

106TH CONGRESS  
2D SESSION

# S. 2807

To amend the Social Security Act to establish a Medicare Prescription Drug and Supplemental Benefit Program and to stabilize and improve the Medicare+Choice program, and for other purposes.

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## IN THE SENATE OF THE UNITED STATES

JUNE 28, 2000

Mr. BREAUX (for himself, Mr. FRIST, Mr. KERREY, Mr. BOND, Mr. SANTORUM, Ms. LANDRIEU, Mr. ASHCROFT, and Ms. COLLINS) introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

To amend the Social Security Act to establish a Medicare Prescription Drug and Supplemental Benefit Program and to stabilize and improve the Medicare+Choice program, and for other purposes.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Medicare Prescription Drug and Modernization Act of  
6 2000”.

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

- Sec. 1. Short title; table of contents.  
 Sec. 2. Findings and purposes.

TITLE I—MEDICARE MANAGEMENT AND ADMINISTRATION

Subtitle A—Establishment of the Competitive Medicare Agency

- Sec. 101. Establishment of the Competitive Medicare Agency.

“TITLE XXII—MEDICARE COMPETITION AND PRESCRIPTION  
 DRUGS

“PART A—ESTABLISHMENT OF THE COMPETITIVE MEDICARE AGENCY

- “Sec. 2201. Competitive Medicare Agency.  
 “Sec. 2202. Commissioner; Deputy Commissioner; other officers.  
 “Sec. 2203. Administrative duties of the Commissioner.  
 “Sec. 2204. Medicare Competition and Prescription Drug Advisory  
 Board.”.

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

- Sec. 103. Salary increase for the HCFA Administrator.

Subtitle B—Redefined Medicare Solvency Measures

- Sec. 151. Requirements for annual financial reporting and oversight of medi-  
 care program.

TITLE II—MEDICARE PRESCRIPTION DRUG AND SUPPLEMENTAL  
 BENEFIT PROGRAM

- Sec. 201. Establishment of program.

“PART B—MEDICARE PRESCRIPTION DRUG AND SUPPLEMENTAL BENEFIT  
 PROGRAM

- “Sec. 2221. Establishment of Prescription Drug and Supplemental Benefit  
 Program.  
 “Sec. 2222. Enrollment under program.  
 “Sec. 2223. Election of a Medicare Prescription Plus plan.  
 “Sec. 2224. Beneficiary information.  
 “Sec. 2225. Outpatient prescription drug and other supplemental benefits.  
 “Sec. 2226. Beneficiary protections.  
 “Sec. 2227. Requirements for entities offering Medicare Prescription Plus  
 plans.  
 “Sec. 2228. Submission of Medicare Prescription Plus plans.  
 “Sec. 2229. Approval of Medicare Prescription Plus plans.  
 “Sec. 2230. Payments to Medicare Prescription Plus plans for benefits.  
 “Sec. 2231. Computation and collection of beneficiary share of premium.  
 “Sec. 2232. Additional prescription drug subsidies through reinsurance.  
 “Sec. 2233. Plan fees for administrative costs.  
 “Sec. 2234. Medicare prescription drug account.  
 “Sec. 2235. Secondary payer provisions.

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

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

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

Sec. 204. Medicaid amendments.

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

Sec. 205. Medigap provisions.

Sec. 206. GAO report on part B payment for drugs and biologicals and related services.

#### TITLE III—MEDICARE+CHOICE REFORMS

Sec. 301. Increase in national per capita Medicare+Choice growth percentage in 2001 and 2002.

Sec. 302. Removing application of budget neutrality beginning in 2002.

Sec. 303. Medicare+Choice competition program.

Sec. 304. Freeze of health risk adjuster at 20 percent.

#### TITLE IV—MEDICARE BENEFICIARY OUTREACH AND EDUCATION

Sec. 401. Medicare Consumer Coalitions.

