

106TH CONGRESS  
1ST SESSION

# H. R. 2925

To amend the Public Health Service Act to finance the provision of outpatient prescription drug coverage for low-income medicare beneficiaries and to provide stop-loss protection for outpatient prescription drug expenses under qualified medicare prescription drug coverage.

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## IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 23, 1999

Mr. BILIRAKIS (for himself, Mr. PETERSON of Minnesota, and Mr. FLETCHER) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To amend the Public Health Service Act to finance the provision of outpatient prescription drug coverage for low-income medicare beneficiaries and to provide stop-loss protection for outpatient prescription drug expenses under qualified medicare prescription drug coverage.

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

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

2 (a) SHORT TITLE.—This Act may be cited as the  
 3 “Medicare Beneficiary Prescription Drug Assistance and  
 4 Stop-Loss Protection Act of 1999”.

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

Sec. 1. Short title; table of contents.

Sec. 2. Promoting prescription drug coverage for medicare beneficiaries.

“TITLE XXVIII—PROMOTING PRESCRIPTION DRUG COVERAGE  
 FOR MEDICARE BENEFICIARIES

“PART A—PRESCRIPTION DRUG COVERAGE ASSISTANCE FOR LOW-INCOME  
 MEDICARE BENEFICIARIES

“Sec. 2801. Purpose; methods of providing assistance.

“Sec. 2802. Beneficiary eligibility.

“Sec. 2803. Coverage requirements for prescription drug coverage.

“Sec. 2804. Payments to States.

“Sec. 2805. State plan, data collection, records, audits, and reports.

“Sec. 2806. Definition of prescription drug assistance and other terms.

“PART B—MEDICARE OUTPATIENT PRESCRIPTION DRUG STOP-LOSS  
 PROTECTION

“Sec. 2811. Medicare outpatient prescription drug stop-loss protection.

“PART C—ACCESS TO PRESCRIPTION DRUG COVERAGE UNDER MEDIGAP  
 POLICIES

“Sec. 2821. Permitting medicare beneficiaries to adjust medigap coverage.

7 **SEC. 2. PROMOTING PRESCRIPTION DRUG COVERAGE FOR**

8 **MEDICARE BENEFICIARIES.**

9 The Public Health Service Act is amended by adding  
 10 at the end the following new title:

1 “TITLE XXVIII—PROMOTING PRESCRIPTION  
2 DRUG COVERAGE FOR MEDICARE BENE-  
3 FICIARIES

4 “PART A—PRESCRIPTION DRUG COVERAGE ASSISTANCE  
5 FOR LOW-INCOME MEDICARE BENEFICIARIES

6 “SEC. 2801. PURPOSE; METHODS OF PROVIDING ASSIST-  
7 ANCE.

8 “(a) IN GENERAL.—The purpose of this part is to  
9 provide funds to States to enable them, at their option,  
10 to establish programs, separate from their medicaid plans,  
11 that provide assistance to low-income medicare bene-  
12 ficiaries in obtaining qualified prescription drug coverage  
13 using the following methods in a manner consistent with  
14 the provisions of this part:

15 “(1) PREMIUM SUBSIDY FOR INDIVIDUALS OB-  
16 TAINING COVERAGE THROUGH ENROLLMENT IN A  
17 MEDICARE+CHOICE PLAN OR A GROUP HEALTH  
18 PLAN.—In the case of a low-income medicare bene-  
19 ficiary enrolled in Medicare+Choice plan or a group  
20 health plan that provides qualified prescription drug  
21 coverage, payment of the portion of the beneficiary  
22 premium (if any) of such plan that is attributable to  
23 the cost of furnishing such coverage to such bene-  
24 ficiary.

1           “(2) OTHER METHODS.—Any other method for  
2           the provision of, or payment for, qualified prescrip-  
3           tion drug coverage that meets the requirements of  
4           this part and that is separate from its medicaid  
5           plan.

6           The Secretary shall provide guidance to States in estab-  
7           lishing reasonable procedures to determine the portion of  
8           the premium described in paragraph (1).

