs or the Department
 2 of Defense for purposes calculating the amounts under
 3 section 1853(a)(5) of such Act (as added by subsection
 4 (b)) and section 1853(c)(8) of such Act (as added by sec-
 5 tion 312(b)).

6 **SEC. 302. APPLICATION OF COMPREHENSIVE RISK ADJUST-**
 7 **MENT METHODOLOGY.**

8 Section 1853(a)(3) is amended to read as follows:

9 “(3) COMPREHENSIVE RISK ADJUSTMENT
 10 METHODOLOGY.—

11 “(A) APPLICATION OF METHODOLOGY.—

12 The Secretary shall apply the comprehensive
 13 risk adjustment methodology described in sub-
 14 paragraph (B) to 100 percent of the amount of
 15 the plan bids under section 1853(d)(1) and the
 16 weighted service area benchmark amounts cal-
 17 culated under section 1853(d)(3).

18 “(B) COMPREHENSIVE RISK ADJUSTMENT

19 METHODOLOGY DESCRIBED.—The comprehen-
 20 sive risk adjustment methodology described in
 21 this subparagraph is the risk adjustment meth-
 22 odology that would apply with respect to
 23 Medicare+Choice plans offered by
 24 Medicare+Choice organizations in 2004, except
 25 that if such methodology does not apply to

1 groups of beneficiaries who are aged or disabled
2 and groups of beneficiaries who have end-stage
3 renal disease, the Secretary shall revise such
4 methodology to apply to such groups.

5 “(C) UNIFORM APPLICATION TO ALL
6 TYPES OF PLANS.—Subject to section
7 1859(e)(4), the comprehensive risk adjustment
8 methodology established under this paragraph
9 shall be applied uniformly without regard to the
10 type of plan.

11 “(D) DATA COLLECTION.—In order to
12 carry out this paragraph, the Secretary shall re-
13 quire Medicare+Choice organizations to submit
14 such data and other information as the Sec-
15 retary deems necessary.

16 “(E) IMPROVEMENT OF PAYMENT ACCU-
17 RACY.—Notwithstanding any other provision of
18 this paragraph, the Secretary may revise the
19 comprehensive risk adjustment methodology de-
20 scribed in subparagraph (B) from time to time
21 to improve payment accuracy.”.

22 **SEC. 303. ANNUAL ANNOUNCEMENT OF BENCHMARK**
23 **AMOUNTS AND OTHER PAYMENT FACTORS.**

24 Section 1853(b) (42 U.S.C. 1395w-23(b)), as
25 amended by section 532(d)(1) of the Public Health Secu-

1 rity and Bioterrorism Preparedness and Response Act of
2 2002 (Public Law 107–188; 116 Stat. 696), is amended—

3 (1) in the heading, by striking “PAYMENT
4 RATES” and inserting “PAYMENT FACTORS”;

5 (2) by striking paragraph (1) and inserting the
6 following:

7 “(1) ANNUAL ANNOUNCEMENT.—Beginning in
8 2004, at the same time as the Secretary publishes
9 the risk adjusters under section 1860D–11, the Sec-
10 retary shall annually announce (in a manner in-
11 tended to provide notice to interested parties) the
12 following payment factors:

13 “(A) The benchmark amount for each
14 Medicare+Choice payment area (as calculated
15 under subsection (a)(4)) for the year.

16 “(B) The factors to be used for adjusting
17 payments under the comprehensive risk adjust-
18 ment methodology described in subsection
19 (a)(3)(B) with respect to each
20 Medicare+Choice payment area for the year.”;

21 (3) in paragraph (3), by striking “monthly ad-
22 justed” and all that follows before the period at the
23 end and inserting “each payment factor described in
24 paragraph (1)”;

25 (4) by striking paragraph (4).

1 **SEC. 304. SUBMISSION OF BIDS BY MEDICARE+CHOICE OR-**
2 **GANIZATIONS.**

3 Section 1854(a) (42 U.S.C. 1395w-24(a)), as
4 amended by section 532(b)(1) of the Public Health Secu-
5 rity and Bioterrorism Preparedness and Response Act of
6 2002 (Public Law 107-188; 116 Stat. 696), is amended
7 to read as follows:

8 “(a) SUBMISSION OF BIDS BY MEDICARE+CHOICE
9 ORGANIZATIONS.—

10 “(1) IN GENERAL.—Not later than the second
11 Monday in September (or July 1 of each year before
12 2002) and except as provided in paragraph (3), each
13 Medicare+Choice organization shall submit to the
14 Secretary, in such form and manner as the Sec-
15 retary may specify, for each Medicare+Choice plan
16 that the organization intends to offer in a service
17 area in the following year—

18 “(A) notice of such intent and information
19 on the service area of the plan;

20 “(B) the plan type for each plan;

21 “(C) if the Medicare+Choice plan is a co-
22 ordinated care plan (as described in section
23 1851(a)(2)(A)) or a private fee-for-service plan
24 (as described in section 1851(a)(2)(C)), the in-
25 formation described in paragraph (2) with re-
26 spect to each payment area;

1 “(D) the enrollment capacity (if any) in re-
2 lation to the plan and each payment area;

3 “(E) the expected mix, by health status, of
4 enrolled individuals; and

5 “(F) such other information as the Sec-
6 retary may specify.

7 “(2) INFORMATION REQUIRED FOR COORDI-
8 NATED CARE PLANS AND PRIVATE FEE-FOR-SERVICE
9 PLANS.—For a Medicare+Choice plan that is a co-
10 ordinated care plan (as described in section
11 1851(a)(2)(A)) or a private fee-for-service plan (as
12 described in section 1851(a)(2)(C)), the information
13 described in this paragraph is as follows:

14 “(A) INFORMATION REQUIRED WITH RE-
15 SPECT TO BENEFITS UNDER PART E.—Informa-
16 tion relating to the coverage of benefits under
17 part E as follows:

18 “(i) The plan bid, which shall consist
19 of a dollar amount that represents the
20 total amount that the plan is willing to ac-
21 cept (after the application of the com-
22 prehensive risk adjustment methodology
23 under section 1853(a)(3)) for providing
24 coverage of the benefits under part E to an

1 individual enrolled in the plan that resides
2 in the service area of the plan for a month.