##### “PART C—MEDICARE CONSUMER COALITIONS

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

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

### 2 (a) FINDINGS.—

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

9 (2) The medicare program relies on general rev-  
 10 enues to pay for 36 percent of total program ex-  
 11 penditures and will continue to use an increasing  
 12 share of general revenues. Part B outlays under  
 13 such program,  $\frac{3}{4}$  of which are funded through gen-

1       eral revenues, have increased 38 percent over the  
2       past 5 years, or about 5 percent faster than the  
3       economy as a whole.

4           (3) Medicare's spending, left unchecked, will  
5       continue to consume an increasing share of the Fed-  
6       eral budget, leaving little room for other priorities,  
7       such as defense, education, debt reduction, tax cuts,  
8       and domestic spending.

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

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

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

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

1           (8) The Balanced Budget Act of 1997 and the  
2 Medicare, Medicaid, and SCHIP Balanced Budget  
3 Refinement Act of 1999 underscore the need to fun-  
4 damentally restructure the medicare program and  
5 reduce Government micromanagement of that pro-  
6 gram.

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

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

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

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

23           (4) to increase the flexibility of the medicare  
24 program and provide medicare beneficiaries timely  
25 access to the latest advances in the practice of medi-

1        cine and delivery of care and to end the congres-  
2        sional micromanagement over prices and delivery of  
3        benefits currently administered through approxi-  
4        mately 130,000 pages of rules and regulations estab-  
5        lished under the medicare program; and

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

14       **TITLE I—MEDICARE MANAGE-**  
15       **MENT AND ADMINISTRATION**  
16       **Subtitle A—Establishment of the**  
17       **Competitive Medicare Agency**

18       **SEC. 101. ESTABLISHMENT OF THE COMPETITIVE MEDI-**  
19       **CARE AGENCY.**

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

1 “TITLE XXII—MEDICARE COMPETITION AND  
2 PRESCRIPTION DRUGS

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

5 “COMPETITIVE MEDICARE AGENCY

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

10 “(b) DUTY.—

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

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



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

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

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

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

22           “(A) GENERAL RESPONSIBILITIES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

3 “(6) DELEGATION OF AUTHORITY.—

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

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

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

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

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

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

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

12          “(2) TERM.—

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

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

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

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

4           “(4) DUTIES.—

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

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

16          “(c) CHIEF ACTUARY.—

17                 “(1) APPOINTMENT.—

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

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

1 perience, superior expertise in the actuarial  
2 sciences.

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

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

13 “ADMINISTRATIVE DUTIES OF THE COMMISSIONER

14 “SEC. 2203. (a) PERSONNEL.—

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

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

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

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

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

11 “(b) BUDGETARY MATTERS.—

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

17 “(2) APPROPRIATIONS REQUESTS.—

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

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

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

3 “(c) SEAL OF OFFICE.—

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

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

9 “(d) DATA EXCHANGES.—

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

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

1 of enactment of the Medicare Prescription Drug  
2 and Modernization Act of 2000; and

3 “(B) the Commissioner shall disclose to  
4 the Secretary or to any State any record or in-  
5 formation requested in writing by the Secretary  
6 to be so disclosed for the purpose of admin-  
7 istering any program administered by the Sec-  
8 retary, if records or information of such type  
9 were so disclosed under applicable rules, regula-  
10 tions, and procedures in effect before the date  
11 of enactment of the Medicare Prescription Drug  
12 and Modernization Act of 2000.

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

21 “(3) ROUTINE USE.—

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



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

3 “(2) REPORTS.—

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

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

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

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

4           “(A) PRESIDENTIAL APPOINTMENTS.—

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

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

11          “(B) SENATORIAL APPOINTMENTS.—2

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

17          “(C) CONGRESSIONAL APPOINTMENTS.—2

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

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

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

5 “(d) TERMS OF APPOINTMENT.—

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

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

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

16 “(B) STAGGERED TERMS.—The terms of  
17 service of the members initially appointed under  
18 this section shall begin on January 1, 2002,  
19 and expire as follows:

20 “(i) PRESIDENTIAL APPOINTMENTS.—

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

25 “(I) 2 years;

1 “(II) 4 years; and

2 “(III) 6 years.