9           “(b)   REQUIRING   PROVISION   OF   ASSISTANCE  
10          THROUGH   MEDICARE+CHOICE   PLANS   OR   GROUP  
11          HEALTH   PLANS   IN   CASE   OF   INDIVIDUALS   ENROLLED   IN  
12          SUCH   PLANS.—If a low-income medicare beneficiary is en-  
13          rolled in a Medicare+Choice plan or in a group health  
14          plan that provides qualified prescription drug coverage—

15                 “(1) a State drug assistance program shall pro-  
16                 vide for assistance under this part to be provided in  
17                 the form of a premium subsidy described in sub-  
18                 section (a)(1); and

19                 “(2) the beneficiary is deemed to have assigned  
20                 the right to such subsidy to the organization or  
21                 sponsor offering such plan.

22          Nothing in this part shall be construed as providing for  
23          any premium subsidy described in subsection (a)(1) to the  
24          extent such subsidy exceeds the amount of the beneficiary

1 premium applicable to qualified prescription drug cov-  
2 erage.

3 “(c) STATE ENTITLEMENT.—This part constitutes  
4 budget authority in advance of appropriations Acts and  
5 represents the obligation of the Federal Government to  
6 provide for the payment to States of amounts provided  
7 under section 2804.

8 **“SEC. 2802. BENEFICIARY ELIGIBILITY.**

9 “(a) IN GENERAL.—In order for a State to receive  
10 payments under section 2804 with respect to a State drug  
11 assistance program, the program must provide prescrip-  
12 tion drug assistance to each individual residing in the  
13 State who applies for such assistance and establishes that  
14 the individual is a low-income medicare beneficiary (as de-  
15 fined in subsection (b)). In applying the previous sentence,  
16 residency rules similar to the residency rules applicable  
17 under medicaid plans shall apply.

18 “(b) LOW-INCOME MEDICARE BENEFICIARY DE-  
19 FINED.—

20 “(1) IN GENERAL.—For purposes of this part  
21 with respect to a State drug assistance program, the  
22 term ‘low-income medicare beneficiary’ means an in-  
23 dividual who—

24 “(A) is entitled to benefits under part A of  
25 title XVIII of the Social Security Act or en-

1 rolled under part B of such title, or both, in-  
2 cluding an individual enrolled in a  
3 Medicare+Choice plan under part C of such  
4 title;

5 “(B) is not entitled to medical assistance  
6 with respect to prescribed drugs under a med-  
7 icaid plan;

8 “(C) is determined by the State under the  
9 program to have family income (as determined  
10 under section 2806(6)) which does not exceed a  
11 percentage of the applicable poverty line (as de-  
12 fined in section 673(2) of the Community Serv-  
13 ices Block Grant Act, including any revision re-  
14 quired by such section), for a family of the size  
15 involved, specified by the State, which percent-  
16 age may not be less 120 percent nor more than  
17 200 percent; and

18 “(D) at the option of the State, is deter-  
19 mined by the State under the program to have  
20 resources (as determined under section 1613 of  
21 the Social Security Act for purposes of the sup-  
22 plemental security income program) that do not  
23 exceed a level specified under the program,  
24 which level shall not be less than the level used

1 by the State under section 1905(p)(1)(C) of  
2 such Act.

3 “(2) EXCLUSION.—Such term does not include  
4 an individual who is—

5 “(A) an inmate of a public institution or a  
6 patient in an institution for mental diseases; or

7 “(B) a member of a family that is eligible  
8 for health benefits coverage under a State  
9 health benefits plan on the basis of a family  
10 member’s employment with a public agency in  
11 the State if such coverage includes outpatient  
12 prescription drug coverage.

13 **“SEC. 2803. COVERAGE REQUIREMENTS FOR PRESCRIP-**  
14 **TION DRUG COVERAGE.**

15 “(a) QUALIFIED PRESCRIPTION DRUG COVERAGE  
16 DEFINED.—For purposes of this part, the term ‘qualified  
17 prescription drug coverage’ means prescription drug cov-  
18 erage that—

19 “(1) provides for a scope and quality of cov-  
20 erage that is not less than the scope and quality of  
21 coverage described in subsection (b);

22 “(2) imposes any cost-sharing (including enroll-  
23 ment fees, premiums, deductibles, copayments, coin-  
24 surance, and similar costs) only consistent with sub-  
25 section (c); and

1           “(3) meets the requirements of subsection (d)  
2           (relating to miscellaneous provisions).

3           “(b) MINIMUM SCOPE AND QUALITY OF COVERAGE  
4           REQUIRED.—

5           “(1) IN GENERAL.—The scope and quality of  
6           coverage described in this subsection is the scope  
7           and quality of coverage for outpatient prescription  
8           drugs and biologicals equivalent to any of the fol-  
9           lowing:

10           “(A) MEDICAID COVERAGE.—Coverage of  
11           outpatient prescribed drugs under the State  
12           medicaid plan.