3 “(ii) For the supplemental benefits
4 package offered (if any)—

5 “(I) the adjusted community rate
6 (as defined in subsection (g)(3)) of
7 the package;

8 “(II) the Medicare+Choice
9 monthly supplemental beneficiary pre-
10 mium (as defined in subsection
11 (b)(2)(C));

12 “(III) a description of any cost-
13 sharing; and

14 “(IV) such other information as
15 the Secretary considers necessary.

16 “(iii) The assumptions that the
17 Medicare+Choice organization used in pre-
18 paring the plan bid with respect to num-
19 bers, in each payment area, of enrolled in-
20 dividuals and the mix, by health status, of
21 such individuals.

22 “(B) INFORMATION REQUIRED WITH RE-
23 SPECT TO PART D.—If the Medicare+Choice
24 organization elects to offer prescription drug
25 coverage, the information required to be sub-

1 mitted by an eligible entity under section
2 1860D–12, including the monthly premiums for
3 standard coverage and any other qualified pre-
4 scription drug coverage available to individuals
5 enrolled under part D.

6 “(3) REQUIREMENTS FOR MSA PLANS.—For an
7 MSA plan described in section 1851(a)(2)(B), the
8 information described in this paragraph is the infor-
9 mation that such a plan would have been required
10 to submit under this part if the 21st Century Medi-
11 care Act had not been enacted.

12 “(4) REVIEW.—

13 “(A) IN GENERAL.—Subject to subpara-
14 graph (B), the Secretary shall review the ad-
15 justed community rates (as defined in section
16 1854(g)(3)), the amounts of the
17 Medicare+Choice monthly basic and supple-
18 mental beneficiary premiums filed under this
19 subsection and shall approve or disapprove such
20 rates and amounts so submitted. The Chief Ac-
21 tuary of the Medicare Competitive Agency shall
22 review the actuarial assumptions and data used
23 by the Medicare+Choice organization with re-
24 spect to such rates and amounts so submitted

1 to determine the appropriateness of such as-
 2 sumptions and data.

3 “(B) EXCEPTION.—The Secretary shall
 4 not review, approve, or disapprove the amounts
 5 submitted under paragraph (3).”.

6 **SEC. 305. ADJUSTMENT OF PLAN BIDS; COMPARISON OF**
 7 **ADJUSTED BID TO BENCHMARK; PAYMENT**
 8 **AMOUNT.**

9 (a) IN GENERAL.—Section 1853 (42 U.S.C. 1395w–
 10 23) is amended—

11 (1) by redesignating subsections (d) through (i)
 12 as subsections (e) through (j), respectively; and

13 (2) by inserting after subsection (c) the fol-
 14 lowing new subsection:

15 “(d) SECRETARY’S DETERMINATION OF PAYMENT
 16 AMOUNT FOR ENHANCED MEDICARE BENEFITS.—

17 “(1) ADJUSTMENT OF PLAN BIDS.—The Sec-
 18 retary shall adjust each plan bid submitted under
 19 section 1854(a) for the coverage of benefits under
 20 part E using the comprehensive risk adjustment
 21 methodology applicable under subsection (a)(3)
 22 based on the assumptions described in section
 23 1854(a)(2)(A)(iii) that the plan used with respect to
 24 numbers of enrolled individuals.

1 “(2) DETERMINATION OF WEIGHTED SERVICE
2 AREA BENCHMARK AMOUNTS.—The Secretary shall
3 calculate a weighted service area benchmark amount
4 for enhanced medicare benefits under part E for
5 each plan equal to the weighted average of the
6 benchmark amounts for enhanced medicare benefits
7 under such part for the payment areas included in
8 the service area of the plan using the assumptions
9 described in section 1854(a)(2)(A)(iii) that the plan
10 used with respect to numbers of enrolled individuals.

11 “(3) DETERMINATION OF PLAN BENCHMARK.—
12 The Secretary shall calculate the plan benchmark
13 amount by adjusting the weighted service area
14 benchmark amount determined under paragraph (1)
15 using—

16 “(A) the comprehensive risk adjustment
17 methodology applicable under subsection (a)(3);
18 and

19 “(B) the assumptions contained in the
20 plan bid that the plan used with respect to
21 numbers of enrolled individuals.

22 “(4) COMPARISON TO BENCHMARK.—The Sec-
23 retary shall determine the difference between each
24 plan bid (as adjusted under paragraph (1)) and the

1 plan benchmark amount (as determined under para-
2 graph (3)) for purposes of determining—

3 “(A) the payment amount under para-
4 graph (5); and

5 “(B) the part E premium reductions and
6 Medicare+Choice monthly basic beneficiary
7 premiums.

8 “(5) DETERMINATION OF PAYMENT AMOUNT.—
9 The Secretary shall determine the payment amount
10 for plans as follows:

11 “(A) BIDS THAT EQUAL OR EXCEED THE
12 BENCHMARK.—The amount of each monthly
13 payment to a Medicare+Choice organization
14 with respect to each individual enrolled in a
15 plan shall be the plan benchmark amount.

16 “(B) BIDS BELOW THE BENCHMARK.—
17 The amount of each monthly payment to a
18 Medicare+Choice organization with respect to
19 each individual enrolled in a plan shall be the
20 plan benchmark amount reduced by 25 percent
21 of the difference between the bid and the bench-
22 mark amount and further reduced by the
23 amount of any premium reduction elected by
24 the plan under section 1854(d)(1)(A)(i).

1 “(6) FACTORS USED IN ADJUSTING BIDS AND
2 BENCHMARKS FOR MEDICARE+CHOICE ORGANIZA-
3 TIONS AND IN DETERMINING ENROLLEE PRE-
4 MIUMS.—Subject to paragraph (7), the Secretary
5 shall use, for purposes of adjusting plan bids and
6 calculating plan benchmarks under this subsection—

7 “(A) with respect to benefits under part

8 E—

9 “(i) the benchmark amount for the
10 Medicare+Choice payment area announced
11 under section 1854(a)(1)(A); and

12 “(ii) the health status and other de-
13 mographic adjustment factors for the
14 Medicare+Choice payment area announced
15 under section 1854(a)(1)(B); and

16 “(B) if the Medicare+Choice organization
17 elects to offer prescription drug coverage, the
18 risk adjusters published under section 1860D-
19 11 applicable with respect to such coverage.