3 “(ii) SENATORIAL APPOINTMENTS.—

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

10 “(I) 3 years; and

11 “(II) 6 years.

12 “(iii) CONGRESSIONAL APPOINT-

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

19 “(I) 4 years; and

20 “(II) 5 years.

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

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

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

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

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

20 “(g) MEETING.—

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

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

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

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

10 “(i) PERSONNEL.—

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

18 “(2) STAFF.—

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

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

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

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

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

22           (b) EFFECTIVE DATE.—

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

1           (2) **TIMING OF INITIAL APPOINTMENTS.**—The  
 2           Commissioner and Deputy Commissioner of the  
 3           Competitive Medicare Agency may not be appointed  
 4           before March 1, 2001.

5           (3) **DUTIES WITH RESPECT TO ELIGIBILITY DE-**  
 6           **TERMINATIONS AND ENROLLMENT.**—The Commis-  
 7           sioner of the Competitive Medicare Agency shall  
 8           carry out enrollment under title XVIII of the Social  
 9           Security Act, make eligibility determinations under  
 10          such title, and carry out part C of such title for  
 11          years beginning on or after January 1, 2003.

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

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

21          (b) **EFFECTIVE DATE.**—The amendments made by  
 22          this subsection shall take effect on March 1, 2001.

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

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

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

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

11 (c) EFFECTIVE DATE.—The amendments made by  
 12 this subsection take effect on March 1, 2001.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 “ESTABLISHMENT OF PRESCRIPTION DRUG AND  
11 SUPPLEMENTAL BENEFIT PROGRAM

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

20 “(b) PROGRAM TO BEGIN IN 2003.—The Commis-  
21 sioner shall establish the program under this part in a  
22 manner so that benefits are first provided for months be-  
23 ginning with January 2003.

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

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

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

10                   “ENROLLMENT UNDER PROGRAM

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

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

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

24       “(b) ENROLLMENT PERIOD.—

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

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

3 “(2) OPEN ENROLLMENT PERIOD FOR BENE-  
4 FICIARIES CURRENTLY COVERED.—In the case of an  
5 individual who is entitled to part A of title XVIII  
6 and enrolled under part B of such title as of Novem-  
7 ber 1, 2002, there shall be an open enrollment pe-  
8 riod of 6 months beginning on that date.

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

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

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

20 “(i) had applicable drug coverage; and

21 “(ii) involuntarily lost such coverage.

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

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

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

1           “(iii) PRESCRIPTION DRUG COVERAGE  
2           UNDER CERTAIN MEDIGAP POLICIES.—  
3           Coverage under a medicare supplemental  
4           policy under section 1882 that provides  
5           benefits for prescription drugs (whether or  
6           not such coverage conforms to the stand-  
7           ards for packages of benefits under section  
8           1882(p)(1)), but only if the policy was in  
9           effect on January 1, 2003.

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

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

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

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

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

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

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

13                  “(B) REPORT.—Not later than January 1,  
14                  2002, the Commissioner shall submit a report  
15                  to Congress on the study conducted under sub-  
16                  paragraph (A), together with any recommenda-  
17                  tions for legislation that the Commissioner de-  
18                  termines to be appropriate as a result of such  
19                  study.

20                  “(c) PERIOD OF COVERAGE.—

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

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

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

10              “(3) LIMITATION.—Coverage under this part  
11       shall not begin prior to January 1, 2003.

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

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

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

1       “(e) FIRST ENROLLMENT PERIOD.—The Commis-  
2 sioner shall ensure that eligible beneficiaries are permitted  
3 to enroll under this part prior to January 1, 2003, in  
4 order to ensure that coverage under this part is effective  
5 as of such date.