13           “(B) COMPREHENSIVE BENCHMARK COV-  
14           ERAGE.—Comprehensive outpatient prescription  
15           drug coverage if included in a benchmark ben-  
16           efit package described in paragraph (2).

17           “(C) OTHER COMPREHENSIVE COV-  
18           ERAGE.—Outpatient prescription drug coverage  
19           that the Secretary determines, upon application  
20           by a State, provides comprehensive outpatient  
21           prescription drug coverage, which may be such  
22           coverage typically available in large group  
23           health plans or in the large group market (as  
24           such term is defined in section 2791(e)(3)).



1 Nothing in subparagraph (C) shall be construed as  
2 authorizing the Secretary to require any particular  
3 type of formulary or pricing structure.

4 “(2) BENCHMARK BENEFIT PACKAGES.—The  
5 benchmark benefit packages are as follows:

6 “(A) FEHBP-EQUIVALENT HEALTH IN-  
7 SURANCE COVERAGE.—The standard Blue  
8 Cross/Blue Shield preferred provider option  
9 service benefit plan, described in and offered  
10 under section 8903(1) of title 5, United States  
11 Code.

12 “(B) STATE EMPLOYEE COVERAGE.—A  
13 health benefits coverage plan that is offered and  
14 generally available to State employees in the  
15 State involved.

16 “(C) COVERAGE OFFERED THROUGH  
17 HMO.—The health insurance coverage plan  
18 that—

19 “(i) is offered by a health mainte-  
20 nance organization (as defined in section  
21 2791(b)(3)), and

22 “(ii) has the largest insured commer-  
23 cial, non-medicaid enrollment of covered  
24 lives of such coverage plans offered by

1           such a health maintenance organization in  
2           the State involved.

3           “(3) SCOPE AND QUALITY OF COVERAGE DE-  
4           FINED.—In this subsection, the term ‘scope and  
5           quality of coverage’ means the extent of prescription  
6           drugs covered (including any exclusions or limita-  
7           tions and the application of any formulary, including  
8           exceptions to the application of such a formulary)  
9           and provisions that assure access to, and the quality  
10          of, covered prescription drugs, but not including  
11          terms and conditions relating to cost-sharing or  
12          other matters described in subsection (c) or (d).

13          “(4) CONSTRUCTION.—Nothing in this sub-  
14          section shall be construed as requiring qualified pre-  
15          scription drug coverage—

16                 “(A) to provide for the same cost-sharing  
17                 as that provided under the State medicaid plan  
18                 or under a benchmark benefit package, respec-  
19                 tively; or

20                 “(B) to provide coverage for items or serv-  
21                 ices for which payment is prohibited under this  
22                 part, notwithstanding that any benchmark ben-  
23                 efit or other package includes coverage for such  
24                 an item or service.

25          “(c) LIMITATIONS ON COST-SHARING.—

1 “(1) NO PREMIUM AND NO DEDUCTIBLE.—

2 “(A) IN GENERAL.—There shall be no pre-  
3 mium or enrollment fee and no deductible im-  
4 posed under the program.

5 “(B) CONSTRUCTION.—Nothing in sub-  
6 paragraph (A) shall be construed as preventing  
7 the imposition of a premium, enrollment fee, or  
8 similar charge or the application of a deductible  
9 for coverage of benefits other than outpatient  
10 prescription drugs under a Medicare+Choice  
11 plan or group health plan to the extent other-  
12 wise permitted under law.

13 “(2) LIMITATIONS ON COPAYMENTS AND COIN-  
14 SURANCE.—

15 “(A) NO COPAYMENTS AND COINSURANCE  
16 FOR LOWEST INCOME BENEFICIARIES.—There  
17 shall be no copayments or coinsurance in the  
18 case of a low-income medicare beneficiary whose  
19 family income does not exceed 120 percent of  
20 the applicable poverty line described in section  
21 2802(b)(1)(C).