20 “(7) ADJUSTMENT FOR NATIONAL COVERAGE
21 DETERMINATIONS AND LEGISLATIVE CHANGES IN
22 BENEFITS.—If the Secretary makes a determination
23 with respect to coverage under this title or there is
24 a change in benefits required to be provided under
25 this part that the Secretary projects will result in a

1 significant increase in the costs to Medicare+Choice
 2 organizations of providing benefits under contracts
 3 under this part (for periods after any period de-
 4 scribed in section 1852(a)(5)), the Secretary shall
 5 appropriately adjust the benchmark amounts or pay-
 6 ment amounts (as determined by the Secretary).
 7 Such projection and adjustment shall be based on an
 8 analysis by the Chief Actuary of the Competitive
 9 Medicare Agency of the actuarial costs associated
 10 with the new benefits.”.

11 (b) CONFORMING AMENDMENT.—Section 1853(c)(7)
 12 (42 U.S.C. 1395w–23(c)(7)) is repealed.

13 **SEC. 306. DETERMINATION OF PREMIUM REDUCTIONS, RE-**
 14 **DUCED COST-SHARING, ADDITIONAL BENE-**
 15 **FITS, AND BENEFICIARY PREMIUMS.**

16 (a) CALCULATION OF BENEFICIARY PREMIUMS.—
 17 Section 1854 (42 U.S.C. 1395–24) is amended by—

18 (1) redesignating subsections (d) through (h) as
 19 subsections (e) through (i), respectively; and

20 (2) inserting after subsection (c) the following
 21 new subsection:

22 “(d) DETERMINATION OF PREMIUM REDUCTIONS,
 23 REDUCED COST-SHARING, ADDITIONAL BENEFITS, AND
 24 BENEFICIARY PREMIUMS.—

25 “(1) BIDS BELOW THE BENCHMARK.—

1 “(A) IN GENERAL.—If the Secretary deter-
2 mines under section 1853(d)(4) that the plan
3 benchmark amount exceeds the plan bid, the
4 Secretary shall require the plan to return 75
5 percent of such excess to the enrollee in the
6 form of, at the option of the organization offer-
7 ing the plan—

8 “(i) subject to subparagraph (B), a
9 monthly medicare premium reduction for
10 individuals enrolled in the plan;

11 “(ii) a reduction in the actuarial value
12 of plan cost-sharing for plan enrollees;

13 “(iii) subject to subparagraph (C),
14 such additional benefits as the organization
15 may specify; or

16 “(iv) any combination of the reduc-
17 tions and benefits described in clauses (i)
18 through (iii).

19 “(B) LIMITATION ON PREMIUM REDUC-
20 TIONS.—The amount of the reduction under
21 subparagraph (A)(i) with respect to any en-
22 rollee in a Medicare+Choice plan—

23 “(i) may not exceed the premium de-
24 scribed in section 1839(a)(3), as adjusted
25 under section 1860E-5; and

1 “(ii) shall apply uniformly to each en-
 2 rollee of the Medicare+Choice plan to
 3 which such reduction applies.

4 “(C) REQUIREMENT OF ENROLLMENT IN
 5 PART D TO RECEIVE PRESCRIPTION DRUG BEN-
 6 EFITS.—An organization may not specify any
 7 additional benefit that provides for the coverage
 8 of any prescription drug (other than that re-
 9 quired under part E).

10 “(2) BIDS ABOVE THE BENCHMARK.—If the
 11 Secretary determines under section 1853(d)(4) that
 12 the plan bid (as adjusted under section 1853(d)(1))
 13 exceeds the plan benchmark amount (determined
 14 under section 1853(d)(3)), the amount of such ex-
 15 cess shall be the Medicare+Choice monthly basic
 16 beneficiary premium (as defined in section
 17 1854(b)(2)(A)).”.

18 (b) CONFORMING PART E PREMIUM REDUCTION
 19 AMENDMENTS.—

20 (1) ADJUSTMENT AND PAYMENT OF PART E
 21 PREMIUMS.—Section 1860E–5 (as added by section
 22 201) is amended—

23 (A) in subsection (a), by inserting “, ex-
 24 cept as reduced by the amount of any reduction

1 elected under section 1854(d)(1)(A)(i)” before
2 the period at the end; and

3 (B) by adding at the end the following new
4 subsection:

5 “(c) MEDICARE+CHOICE PREMIUM REDUCTIONS.—
6 In the case of an individual enrolled in a Medicare+Choice
7 plan, the Secretary shall reduce (but not below zero) the
8 amount of the monthly beneficiary premium to reflect any
9 reduction elected under section 1854(d)(1)(A)(i). Such
10 premium adjustment may be provided in such manner as
11 the Secretary may specify.”.

12 (2) TREATMENT OF REDUCTION FOR PURPOSES
13 OF DETERMINING GOVERNMENT CONTRIBUTION
14 UNDER PART E.—Section 1844(c) (42 U.S.C.
15 1395w) is amended by striking “section
16 1854(f)(1)(E)” and inserting “section
17 1854(d)(1)(A)(i)”.

18 (c) SUNSET OF SPECIFIC REQUIREMENTS FOR ADDI-
19 TIONAL BENEFITS.—Section 1854(g) (as redesignated by
20 subsection (a)(1)) is amended—

21 (1) in paragraph (1)(A), by striking “Each
22 Medicare+Choice organization” and inserting “For
23 years before 2005, each Medicare+Choice organiza-
24 tion”; and

1 (2) in paragraph (2), by striking “A
2 Medicare+Choice organization” and inserting “For
3 years before 2005, a Medicare+Choice organiza-
4 tion”.