6       “ELECTION OF A MEDICARE PRESCRIPTION PLUS PLAN

7       “SEC. 2223. (a) IN GENERAL.—

8               “(1) PROCESS.—

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

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

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

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

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

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

16                  “(b) ASSURING ACCESS TO PRESCRIPTION DRUG  
17                  COVERAGE IN AREAS WITH NO MEDICARE PRESCRIPTION  
18                  PLUS PLAN OR MEDICARE+CHOICE PLAN PROVIDING  
19                  DRUG COVERAGE AVAILABLE.—The Commissioner shall  
20                  develop procedures for the provision of the benefits re-  
21                  quired under section 2225(a) to each eligible beneficiary  
22                  that resides in an area where there are no Medicare Pre-  
23                  scription Plus plans or Medicare+Choice plans available  
24                  that provide qualified prescription drug coverage.

1 “BENEFICIARY INFORMATION

2 “SEC. 2224. (a) IN GENERAL.—The Commissioner  
3 shall conduct activities that are designed to broadly dis-  
4 seminate information to eligible beneficiaries (and pro-  
5 spective eligible beneficiaries) regarding the coverage pro-  
6 vided under this part.

7 “(b) REQUIREMENTS.—The activities conducted  
8 under this subsection shall be—

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

12 “(2) coordinated with the activities performed  
13 by the Commissioner under such section and under  
14 section 1804.

15 “OUTPATIENT PRESCRIPTION DRUG AND OTHER

16 SUPPLEMENTAL BENEFITS

17 “SEC. 2225. (a) REQUIREMENTS.—

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

22 “(A) STANDARD COVERAGE WITH ACCESS  
23 TO NEGOTIATED PRICES.—Standard coverage  
24 (as defined in subsection (d)) and access to ne-  
25 gotiated prices under subsection (f).

1           “(B) ACTUARIALLY EQUIVALENT COV-  
2           ERAGE WITH ACCESS TO NEGOTIATED  
3           PRICES.—Coverage of covered outpatient drugs  
4           which meets the alternative coverage require-  
5           ments of subsection (e) and access to negotiated  
6           prices under subsection (f).

7           “(2) PERMITTING ADDITIONAL OUTPATIENT  
8           PRESCRIPTION DRUG COVERAGE.—

9           “(A) IN GENERAL.—Subject to subpara-  
10          graph (B) and section 2229(c)(2), nothing in  
11          this part shall be construed as preventing quali-  
12          fied prescription drug coverage from including  
13          coverage of covered outpatient drugs that ex-  
14          ceeds the coverage required under paragraph  
15          (1).

16          “(B) REQUIREMENT.—An eligible entity  
17          may not offer a Medicare Prescription Plus  
18          plan that provides additional benefits pursuant  
19          to subparagraph (A) in an area unless the eligi-  
20          ble entity offering such plan also offers a Medi-  
21          care Prescription Plus plan in the area that  
22          only provides the coverage of prescription drugs  
23          that is required under subsection (a)(1).

24          “(3) COST CONTROL MECHANISMS.—In pro-  
25          viding qualified prescription drug coverage, the enti-

1 ty offering the Medicare Prescription Plus plan or  
2 the Medicare+Choice plan may use cost control  
3 mechanisms that are customarily used in employer-  
4 sponsored health care plans that offer coverage for  
5 outpatient prescription drugs, including the use of  
6 formularies, tiered copayments, selective contracting  
7 with providers of outpatient prescription drugs, and  
8 mail order pharmacies.

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

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

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

22 “(A) the eligible entity offering such plan  
23 also offers a Medicare Prescription Plus plan in  
24 the area that only provides the coverage of pre-

1            prescription drugs that is required under sub-  
2            section (a)(1); and

3            “(B) if the additional benefits include any  
4            of the core group of basic benefits described in  
5            section 1882(p)(2)(B), the Medicare Prescrip-  
6            tion Plus plan provides all of such core group  
7            of basic benefits.

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

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

16           “(1) DEDUCTIBLE.—The coverage has an an-  
17           nual deductible—

18           “(A) for 2003, that is equal to \$250; or

19           “(B) for a subsequent year, that is equal  
20           to the amount specified under this paragraph  
21           for the previous year increased by the percent-  
22           age specified in paragraph (5) for the year in-  
23           volved.