22 “(B) OTHER BENEFICIARIES.—

23 “(i) IN GENERAL.—In the case of a  
24 low-income medicare beneficiary whose  
25 family income exceeds 120 percent of such

1 poverty line, any cost-sharing in the form  
2 of a copayment or coinsurance imposed  
3 with respect to coverage under the pro-  
4 gram does not exceed—

5 “(I) a copayment of \$5 per pre-  
6 scription unit (such a unit being de-  
7 termined consistent with reasonable  
8 rules established under the program  
9 that reflect common industry prac-  
10 tice), or

11 “(II) coinsurance of 20 percent,  
12 whichever is greater. Any such cost-sharing  
13 may not exceed, in the aggregate in any  
14 year, \$1,500 with respect to a low-income  
15 medicare beneficiary.

16 “(ii) SLIDING SCALE PERMITTED.—In  
17 the case of such beneficiaries, a program  
18 may vary the cost-sharing based on family  
19 income, but only in a manner, consistent  
20 with clause (i), so that the cost sharing in-  
21 creases as family income increases.

22 “(iii) PUBLICATION.—Any cost-shar-  
23 ing imposed under this subparagraph shall  
24 be imposed pursuant to a public schedule.

1                   “(iv) INDEXING LIMITATION ON COST-  
2                   SHARING.—For a year after 2000, the dol-  
3                   lar amount specified in the last sentence of  
4                   clause (i) shall be increased by the same  
5                   percentage as the percentage increase (if  
6                   any) in per capita expenditures for pre-  
7                   scription drugs (as estimated by the Sec-  
8                   retary based on the best data available  
9                   from the Bureau of Labor Statistics) be-  
10                  tween July 1999 and July of the previous  
11                  year, except that any such increase which  
12                  is not a multiple of \$10 shall be rounded  
13                  to the nearest multiple of \$10.

14                  “(3) NO BALANCE BILLING.—The coverage  
15                  does not permit the imposition of any cost-sharing  
16                  or balance billing except as permitted under para-  
17                  graph (2).

18                  “(d) ADDITIONAL CONDITIONS.—The conditions  
19                  specified in this subsection with respect to outpatient pre-  
20                  scription drug coverage are as follows:

21                  “(1) NO DURATIONAL LIMITATION ON BEN-  
22                  EFIT.—

23                  “(A) IN GENERAL.—Subject to subpara-  
24                  graph (B), the coverage does not impose any  
25                  maximum annual, lifetime, or other durational

1 limit on benefits that may be paid with respect  
2 to covered prescription drugs.

3 “(B) CONSTRUCTION.—Subparagraph (A)  
4 shall not be construed from preventing the im-  
5 position of limits so long as such limits are no  
6 lower than the limits imposed under the State’s  
7 medicaid plan.

8 “(2) RESTRICTION ON APPLICATION OF PRE-  
9 EXISTING CONDITION EXCLUSIONS.—The coverage  
10 shall not impose any preexisting condition exclusion  
11 (as defined in section 2701(b)(1)(A)) for covered  
12 benefits.

13 “(e) NO APPLICATION OF MEDICAID OR OTHER FED-  
14 ERAL PRESCRIPTION DRUG REBATE SYSTEM.—Federal  
15 rebate systems (including that under section 1927 of the  
16 Social Security Act) applicable to the purchase of prescrip-  
17 tion drugs shall not apply to the prescription drugs fur-  
18 nished under this part.

19 **“SEC. 2804. PAYMENTS TO STATES.**

20 “(a) IN GENERAL.—Subject to the succeeding provi-  
21 sions of this section, the Secretary shall pay to each State  
22 which has submitted a plan pursuant to section 2805(a)  
23 an amount for each quarter (beginning on or after October  
24 1, 1999) equal to the sum of—

1           “(1) the enhanced FMAP (as defined in section  
2           2105(b) of the Social Security Act) of expenditures  
3           in the quarter for prescription drug assistance under  
4           the program for low-income medicare beneficiaries  
5           whose family income is below 150 percent of the  
6           poverty line;

7           “(2) the Federal medical assistance percentage  
8           (as defined in section 1905(b) of the Social Security  
9           Act) of expenditures in the quarter for prescription  
10          drug assistance under the program for low-income  
11          medicare beneficiaries not described in paragraph  
12          (1); plus

13          “(3) only to the extent permitted consistent  
14          with subsection (b)(1), the enhanced FMAP (as de-  
15          fined in section 2105(b) of the Social Security Act)  
16          of expenditures—

17                  “(A) for outreach activities described in  
18                  section 2805(a)(2) under the program; and

19                  “(B) for other reasonable costs incurred by  
20                  the State to administer the program.