5 (d) LIMITATION ON ENROLLEE LIABILITY.—

6 (1) FOR BENEFITS UNDER PART E.—Section
7 1854(f)(1) (as redesignated by subsection (a)(1)) is
8 amended to read as follows:

9 “(1) FOR ENHANCED MEDICARE BENEFITS.—

10 The sum of—

11 “(A) the Medicare+Choice monthly basic
12 beneficiary premium (multiplied by 12) and the
13 actuarial value of the deductibles, coinsurance,
14 and copayments (taking into account any reduc-
15 tions in cost-sharing described in subsection
16 (d)(1)(A)(ii)) applicable on average to individ-
17 uals enrolled under this part with a
18 Medicare+Choice plan described in subpara-
19 graph (A) or (C) of section 1851(a)(2) of an or-
20 ganization with respect to required benefits de-
21 scribed in section 1852(a)(1)(A) and any addi-
22 tional benefits described in subsection
23 (a)(2)(A)(iii) for a year; must equal

24 “(B) the actuarial value of the deductibles,
25 coinsurance, and copayments that would be ap-

1 plicable on average to individuals who have
2 elected to receive enhanced medicare benefits
3 under part E if they were not members of a
4 Medicare+Choice organization for the year (ad-
5 justed as determined appropriate by the Sec-
6 retary to account for geographic differences and
7 for plan cost and utilization differences).”.

8 (2) FOR SUPPLEMENTAL BENEFITS.—Section
9 1854(f)(2) (as so redesignated) is amended to read
10 as follows:

11 “(2) FOR SUPPLEMENTAL BENEFITS.—If the
12 Medicare+Choice organization provides to its mem-
13 bers enrolled under this part in a Medicare+Choice
14 plan described in subparagraph (A) or (C) of section
15 1851(a)(2) with respect to supplemental benefits re-
16 lating to benefits under part E described in section
17 1852(a)(3)(A), the sum of the Medicare+Choice
18 monthly supplemental beneficiary premium (multi-
19 plied by 12) charged and the actuarial value of its
20 deductibles, coinsurance, and copayments charged
21 with respect to such benefits for a year must equal
22 the adjusted community rate (as defined in sub-
23 section (g)(3)) for such benefits for the year.”.

1 (e) PREMIUMS CHARGED; PREMIUM TERMI-
2 NOLOGY.—Section 1854(b) (42 U.S.C. 1395w-24) is
3 amended to read as follows:

4 “(b) MONTHLY PREMIUMS CHARGED.—

5 “(1) IN GENERAL.—

6 “(A) COORDINATED CARE AND PRIVATE
7 FEE-FOR-SERVICE PLANS.—The monthly
8 amount of the premium charged to an indi-
9 vidual enrolled in a Medicare+Choice plan
10 (other than an MSA plan) offered by a
11 Medicare+Choice organization shall be equal to
12 the sum of the following:

13 “(i) The Medicare+Choice monthly
14 basic beneficiary premium (if any).

15 “(ii) The Medicare+Choice monthly
16 supplemental beneficiary premium (if any).

17 “(iii) The Medicare+Choice monthly
18 obligation for qualified prescription drug
19 coverage (if any).

20 “(B) MSA PLANS.—The rules under this
21 section that would have applied with respect to
22 an MSA plan if the 21st Century Medicare Act
23 had not been enacted shall continue to apply to
24 MSA plans after the date of enactment of such
25 Act.

1 “(2) PREMIUM TERMINOLOGY.—For purposes
2 of this part:

3 “(A) MEDICARE+CHOICE MONTHLY BASIC
4 BENEFICIARY PREMIUM.—The term
5 ‘Medicare+Choice monthly basic beneficiary
6 premium’ means, with respect to a
7 Medicare+Choice plan, the amount required to
8 be charged under subsection (d)(2) for the plan.

9 “(B) MEDICARE+CHOICE MONTHLY OBLI-
10 GATION FOR QUALIFIED PRESCRIPTION DRUG
11 COVERAGE.—The term ‘Medicare+Choice
12 monthly obligation for qualified prescription
13 drug coverage’ means, with respect to a
14 Medicare+Choice plan, the amount determined
15 under section 1853(k)(3).

16 “(C) MEDICARE+CHOICE MONTHLY SUP-
17 PLEMENTAL BENEFICIARY PREMIUM.—The
18 term ‘Medicare+Choice monthly supplemental
19 beneficiary premium’ means, with respect to a
20 Medicare+Choice plan, the amount required to
21 be charged under subsection (f)(2) for the plan,
22 or, in the case of an MSA plan, the amount
23 filed under subsection (a)(3).

24 “(D) MEDICARE+CHOICE MONTHLY MSA
25 PREMIUM.—The term ‘Medicare+Choice

1 monthly MSA premium’ means, with respect to
2 a Medicare+Choice plan, the amount of such
3 premium filed under subsection (a)(3) for the
4 plan.”.

5 (f) CONFORMING AMENDMENTS.—

6 (1) Section 1851(d)(2)(D) (42 U.S.C. 1395w–
7 21(d)(2)(D)) is amended by inserting “and
8 Medicare+Choice monthly obligation for qualified
9 prescription drug coverage” after “Medicare+Choice
10 monthly basic and supplemental beneficiary pre-
11 miums”.

12 (2) Section 1851(g)(3)(B)(i) (42 U.S.C.
13 1395w–21(g)(3)(B)(i)) is amended by striking “any
14 Medicare+Choice monthly basic and supplemental
15 beneficiary premiums” and inserting “any
16 Medicare+Choice monthly basic beneficiary pre-
17 mium, Medicare+Choice monthly obligation for
18 qualified prescription drug coverage,
19 Medicare+Choice monthly supplemental beneficiary
20 premium,”.

21 (3) Section 1852(c)(1)(F) (42 U.S.C. 1395w–
22 22(c)(1)(F)) is amended to read as follows:

23 “(F) SUPPLEMENTAL BENEFITS.—Supple-
24 mental benefits available from the organization
25 offering the plan, including the supplemental

1 benefits covered and the Medicare+Choice
2 monthly supplemental beneficiary premium for
3 such benefits.”.

4 (4) Section 1853(f)(1) (as redesignated by sec-
5 tion 305(1)) is amended by striking “(as defined in
6 section 1854(b)(2)(C))” and inserting “(as defined
7 in section 1854(b)(2)(D))”.