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

4 “(2) LIMITS ON COST-SHARING.—The coverage  
5 has cost-sharing (for costs above the annual deduct-  
6 ible specified in paragraph (1) and up to the initial  
7 coverage limit under paragraph (3)) that is equal to  
8 50 percent or that is actuarially consistent (using  
9 processes established under subsection (g)) with an  
10 average expected payment of 50 percent of such  
11 costs.

12 “(3) INITIAL COVERAGE LIMIT.—Subject to  
13 paragraph (4), the coverage has an initial coverage  
14 limit on the maximum costs that may be recognized  
15 for payment purposes (above the annual deduct-  
16 ible)—

17 “(A) for 2003, that is equal to \$2,100; or

18 “(B) for a subsequent year, that is equal  
19 to the amount specified in this paragraph for  
20 the previous year, increased by the annual per-  
21 centage increase described in paragraph (5) for  
22 the year involved.

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

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

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

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

13                 “(i) for 2003, is equal to \$6,000; or

14                 “(ii) for a subsequent year, is equal to  
15                 the amount specified in the subparagraph  
16                 for the previous year, increased by the an-  
17                 nual percentage increase described in para-  
18                 graph (5) for the year involved.

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

22          “(C) APPLICATION.—In applying subpara-  
23          graph (A)—

24                 “(i) incurred costs shall only include  
25                 costs incurred for the annual deductible

1 (described in paragraph (1)), cost-sharing  
2 (described in paragraph (2)), and amounts  
3 for which benefits are not provided because  
4 of the application of the initial coverage  
5 limit described in paragraph (3); but

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

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 outpatient drugs in  
19 the United States for medicare beneficiaries, as de-  
20 termined by the Commissioner for the 12-month pe-  
21 riod ending in July of the previous year.

22 “(e) ALTERNATIVE COVERAGE REQUIREMENTS.—A  
23 Medicare Prescription Plus plan or Medicare+Choice plan  
24 may provide a different prescription drug benefit design

1 from the standard coverage described in subsection (d) so  
2 long as the following requirements are met:

3           “(1) ASSURING AT LEAST ACTUARIALLY EQUIV-  
4           ALENT COVERAGE.—

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

10                   “(B) ASSURING EQUIVALENT UNSUB-  
11           SIDIZED VALUE OF COVERAGE.—The unsub-  
12           sidized value of the coverage is at least equal to  
13           the unsubsidized value of standard coverage.  
14           For purposes of this subparagraph, the unsub-  
15           sidized value of coverage is the amount by  
16           which the actuarial value of the coverage (as  
17           determined under subsection (g)) exceeds the  
18           actuarial value of the reinsurance subsidy pay-  
19           ments under section 2232 with respect to such  
20           coverage.

21                   “(C) ASSURING STANDARD PAYMENT FOR  
22           COSTS AT INITIAL COVERAGE LIMIT.—The cov-  
23           erage is designed, based upon an actuarially  
24           representative pattern of utilization (as deter-  
25           mined under subsection (g)), to provide for the

1 payment, with respect to costs incurred that are  
2 equal to the sum of the deductible under sub-  
3 section (d)(1) and the initial coverage limit  
4 under subsection (d)(3), of an amount equal to  
5 at least such initial coverage limit multiplied by  
6 the percentage specified in subsection (d)(2).

7 Benefits other than qualified prescription drug cov-  
8 erage shall not be taken into account for purposes  
9 of this paragraph.

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

14 “(f) ACCESS TO NEGOTIATED PRICES.—Under quali-  
15 fied prescription drug coverage offered by an eligible entity  
16 or a Medicare+Choice organization, the entity or organi-  
17 zation shall provide beneficiaries with access to negotiated  
18 prices (including applicable discounts) used for payment  
19 for covered outpatient drugs, regardless of the fact that  
20 no benefits may be payable under the coverage with re-  
21 spect to such drugs because of the application of cost-shar-  
22 ing or an initial coverage limit (described in subsection  
23 (d)(3)). In providing such access, the eligible entity or  
24 Medicare+Choice organization shall issue a card pursuant  
25 to section 2226(b)(1).