21          “(b) LIMITATION ON CERTAIN PAYMENTS FOR CER-  
22          TAIN EXPENDITURES.—

23                  “(1) LIMITATION ON ADMINISTRATIVE EXPEND-  
24                  ITURES.—Payment shall not be made under sub-  
25                  section (a) for expenditures for items described in

1 subsection (a)(3) for a fiscal year to the extent the  
2 payment for expenditures under subsection (a)(3)  
3 exceeds 10 percent of the total of all payments made  
4 to the State under subsection (a) for such fiscal year  
5 (or 20 percent of such total for the first such fiscal  
6 year).

7 “(2) USE OF NON-FEDERAL FUNDS FOR STATE  
8 MATCHING REQUIREMENT.—Amounts provided by  
9 the Federal Government, or services assisted or sub-  
10 sidized to any significant extent by the Federal Gov-  
11 ernment, may not be included in determining the  
12 amount of non-Federal contributions required under  
13 subsection (a).

14 “(3) OFFSET OF RECEIPTS ATTRIBUTABLE TO  
15 COST-SHARING.—For purposes of subsection (a), the  
16 amount of the expenditures under the program shall  
17 be reduced by the amount of any cost-sharing re-  
18 ceived by the State.

19 “(4) PREVENTION OF DUPLICATIVE PAYMENTS  
20 AND LIMITATION ON PAYMENT FOR ABORTIONS.—  
21 The provisions of paragraphs (6) and (7) of section  
22 2105(e) of the Social Security Act apply to pay-  
23 ments under this section for low-income medicare  
24 beneficiaries and prescription drug assistance in the  
25 same manner as they apply to payments under sec-



1       tion 2105 of such Act for targeted low-income chil-  
2       dren and child health assistance, and any reference  
3       in such paragraph (6) to a private insurer is deemed  
4       a reference to the issuer of a medicare supplemental  
5       policy (as defined in section 1882(g) of the Social  
6       Security Act) or an organization offering a  
7       Medicare+Choice plan.

8               “(5) APPLICATION OF RULES RELATING TO  
9       PROVIDER TAXES AND DONATIONS.—Section  
10       1902(w) of the Social Security Act shall apply to  
11       States under this part in the same manner as it ap-  
12       plies to a State under title XIX of such Act.

13               “(c) ADVANCE PAYMENT; RETROSPECTIVE ADJUST-  
14       MENT.—The Secretary may make payments under this  
15       section for each quarter on the basis of advance estimates  
16       of expenditures submitted by the State and such other in-  
17       vestigation as the Secretary may find necessary, and may  
18       reduce or increase the payments as necessary to adjust  
19       for any overpayment or underpayment for prior quarters.

20       **“SEC. 2805. STATE PLAN, DATA COLLECTION, RECORDS, AU-  
21               DITS, AND REPORTS.**

22               “(a) SUBMISSION OF PLAN.—

23                       “(1) IN GENERAL.—A State is eligible for pay-  
24       ment under this part if—

1           “(A) the State has submitted to the Sec-  
2           retary a plan that includes—

3                   “(i) a written document that  
4                   outlines—

5                           “(I) how the State intends to use  
6                           the funds provided under this part to  
7                           provide prescription drug assistance  
8                           consistent with the provisions of this  
9                           part; and

10                           “(II) the procedures to be used  
11                           by the State to provide for outreach to  
12                           low-income medicare beneficiaries; and

13                           “(ii) a certification by the chief execu-  
14                           tive officer of the States that the State  
15                           drug assistance program operated under  
16                           such plan is operated consistent with the  
17                           specific requirements of this part; and

18                           “(B) the State is not otherwise ineligible to  
19                           receive such payment under a specific provision  
20                           of this part.

21                   “(2) LIMITATION ON SECRETARIAL AUTHOR-  
22                   ITY.—The Secretary may not impose conditions, in  
23                   addition to those specified in this part, for State  
24                   plans or State drugs assistance programs under this  
25                   part.

1       “(b) DATA COLLECTION, RECORDS, AUDITS, AND  
2 REPORTS.—As a condition for the receipt of funds under  
3 this part, a State, in its plan under subsection (a), shall  
4 provide assurances satisfactory to the Secretary that—

5           “(1) the State will collect the data, maintain  
6 the records, and furnish the reports to the Sec-  
7 retary, at the times and in the standardized format  
8 the Secretary may require, in order to enable the  
9 Secretary to monitor State program administration  
10 and compliance and to evaluate and compare the ef-  
11 fectiveness of State programs under this part;

12           “(2) the State will afford the Secretary access  
13 to any records or information relating to the State  
14 program under this part for the purposes of review  
15 or audit; and

16           “(3) the State will—

17           “(A) assess the operation of the State pro-  
18 gram in each fiscal year, including the progress  
19 made in covering low-income medicare bene-  
20 ficiaries; and

21           “(B) report to the Secretary, by January  
22 1 following the end of the fiscal year, on the re-  
23 sult of the assessment.