8 (5) Section 1854(c) (42 U.S.C. 1395w-24(c)) is
9 amended by striking “The Medicare+Choice month-
10 ly basic and supplemental beneficiary premium” and
11 inserting “The Medicare+Choice monthly basic ben-
12 eficiary premium, the Medicare+Choice monthly ob-
13 ligation for qualified prescription drug coverage, or
14 the Medicare+Choice monthly supplemental bene-
15 ficiary premium”.

16 (6) Section 1854(e) (as redesignated by sub-
17 section (a)(1)) is amended by inserting “and the
18 Medicare+Choice monthly obligation for qualified
19 prescription drug coverage” after “Medicare+Choice
20 monthly basic and supplemental beneficiary pre-
21 miums”.

22 (7) Section 1859(c)(4) (42 U.S.C. 1395w-
23 28(c)(4)) is amended to read as follows:

24 “(4) MEDICARE+CHOICE MONTHLY BASIC BEN-
25 EFICIARY PREMIUM; MEDICARE+CHOICE MONTHLY

1 OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG
 2 COVERAGE; MEDICARE+CHOICE MONTHLY SUPPLE-
 3 MENTAL BENEFICIARY PREMIUM.—The terms
 4 ‘Medicare+Choice monthly basic beneficiary pre-
 5 mium’, ‘Medicare+Choice monthly obligation for
 6 qualified prescription drug coverage’, and
 7 ‘Medicare+Choice monthly supplemental beneficiary
 8 premium’ are defined in section 1854(b)(2).”.

9 **SEC. 307. ELIGIBILITY, ELECTION, AND ENROLLMENT IN**
 10 **COMPETITIVE MEDICARE+CHOICE PLANS.**

11 (a) ELIGIBILITY.—Section 1851(a)(3) is amended to
 12 read as follows:

13 “(3) MEDICARE+CHOICE ELIGIBLE INDIVIDUAL.—In this title, the term ‘Medicare+Choice
 14 eligible individual’ means an individual who—

15
 16 “(A) is entitled to benefits under part A
 17 and enrolled under part B; and

18 “(B) has elected to receive enhanced medi-
 19 care benefits under part E.”.

20 (b) ELECTIONS.—

21 (1) IN GENERAL.—Section 1851(a)(1)(A) is
 22 amended by inserting “(including through the elec-
 23 tion of enhanced medicare benefits under part E)
 24 and, if elected by the beneficiary and offered by the
 25 Medicare+Choice plan, through the voluntary pre-

1 scription drug delivery program under part D” after
2 “parts A and B”.

3 (2) DEFAULT ELECTION.—Section 1851(c)(3)
4 (42 U.S.C. 1395w–21(c)(3)) is amended by inserting
5 “to receive enhanced medicare benefits under part E
6 of the” after “deemed to have chosen”.

7 (3) COVERAGE ELECTION PERIODS.—Section
8 1851(e)(1) (42 U.S.C. 1395w–21(e)(1)) is amended
9 by striking “entitled to benefits under part A and
10 enrolled under part B” and inserting “eligible to
11 elect to receive enhanced medicare benefits under
12 part E”.

13 (4) GUARANTEED ISSUANCE AND RENEWAL.—
14 Section 1851(g)(3)(C) (42 U.S.C. 1395w–
15 21(g)(3)(C)) is amended—

16 (A) in clause (i), by inserting “elected to
17 receive enhanced medicare benefits under part
18 E of the” after “deemed to have”; and

19 (B) in clause (ii), by striking “deemed to
20 have chosen to change coverage to” and insert-
21 ing “deemed to have elected to receive enhanced
22 medicare benefits under part E through the”.

23 (5) EFFECT OF ELECTION OF
24 MEDICARE+CHOICE PLAN OPTION.—Section 1851(i)
25 (42 U.S.C. 1395w–21(i)) is amended—

1 (A) in paragraph (1)—

2 (i) by striking “1853(g), 1853(h)”

3 and inserting “1853(h), 1853(i)”; and

4 (ii) by inserting “(as modified under
5 part E)” after “parts A and B”; and

6 (B) in paragraph (2), by striking
7 “1853(e), 1853(g), 1853(h)” and inserting
8 “1853(f), 1853(h), 1853(i)”.

9 (c) PROVIDING INFORMATION TO PROMOTE IN-
10 FORMED CHOICE.—

11 (1) GENERAL INFORMATION ON BENEFITS.—
12 Section 1851(d)(3) (42 U.S.C. 1395w–21(d)(3)) is
13 amended—

14 (A) by striking subparagraph (A) and in-
15 serting the following:

16 “(A) BENEFITS UNDER ENHANCED MEDI-
17 CARE FEE-FOR-SERVICE PROGRAM OPTION.—A
18 general description of the enhanced medicare
19 benefits covered under the original medicare
20 fee-for-service program under parts A and B
21 for individuals who have elected to receive such
22 benefits under part E, including—

23 “(i) covered items and services;

1 “(ii) beneficiary cost-sharing, such as
2 deductibles, coinsurance, and copayment
3 amounts; and

4 “(iii) any beneficiary liability for bal-
5 ance billing.”;

6 (B) by redesignating subparagraphs (B)
7 through (E) as subparagraphs (C) through (F),
8 respectively;

9 (C) by inserting after subparagraph (A)
10 the following new subparagraph:

11 “(B) OUTPATIENT PRESCRIPTION DRUG
12 COVERAGE BENEFITS.—For Medicare+Choice
13 eligible individuals who are enrolled under part
14 D, the information required under section
15 1860D–4 if the Medicare+Choice organization
16 elects to offer prescription drug coverage.”; and

17 (D) in subparagraph (D) (as redesignated
18 by subparagraph (B)), by inserting “(with the
19 enhanced medicare benefits under part E)”
20 after “the original medicare fee-for-service pro-
21 gram”.

22 (2) INFORMATION COMPARING PLAN OP-
23 TIONS.—Section 1851(d)(4) (42 U.S.C. 1395w–
24 21(d)(4)) is amended—

1 (A) in subparagraph (A), by adding at the
2 end the following new clause:

3 “(ix) For Medicare+Choice eligible in-
4 dividuals who are enrolled under part D,
5 the comparative information described in
6 section 1860D-4(b)(2) if the
7 Medicare+Choice organization elects to
8 offer prescription drug coverage.”; and

9 (B) in subparagraph (D), by inserting
10 “with respect to eligible beneficiaries who elect
11 to receive enhanced medicare benefits under
12 part E” after “under parts A and B”.