1       “(g) ACTUARIAL VALUATION; DETERMINATION OF  
2 ANNUAL PERCENTAGE INCREASES.—

3               “(1) PROCESSES.—For purposes of this section,  
4 the Commissioner shall establish processes and  
5 methods—

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

8                               “(i) an actuarial valuation of standard  
9 coverage and of the reinsurance subsidy  
10 payments under section 2232;

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

13                               “(iii) applying the same methodology  
14 for determinations of alternative coverage  
15 under subsection (e) as is used with re-  
16 spect to determinations of standard cov-  
17 erage under subsection (d); and

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

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

1 “BENEFICIARY PROTECTIONS

2 “SEC. 2226. (a) DISSEMINATION OF INFORMA-  
3 TION.—

4 “(1) GENERAL INFORMATION.—An eligible enti-  
5 ty offering a Medicare Prescription Plus plan shall  
6 disclose, in a clear, accurate, and standardized form  
7 to each enrollee at the time of enrollment and at  
8 least annually thereafter, the information described  
9 in section 1852(c)(1) relating to such plan. Such in-  
10 formation includes the following:

11 “(A) Access to covered outpatient drugs.

12 “(B) How any formulary used by the enti-  
13 ty functions.

14 “(C) Co-payments, coinsurance, and de-  
15 ductible requirements.

16 “(D) Grievance and appeals procedures.

17 “(2) DISCLOSURE UPON REQUEST OF GENERAL  
18 COVERAGE, UTILIZATION, AND GRIEVANCE INFORMA-  
19 TION.—Upon request of an individual eligible to en-  
20 roll in a Medicare Prescription Plus plan, the eligible  
21 entity offering such plan shall provide the informa-  
22 tion described in section 1852(c)(2) to such indi-  
23 vidual.

24 “(3) RESPONSE TO BENEFICIARY QUESTIONS.—

25 An eligible entity offering a Medicare Prescription

1 Plus plan shall have a mechanism for providing spe-  
2 cific information to enrollees upon request, including  
3 information on specific changes in its formulary.

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

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

16 “(1) ACCESS TO NEGOTIATED PRICES FOR PRE-  
17 SCRIPTON DRUGS.—An eligible entity offering a  
18 Medicare Prescription Plus plan shall issue such a  
19 card that may be used by an enrolled beneficiary to  
20 assure access to negotiated prices under section  
21 2225(f) for the purchase of prescription drugs for  
22 which coverage is not otherwise provided under the  
23 Medicare Prescription Plus plan.

24 “(2) REQUIREMENTS ON DEVELOPMENT AND  
25 APPLICATION OF FORMULARIES.—Insofar as an eli-

1       gible entity offering a Medicare Prescription Plus  
2       plan uses a formulary with respect to qualified pre-  
3       scription drug coverage, the following requirements  
4       must be met:

5               “(A) INCLUSION OF DRUGS IN ALL THERA-  
6               PEUTIC CATEGORIES.—The formulary must in-  
7               clude drugs within all therapeutic categories  
8               and classes of covered outpatient drugs (al-  
9               though not necessarily for all drugs within such  
10              categories and classes).

11             “(B) APPEALS AND EXCEPTIONS TO AP-  
12             PLICATION.—The eligible entity must have, as  
13             part of the appeals process under subsection  
14             (e)(2), a process for appeals for denials of cov-  
15             erage based on such application of the for-  
16             mulary.

17       “(c) COST AND UTILIZATION MANAGEMENT.—

18             “(1) IN GENERAL.—An eligible entity shall have  
19       in place—

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

23               “(B) quality assurance measures to reduce  
24               medical errors and adverse drug interactions,

1           which may include the measures described in  
2           paragraph (2); and

3                   “(C) a program to control fraud, abuse,  
4           and waste.