1 **“SEC. 2806. DEFINITION OF PRESCRIPTION DRUG ASSIST-**  
2 **ANCE AND OTHER TERMS.**

3 “For purposes of this part:

4 “(1) PRESCRIPTION DRUG ASSISTANCE.—

5 “(A) IN GENERAL.—The term ‘prescription  
6 drug assistance’ means, subject to subpara-  
7 graph (B), payment for part or all of the cost  
8 of coverage of self-administered outpatient pre-  
9 scription drugs and biologicals (including insu-  
10 lin and insulin supplies) for low-income medi-  
11 care beneficiaries.

12 “(B) EXCLUSIONS.—Such term does not  
13 include payment or coverage with respect to—

14 “(i) items covered under title XVIII of  
15 the Social Security Act;

16 “(ii) items for which coverage is not  
17 available under a State medicaid plan; or

18 “(iii) drugs and biologicals furnished  
19 for the purpose of causing, or assisting in  
20 causing, the death, suicide, euthanasia, or  
21 mercy killing of a person.

22 “(2) STATE DRUG ASSISTANCE PROGRAM; PRO-  
23 GRAM.—The terms ‘State drug assistance program’  
24 and ‘program’ mean a State drug assistance pro-  
25 gram receiving funds under this part.

1           “(3) GROUP HEALTH PLAN.—The term ‘group  
2           health plan’ has the meaning given such term in sec-  
3           tion 2791(a)(1).

4           “(4) MEDICAID PLAN.—The term ‘medicaid  
5           plan’ means a plan of a State under title XIX of the  
6           Social Security Act and includes such a plan oper-  
7           ating under a waiver under such Act.

8           “(5) MEDICARE+CHOICE PLAN.—The term  
9           ‘Medicare+Choice plan’ means such a plan offered  
10          under part C of title XVIII of the Social Security  
11          Act.

12          “(6) FAMILY INCOME.—Family income shall be  
13          determined in the same manner as it is determined  
14          for purposes of section 1905(p) of the Social Secu-  
15          rity Act, except that such determinations shall be  
16          made only on an annual basis.

17          “PART B—MEDICARE OUTPATIENT PRESCRIPTION  
18                          DRUG STOP-LOSS PROTECTION

19          “SEC. 2811. MEDICARE OUTPATIENT PRESCRIPTION DRUG  
20                          STOP-LOSS PROTECTION.

21          “(a) IN GENERAL.—This section establishes a pro-  
22          gram under which, in the case of medicare beneficiaries  
23          who are covered under qualified medicare prescription  
24          drug coverage (as defined in subsection (b)(1)), the pro-  
25          gram provides for payment through carriers or other

1 qualified entities to the organization, issuer, or sponsor  
2 offering the coverage of the cost of providing benefits (pro-  
3 vided on or after January 1, 2000) under the coverage  
4 in a year after the beneficiary has incurred out-of-pocket  
5 costs for outpatient prescription drugs covered under such  
6 coverage equal to \$1,500. For purposes of this section,  
7 the term ‘medicare beneficiary’ means an individual enti-  
8 tled to benefits under part A, B, or C of title XVIII of  
9 the Social Security Act.

10 “(b) QUALIFIED MEDICARE PRESCRIPTION DRUG  
11 COVERAGE DEFINED.—

12 “(1) IN GENERAL.—For purposes of this sec-  
13 tion, the term ‘qualified medicare prescription drug  
14 coverage’ means outpatient prescription drug cov-  
15 erage under a plan or policy described in paragraph  
16 (2) with respect to a medicare beneficiary if the fol-  
17 lowing requirements are met:

18 “(A) The amount of any deductible im-  
19 posed with respect to such coverage for such a  
20 beneficiary does not exceed \$500 in any year.

21 “(B) The cost-sharing (in the form of co-  
22 payment or coinsurance or both) imposed (after  
23 the imposition of any such deductible) with re-  
24 spect to such coverage for such a beneficiary  
25 does not exceed 50 percent of the payment

1 amount to purchase the covered outpatient pre-  
2 scription drug involved.