13 **SEC. 308. BENEFITS AND BENEFICIARY PROTECTIONS**
14 **UNDER COMPETITIVE MEDICARE+CHOICE**
15 **PLANS.**

16 (a) BASIC BENEFITS.—Section 1852(a) (42 U.S.C.
17 1395w-22(a)(1)(A)) is amended—

18 (1) in paragraph (1)—

19 (A) by striking subparagraph (A) and in-
20 serting the following new subparagraph:

21 “(A) those items and services (other than
22 hospice care) for which benefits are available
23 under parts A and B to individuals residing in
24 the area served by the plan and who have elect-

1 ed to receive enhanced medicare benefits under
2 part E;”;

3 (B) by redesignating subparagraph (B) as
4 subparagraph (C);

5 (C) by inserting after subparagraph (A)
6 the following new subparagraph:

7 “(B) if the Medicare+Choice organization
8 elects to offer prescription drug coverage, pre-
9 scription drug coverage under part D to individ-
10 uals who are enrolled under that part and who
11 reside in the area served by the plan; and”;

12 (D) in subparagraph (C) (as redesignated
13 by paragraph (2)), by striking “1854(f)(1)(A)”
14 and inserting “1854(d)(1)”;

15 (2) in paragraph (2), by striking “parts A and
16 B (including any balance billing permitted under
17 such parts” and inserting “part E (including any
18 balance billing permitted under such part”;

19 (3) in paragraph (3), by adding at the end the
20 following new subparagraph:

21 “(D) REQUIREMENT OF ENROLLMENT IN
22 PART D TO RECEIVE PRESCRIPTION DRUG BEN-
23 EFITS.—Notwithstanding the preceding provi-
24 sions of this paragraph, the Secretary may not
25 approve any supplemental health care benefit

1 that provides for the coverage of any prescrip-
2 tion drug (other than that required under part
3 E).”; and

4 (4) in paragraph (5), by striking “Health Care
5 Financing Administration” and inserting “Medicare
6 Competitive Agency” in the flush matter following
7 subparagraph (B).

8 (b) ESRD ANTIDISCRIMINATION.—Section
9 1852(b)(1) (42 U.S.C. 1395w–22(b)(1)) is amended to
10 read as follows:

11 “(1) BENEFICIARIES.—A Medicare+Choice or-
12 ganization may not deny, limit, or condition the cov-
13 erage or provision of benefits under this part, for in-
14 dividuals permitted to be enrolled with the organiza-
15 tion under this part, based on any health status-re-
16 lated factor described in section 2702(a)(1) of the
17 Public Health Service Act.”.

18 (c) DISCLOSURE REQUIREMENTS.—Section
19 1852(c)(1)(B) (42 U.S.C. 1395w–22(c)(1)(B)) is amend-
20 ed by striking “section 1851(d)(3)(A)” and inserting
21 “subparagraphs (A) and (B) of section 1851(d)(3)”.

22 (d) ASSURING ACCESS TO SERVICES IN
23 MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE
24 PLANS.—Section 1852(d)(4)(A) is amended by striking
25 “part A, part B, or both, for such services, or” and insert-

1 ing “part E for such services (and, if the
 2 Medicare+Choice organization elects to offer prescription
 3 drug coverage, that are not less than the payment rates
 4 provided under part D for such services for
 5 Medicare+Choice eligible individuals enrolled under that
 6 part); or”.

7 (e) INFORMATION ON BENEFICIARY LIABILITY FOR
 8 MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE
 9 PLANS.—Section 1852(k)(2)(C)(i) (42 U.S.C. 1395w–
 10 22(k)(2)(C)(i)) is amended by striking “parts A and B”
 11 and inserting “part E, under part D for individuals en-
 12 rolled under that part (if the Medicare+Choice organiza-
 13 tion elects to offer prescription drug coverage),”.

14 **SEC. 309. PAYMENTS TO MEDICARE+CHOICE ORGANIZA-**
 15 **TIONS FOR ENHANCED MEDICARE BENEFITS**
 16 **UNDER PART E BASED ON RISK-ADJUSTED**
 17 **BIDS.**

18 (a) IN GENERAL.—Section 1853(a)(1)(A) (42 U.S.C.
 19 1395w–23(a)(1)(A)) is amended to read as follows:

20 “(1) MONTHLY PAYMENTS.—Under a contract
 21 under section 1857 and subject to subsections (f),
 22 (h), and (j) and section 1859(e)(4), the Secretary
 23 shall make, to each Medicare+Choice organization,
 24 with respect to coverage of an individual for a month

1 under this part in a Medicare+Choice payment area,
2 separate monthly payments with respect to—

3 “(A) enhanced medicare benefits under
4 part E in accordance with subsection (d); and

5 “(B) if the Medicare+Choice organization
6 elects to offer prescription drug coverage, bene-
7 fits under part D in accordance with subsection
8 (k) for individuals enrolled under that part.”.

9 (b) CONFORMING AMENDMENT.—Section
10 1853(g)(1)(A) (42 U.S.C. 1395w–23(g)(1)(A)) is amend-
11 ed by inserting “as part of the enhanced medicare benefits
12 elected under part E of” before “the original medicare fee-
13 for-service program option”.

14 **SEC. 310. SEPARATE PAYMENTS TO MEDICARE+CHOICE OR-**
15 **GANIZATIONS FOR PART D BENEFITS.**

16 (a) IN GENERAL.—Section 1853 (42 U.S.C. 1395w–
17 27) is amended by adding at the end the following new
18 subsection:

19 “(k) AVAILABILITY OF PRESCRIPTION DRUG BENE-
20 FITS.—

21 “(1) SCOPE OF PRESCRIPTION DRUG BENE-
22 FITS.—

23 “(A) AVAILABILITY OF STANDARD COV-
24 ERAGE.—If a Medicare+Choice organization
25 elects to offer prescription drug coverage under

1 a Medicare+Choice plan, such organization
2 shall make such coverage (other than that re-
3 quired under part E) available to each enrollee
4 under that plan who is also enrolled under part
5 D that includes only standard coverage and
6 that meets the requirements of this subsection.