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

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

16                  “(e) COVERAGE DETERMINATIONS, RECONSIDER-  
17          ATIONS, AND APPEALS.—

18                   “(1) IN GENERAL.—An eligible entity shall  
19          meet the requirements of section 1852(g) with re-  
20          spect to covered benefits under the Medicare Pre-  
21          scription Plus plan it offers under this part in the  
22          same manner as such requirements apply to a  
23          Medicare+Choice organization with respect to bene-  
24          fits it offers under a Medicare+Choice plan under  
25          part C of title XVIII.



1           “(A) IN GENERAL.—Subject to subpara-  
2           graph (B), the entity assumes full financial risk  
3           on a prospective basis for the benefits that it  
4           offers under a Medicare Prescription Plus plan  
5           and that is not covered under reinsurance  
6           under section 2232.

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

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

16          “(b) CONTRACT REQUIREMENTS.—The Commis-  
17          sioner shall not permit an eligible beneficiary to elect a  
18          Medicare Prescription Plus plan offered by an eligible en-  
19          tity under this part, and the entity shall not be eligible  
20          for payments under section 2230, 2231(e), or 2232, unless  
21          the Commissioner has entered into a contract under this  
22          subsection with the entity with respect to the offering of  
23          such plan. Such a contract with an entity may cover more  
24          than 1 Medicare Prescription Plus plan. Such contract  
25          shall provide that the entity agrees to comply with the ap-

1 plicable requirements and standards of this part and the  
2 terms and conditions of payment as provided for in this  
3 part.

4 “(c) WAIVER OF CERTAIN REQUIREMENTS TO EX-  
5 PAND CHOICE.—

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

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

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

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

7           “(5) REFERENCES TO CERTAIN PROVISIONS.—  
8           For purposes of this subsection, in applying the pro-  
9           visions of section 1855(a)(2) under this subsection  
10          to Medicare Prescription Plus plans and eligible  
11          entities—

12                 “(A) any reference to a waiver application  
13                 under section 1855 shall be treated as a ref-  
14                 erence to a waiver application under paragraph  
15                 (1); and

16                 “(B) any reference to solvency standards  
17                 were treated as a reference to solvency stand-  
18                 ards established under subsection (d).

19          “(d) SOLVENCY STANDARDS FOR NON-LICENSED  
20          ENTITIES.—

21                 “(1) ESTABLISHMENT.—The Commissioner  
22                 shall establish, by not later than October 1, 2001,  
23                 financial solvency and capital adequacy standards  
24                 that an entity that does not meet the requirements

1 of subsection (a)(1) must meet to qualify as an eligi-  
2 ble entity under this part.

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

12 “(e) OTHER STANDARDS.—The Commissioner shall  
13 establish by regulation other standards (not described in  
14 subsection (d)) for eligible entities and Medicare Prescrip-  
15 tion Plus plans consistent with, and to carry out, this part.  
16 The Commissioner shall publish such regulations by Octo-  
17 ber 1, 2001.

18 “(f) RELATION TO STATE LAWS.—

19 “(1) IN GENERAL.—The standards established  
20 under this section shall supersede any State law or  
21 regulation (including standards described in para-  
22 graph (2)) with respect to Medicare Prescription  
23 Plus plans which are offered by eligible entities  
24 under this part to the extent such law or regulation  
25 is inconsistent with such standards, in the same

1 manner as such laws and regulations are superseded  
2 under section 1856(b)(3).

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

6 “(A) Benefit requirements.

7 “(B) Requirements relating to inclusion or  
8 treatment of providers.

9 “(C) Coverage determinations (including  
10 related appeals and grievance processes).

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

18 “SUBMISSION OF MEDICARE PRESCRIPTION PLUS PLANS  
19 “SEC. 2228. (a) IN GENERAL.—Each eligible entity  
20 that intends to offer a Medicare Prescription Plus plan  
21 in a year (beginning with 2003) shall submit to the Com-  
22 missioner, at such time and in such manner as the Com-  
23 missioner may specify, such information as the Commis-  
24 sioner may require, including the information described in  
25 subsection (b).

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

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

7           “(2) Information on the actuarial value of the  
8 qualified prescription drug coverage.