3 “(C) There is a annual limit of not more  
4 than \$1,500 on the out-of-pocket expenses for  
5 covered outpatient prescription drugs under the  
6 coverage of such a beneficiary.

7 “(D) The organization, issuer, or sponsor  
8 offering the coverage has entered into an agree-  
9 ment with the carrier or other qualified entity  
10 operating the program under subsection (c)  
11 under which it agrees to provide for the ex-  
12 change of such information, in such electronic  
13 or other form as the agreement specifies, as the  
14 carrier or entity may require in order to verify  
15 the eligibility for payment described in sub-  
16 section (a).

17 “(2) PLANS AND POLICIES COVERED.—A plan  
18 or policy described in this paragraph is any of the  
19 following:

20 “(A) MEDICARE+CHOICE PLAN.—A  
21 Medicare+Choice plan under part C of title  
22 XVIII of the Social Security Act.

23 “(B) MEDIGAP POLICY.—A medicare sup-  
24 plemental policy, as defined in section 1882(g)

1 of the Social Security Act (42 U.S.C.  
2 1395ss(g)).

3 “(C) GROUP HEALTH PLAN.—A group  
4 health plan, as defined in section 607(1) of Em-  
5 ployee Retirement Income Security Act of 1974  
6 (29 U.S.C. 1167(1)), but only with respect to  
7 a participant or beneficiary who is a medicare  
8 beneficiary.

9 “(c) OPERATION OF PROGRAM THROUGH PRIVATE  
10 ENTITIES.—

11 “(1) IN GENERAL.—The Secretary shall enter  
12 into contracts with one or more carriers or other  
13 qualified entities to operate the stop-loss program  
14 provided under this section.

15 “(2) LIMITATION ON AUTHORITY.—Nothing in  
16 this section shall be construed as authorizing the  
17 Secretary, a carrier, or other qualified entity acting  
18 under paragraph (1) to deny or limit payment to an  
19 entity that is offering qualified medicare prescription  
20 drug coverage and has made payments for the cost  
21 of providing benefits under such coverage based on  
22 the drugs so covered or the amount so paid. The  
23 previous sentence shall not be construed as pre-  
24 venting the Secretary, a carrier, or entity from com-  
25 puting costs taking into account discounts or other



1 rebates related to the provision of qualified prescrip-  
 2 tion drug coverage.

3 “(d) ENTITLEMENT.—This section constitutes budg-  
 4 et authority in advance of appropriations Acts and rep-  
 5 resents the obligation of the Federal Government to pro-  
 6 vide for the payment under this section of stop-loss bene-  
 7 fits described in subsection (a).

8 “(e) INDEXING DOLLAR AMOUNTS.—For a year after  
 9 2000, each of the dollar amounts specified in this section  
 10 shall be increased by the same percentage as the percent-  
 11 age increase (if any) in per capita expenditures for pre-  
 12 scription drugs (as estimated by the Secretary based on  
 13 the best data available from the Bureau of Labor Statis-  
 14 tics) between July 1999 and July of the previous year,  
 15 except that any such increase which is not a multiple of  
 16 \$10 shall be rounded to the nearest multiple of \$10.

17 “PART C—ACCESS TO PRESCRIPTION DRUG COVERAGE  
 18 UNDER MEDIGAP POLICIES

19 “**SEC. 2821. PERMITTING MEDICARE BENEFICIARIES TO AD-  
 20 JUST MEDIGAP COVERAGE.**

21 “(a) ALLOWING MEDICARE BENEFICIARIES PRO-  
 22 VIDED LOW-INCOME ASSISTANCE TO DROP PRESCRIP-  
 23 TION DRUG MEDIGAP COVERAGE.—

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

1           “(A) may not deny or condition the  
2           issuance or effectiveness of a medicare supple-  
3           mental policy that has a benefit package classi-  
4           fied as ‘A’, ‘B’, ‘C’, ‘D’, ‘E’, ‘F’, or ‘G’ (under  
5           the standards established under subsection  
6           (p)(2) of section 1882 of the Social Security  
7           Act) and that is offered and is available for  
8           issuance to new enrollees by such issuer;

9           “(B) may not discriminate in the pricing  
10          of such policy, because of health status, claims  
11          experience, receipt of health care, or medical  
12          condition; and

13          “(C) may not impose an exclusion of bene-  
14          fits based on a pre-existing condition under  
15          such policy,

16          in the case of an individual described in paragraph  
17          (2) who seeks to enroll under the policy not later  
18          than 63 days after the date of the termination of en-  
19          rollment described in such paragraph and who sub-  
20          mits evidence of the date of termination or  
21          disenrollment along with the application for such  
22          medicare supplemental policy.