7 “(B) ADDITIONAL QUALIFIED PRESCRIP-
8 TION DRUG COVERAGE.—In addition to the
9 standard coverage option made available to
10 each enrollee under paragraph (1), a
11 Medicare+Choice plan may make available to
12 each enrollee that is also enrolled under part D,
13 other qualified prescription drug coverage
14 (other than that required under part E) that
15 meets the requirements of this subsection under
16 a Medicare+Choice plan offered under this
17 part.

18 “(C) REQUIREMENT OF ENROLLMENT IN
19 PART D TO RECEIVE PRESCRIPTION DRUG BEN-
20 EFITS.—A Medicare+Choice organization may
21 not provide for the coverage of any prescription
22 drugs (other than that required under part E)
23 to an enrollee unless that enrollee is also en-
24 rolled under part D.

1 “(2) PAYMENT OF FULL AMOUNT OF PREMIUM
2 TO ORGANIZATIONS FOR QUALIFIED PRESCRIPTION
3 DRUG COVERAGE.—For each year (beginning with
4 2005), the Secretary shall pay to each
5 Medicare+Choice organization offering a
6 Medicare+Choice plan that provides qualified pre-
7 scription drug coverage in which a Medicare+Choice
8 eligible individual is enrolled, an amount equal to the
9 full amount of the monthly premium submitted
10 under section 1854(a)(2)(B) on behalf of each such
11 individual enrolled in such plan for the year, as ad-
12 justed using the risk adjusters that apply to the
13 standard coverage under section 1853(b)(4)(B).

14 “(3) AMOUNT OF MEDICARE+CHOICE MONTHLY
15 OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG
16 COVERAGE.—In the case of a Medicare+Choice eligi-
17 ble individual receiving qualified prescription drug
18 coverage under a Medicare+Choice plan, the obliga-
19 tion for qualified prescription drug coverage of such
20 individual in a year shall be determined as follows:

21 “(A) PREMIUMS EQUAL TO THE MONTHLY
22 NATIONAL AVERAGE.—If the amount of the
23 monthly premium for qualified prescription
24 drug coverage submitted under section
25 1854(a)(2)(B) for the plan for the year is equal

1 to the monthly national average premium (as
2 computed under section 1860D–15) for the
3 year, the monthly obligation of the individual in
4 that year shall be an amount equal to the appli-
5 cable percent (as defined in section 1860D–
6 17(c)) of the amount of the monthly national
7 average premium.

8 “(B) PREMIUMS THAT ARE LESS THAN
9 THE MONTHLY NATIONAL AVERAGE.—If the
10 amount of the monthly premium for qualified
11 prescription drug coverage submitted under sec-
12 tion 1854(a)(2)(B) for the plan for the year is
13 less than the monthly national average premium
14 (as computed under section 1860D–15) for the
15 year, the monthly obligation of the individual in
16 that year shall be an amount equal to—

17 “(i) the applicable percent (as defined
18 in section 1860D–17(c)) of the amount of
19 the monthly national average premium;
20 minus

21 “(ii) the amount by which the month-
22 ly national average premium exceeds the
23 amount of the premium submitted under
24 section 1854(a)(2)(B).

1 “(C) PREMIUMS THAT ARE GREATER THAN
2 THE MONTHLY NATIONAL AVERAGE.—If the
3 amount of the monthly premium for qualified
4 prescription drug coverage submitted under sec-
5 tion 1854(a)(2)(B) for the plan for the year ex-
6 ceeds the monthly national average premium
7 (as computed under section 1860D–15) for the
8 year, the monthly obligation of the individual in
9 that year shall be an amount equal to the sum
10 of—

11 “(i) the applicable percent (as defined
12 in section 1860D–17(e)) of the amount of
13 the monthly national average premium;
14 plus

15 “(ii) the amount by which the pre-
16 mium submitted under section
17 1854(a)(2)(B) exceeds the amount of the
18 monthly national average premium.

19 “(4) COLLECTION OF MEDICARE+CHOICE
20 MONTHLY OBLIGATION FOR QUALIFIED PRESCRIP-
21 TION DRUG COVERAGE.—The provisions of section
22 1860D–18, including subsection (b) of such section,
23 shall apply to the amount of the monthly premium
24 required to be paid by a Medicare+Choice eligible
25 individual receiving qualified prescription drug cov-

1 erage under a Medicare+Choice plan (as determined
2 under paragraph (3)) in the same manner as such
3 provisions apply to the monthly beneficiary obliga-
4 tion required to be paid by an eligible beneficiary en-
5 rolled in a Medicare Prescription Drug plan.

6 “(5) COMPLIANCE WITH ADDITIONAL BENE-
7 FICIARY PROTECTIONS.—With respect to the offer-
8 ing of qualified prescription drug coverage by a
9 Medicare+Choice organization under a
10 Medicare+Choice plan, the organization and plan
11 shall meet the requirements of section 1860D–5, in-
12 cluding requirements relating to information dis-
13 semination and grievance and appeals, in the same
14 manner as they apply to an eligible entity and a
15 Medicare Prescription Drug plan under part D. The
16 Secretary shall waive such requirements to the ex-
17 tent the Secretary determines that such require-
18 ments duplicate requirements otherwise applicable to
19 the organization or plan under this part.

20 “(6) COVERAGE OF PRESCRIPTION DRUGS FOR
21 ENROLLEES IN PLANS THAT DO NOT OFFER PRE-
22 SCRIPTON DRUG COVERAGE.—If an individual who
23 is enrolled under part D is enrolled in a
24 Medicare+Choice plan that does not offer prescrip-
25 tion drug coverage, such individual shall be per-

1 mitted to enroll for prescription drug coverage under
2 such part in the same manner as if such individual
3 was not enrolled in a Medicare+Choice plan.

4 “(7) AVAILABILITY OF PREMIUM SUBSIDY AND
5 COST-SHARING REDUCTIONS FOR LOW-INCOME EN-
6 ROLLEES.—For provisions—

7 “(A) providing premium subsidies and
8 cost-sharing reductions for low-income individ-
9 uals receiving qualified prescription drug cov-
10 erage through a Medicare+Choice plan, see sec-
11 tion 1860D–19; and

12 “(B) providing a Medicare+Choice organi-
13 zation with insurance subsidy payments for pro-
14 viding qualified prescription drug coverage
15 through a Medicare+Choice plan, see section
16 1860D–20.

17 “(8) QUALIFIED PRESCRIPTION DRUG COV-
18 ERAGE; STANDARD COVERAGE.—For purposes of
19 this part, the terms ‘qualified prescription drug cov-
20 erage’ and ‘standard coverage’ have the meanings
21 given such terms in paragraphs (9) and (10), respec-
22 tively, of section 1860D.”.

23 (b) SANCTIONS FOR IMPROPER PRESCRIPTION DRUG
24 COVERAGE.—Section 1857(g)(1) (42 U.S.C. 1395w–
25 27(g)(1)) is amended—

1 (1) in subparagraph (F), by striking “or” after
2 the semicolon at the end;

3 (2) in subparagraph (G), by adding “or” after
4 the semicolon at the end; and

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

7 “(H) charges any individual an amount in
8 excess of the Medicare+Choice monthly obliga-
9 tion for qualified prescription drug coverage
10 under section 1853(k)(3), provides coverage for
11 prescription drugs that is not qualified prescrip-
12 tion drug coverage (as defined in section
13 1853(k)(7)), offers prescription drug coverage,
14 but does not make standard prescription drug
15 coverage available (as defined in such section),
16 or provides coverage for prescription drugs
17 (other than those covered under part E) to an
18 individual who is not enrolled under part D;”.

19 **SEC. 311. ADMINISTRATION BY THE MEDICARE COMPETI-**
20 **TIVE AGENCY.**

21 On and after January 1, 2005, the Medicare+Choice
22 program under part C of title XVIII of the Social Security
23 Act shall be administered by the Medicare Competitive
24 Agency in accordance with subpart 3 of part D of such
25 title (as added by section 101), and, in accordance with

1 section 1860D–25(c)(3)(C) of such Act (as added by sec-
 2 tion 101), each reference to the Secretary made in this
 3 title, or the amendments made by this title, shall be
 4 deemed to be a reference to the Administrator of the Medi-
 5 care Competitive Agency.

6 **SEC. 312. CONTINUED CALCULATION OF ANNUAL**
 7 **MEDICARE+CHOICE CAPITATION RATES.**

8 (a) CONTINUED CALCULATION.—

9 (1) IN GENERAL.—Section 1853(c) (as amend-
 10 ed by subsection (b)) is amended by adding at the
 11 end the following new paragraph:

12 “(7) TRANSITION TO MEDICARE+CHOICE COM-
 13 PETITION.—

14 “(A) IN GENERAL.—For each year (begin-
 15 ning with 2005) payments to Medicare+Choice
 16 plans shall not be computed under this sub-
 17 section, but instead shall be based on the pay-
 18 ment amount determined under subsection (d).

19 “(B) CONTINUED CALCULATION OF CAPI-
 20 TATION RATES.—For each year (beginning with
 21 2004) the Secretary shall calculate and publish
 22 the annual Medicare+Choice capitation rates
 23 under this subsection and shall use the annual
 24 Medicare+Choice capitation rate determined
 25 under subsection (c)(1)(B) for purposes of de-

1 termining the benchmark amount under sub-
2 section (a)(4).”.

3 (2) CONFORMING AMENDMENT.—Section
4 1853(e)(1) (42 U.S.C. 1395w–23(e)(1)) is amended
5 by striking “For purposes of this part, subject to
6 paragraphs (6)(C) and (7),” and inserting “For pur-
7 poses of making payments under this part for years
8 before 2004 and for purposes of calculating the an-
9 nual Medicare+Choice capitation rates under para-
10 graph (7) beginning with such year, subject to para-
11 graph (6)(C),” in the matter preceding subpara-
12 graph (A).

13 (b) INCLUSION OF COSTS OF VA AND DoD MILITARY
14 FACILITY SERVICES IN CONTINUED CALCULATION.—Sec-
15 tion 1853(e) (42 U.S.C. 1395w–23(e)), as amended by
16 subsection (a)(1), is amended by adding at the end the
17 following new paragraph:

18 “(8) INCLUSION OF COSTS OF VA AND DoD
19 MILITARY FACILITY SERVICES TO MEDICARE-ELIGI-
20 BLE BENEFICIARIES.—For purposes of determining
21 the blended capitation rate under subparagraph (A)
22 of paragraph (1) and the minimum percentage in-
23 crease under subparagraph (C) of such paragraph
24 for a year, the annual per capita rate of payment for
25 1997 determined under section 1876(a)(1)(C) shall

1 be adjusted to include in such rate, to the extent
2 practicable, the Secretary's estimate, on a per capita
3 basis, of the amount of additional payments that
4 would have been made in the area involved under
5 this title if individuals entitled to benefits under this
6 title had not received services from facilities of the
7 Department of Veterans Affairs or the Department
8 of Defense.”.

9 **SEC. 313. FIVE-YEAR EXTENSION OF MEDICARE COST CON-**
10 **TRACTS.**

11 (a) IN GENERAL.—Section 1876(h)(5)(C) (42 U.S.C.
12 1395mm(h)(5)(C)), as redesignated by section 634(1) of
13 BIPA (114 Stat. 2763A–568), is amended by striking
14 “2004” and inserting “2009”.

15 (b) EFFECTIVE DATE.—The amendment made by
16 subsection (a) shall take effect on the date of enactment
17 of this Act.

18 **SEC. 314. EFFECTIVE DATE.**

19 (a) IN GENERAL.—Except as provided in section
20 306(b)(1)(B), section 313(b), and subsection (b), the
21 amendments made by this title shall apply to plan years
22 beginning on and after January 1, 2005.

23 (b) MEDICARE+CHOICE MSA PLANS.—Notwith-
24 standing any provision of this title, the Secretary shall
25 apply the payment and other rules that apply with respect

1 to an MSA plan described in section 1851(a)(2)(B) of the
2 Social Security Act (42 U.S.C. 1395w-21(a)(2)(B)) as if
3 this title had not been enacted.

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