23          “(2) INDIVIDUAL COVERED.—An individual de-  
24          scribed in this paragraph is an individual who—

1           “(A) is a low-income medicare beneficiary  
2           (as defined in section 2802(b)) who is being  
3           provided prescription drug assistance under  
4           part A; and

5           “(B) at the time the individual is first pro-  
6           vided such assistance, was enrolled and termi-  
7           nates enrollment in a medicare supplemental  
8           policy which has a benefit package classified  
9           as—

10           “(I) ‘H’,

11           “(II) ‘I’, or

12           “(III) ‘J’,

13           under the standards referred to in paragraph (1)(A).

14           “(b) ALLOWING MEDICARE BENEFICIARIES WHO  
15 LOSE LOW-INCOME PRESCRIPTION DRUG ASSISTANCE TO  
16 RESTORE MEDIGAP COVERAGE THAT INCLUDED PRE-  
17 SCRIPTION DRUG COVERAGE.—

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

20           “(A) may not deny or condition the  
21           issuance or effectiveness of a medicare supple-  
22           mental policy described in paragraph (3) that is  
23           offered and is available for issuance to new en-  
24           rollees by such issuer;

1           “(B) may not discriminate in the pricing  
2 of such policy, because of health status, claims  
3 experience, receipt of health care, or medical  
4 condition; and

5           “(C) may not impose an exclusion of bene-  
6 fits based on a pre-existing condition under  
7 such policy,

8 in the case of an individual described in paragraph  
9 (2) who seeks to enroll under the policy not later  
10 than 63 days after the date of the termination of  
11 prescription drug assistance described in such para-  
12 graph and who submits evidence of the date of ter-  
13 mination along with the application for such medi-  
14 care supplemental policy.

15           “(2) INDIVIDUAL COVERED.—An individual de-  
16 scribed in this paragraph is an individual—

17           “(A) who was described in paragraph  
18 (4)(B) of section 1882(s) of the Social Security  
19 Act and changed enrollment under paragraph  
20 (4)(A); and

21           “(B) whose prescription drug assistance  
22 under part A of this title is terminated.

23           “(3) POLICY DESCRIBED.—A medicare supple-  
24 mental policy described in this paragraph is the  
25 medicare supplemental policy described in paragraph

1 (4)(B) of section 1882(s) of the Social Security Act  
2 from which the individual discontinued enrollment  
3 under paragraph (4)(A) of such section.

4 “(c) GUARANTEED ISSUE IN ANOTHER CASE.—

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

7 “(A) may not deny or condition the  
8 issuance or effectiveness of a medicare supple-  
9 mental policy which has a benefit package clas-  
10 sified as—

11 “(i) ‘H’,

12 “(ii) ‘I’, or

13 “(iii) ‘J’,

14 under the standards referred to in subsection  
15 (a)(1)(A) that is offered and is available for  
16 issuance to new enrollees by such issuer;

17 “(B) may not discriminate in the pricing  
18 of such policy, because of health status, claims  
19 experience, receipt of health care, or medical  
20 condition; and

21 “(C) subject to paragraph (2), may not im-  
22 pose an exclusion of benefits based on a pre-ex-  
23 isting condition under such policy;

24 in the case of an individual who is 65 years of age  
25 or older and who seeks to enroll under the policy

1 during a 6-month open enrollment period specified  
2 by the Secretary.

3 “(2) The provisions of subparagraphs (B) and  
4 (C) of paragraph (1) of section 1882(s) of the Social  
5 Security Act shall apply with respect to paragraph  
6 (1) in the same manner as they apply with respect  
7 to paragraph (1)(A) of such section.

8 “(d) ENFORCEMENT.—The provisions of subsections  
9 (a) through (c) shall be enforced as though they were in-  
10 cluded in section 1882(s) of the Social Security Act.

11 “(e) DEFINITIONS.—For purposes of this section, the  
12 term ‘medicare supplemental policy’ has the meaning  
13 given such term in section 1882(g) of the Social Security  
14 Act.”.

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