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

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

13           “(B) the portion of such premium attrib-  
14 utable to benefits in excess of standard cov-  
15 erage; and

16           “(C) the reduction in such premium result-  
17 ing from the reinsurance subsidy payments pro-  
18 vided under section 2232.

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

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

22       “APPROVAL OF MEDICARE PRESCRIPTION PLUS PLANS

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

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

8       “(c) SPECIAL RULES FOR APPROVAL.—

9           “(1) SERVICE AREA.—The Commissioner may  
10 approve a service area submitted under section  
11 2228(b)(4) only if the Commissioner finds that—

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

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

18           “(2) AVOIDANCE OF FAVORABLE SELECTION.—

19 The Commissioner may approve a Medicare Pre-  
20 scription Plus plan submitted under section 2228  
21 only if the benefits under such plan—

22               “(A) include the required benefits under  
23 section 2225(a)(1); and



1 plan providing coverage under this part for a year  
2 shall be an amount equal to—

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

7 “(B) the amount of the discount deter-  
8 mined under subsection (b).

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

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

19 “(B) INFORMATION NECESSARY FOR COL-  
20 LECTION.—In order to carry out subparagraph  
21 (A), the Commissioner shall transmit to the  
22 Commissioner of Social Security—

23 “(i) at the beginning of each year, the  
24 name, social security account number, and  
25 annual beneficiary premium owed by each

1 individual enrolled in a Medicare Prescrip-  
2 tion Plus plan for each month during the  
3 year; and

4 “(ii) periodically throughout the year,  
5 information to update the information pre-  
6 viously transmitted under this paragraph  
7 for the year.

8 “(b) DISCOUNTS FOR REQUIRED DRUG PORTION OF  
9 PREMIUM.—

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

18 “(A) to a premium discount equal to 100  
19 percent of the amount described in subsection  
20 (c); and

21 “(B) subject to subsection (d), to the sub-  
22 stitution for the beneficiary cost-sharing de-  
23 scribed in paragraphs (1) and (2) of section  
24 2225(d) (up to the initial coverage limit speci-

1           fied in paragraph (3) of such section) of  
2           amounts that are nominal.

3           “(2) SLIDING SCALE PREMIUM DISCOUNT FOR  
4           INDIVIDUALS WITH INCOME ABOVE 135, BUT BELOW  
5           150 PERCENT, OF FEDERAL POVERTY LEVEL.—In  
6           the case of a low-income individual who is deter-  
7           mined to have income that exceeds 135 percent, but  
8           does not exceed 150 percent, of the Federal poverty  
9           level, the individual is entitled under this section to  
10          a premium discount determined on a linear sliding  
11          scale ranging from 100 percent of the amount de-  
12          scribed in subsection (c) for individuals with incomes  
13          at 135 percent of such level to 25 percent of such  
14          amount for individuals with incomes at 150 percent  
15          of such level.

16          “(3) PARTIAL PREMIUM DISCOUNT FOR INDI-  
17          VIDUALS WITH INCOME ABOVE 150 PERCENT OF  
18          FEDERAL POVERTY LEVEL.—In the case of an eligi-  
19          ble beneficiary who is not a low-income individual,  
20          the beneficiary is entitled under this section to a  
21          premium discount equal to 25 percent of the amount  
22          described in subsection (c).

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

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

7           “(B) STATEMENT OF TAXABLE AMOUNT.—  
8 Not later than January 31 of each year (begin-  
9 ning with 2004), the Commissioner shall  
10 provide—

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

17           “(ii) the Secretary of the Treasury  
18 with the information described in clause  
19 (i).

20           “(5) DETERMINATION OF ELIGIBILITY.—

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

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

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

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

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

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

20                 “(i) income shall be determined in the  
21                 manner         described         in         section  
22                 1905(p)(1)(B); and

23                 “(ii) the term ‘Federal poverty line’  
24                 means the official poverty line (as defined  
25                 by the Office of Management and Budget,

1 and revised annually in accordance with  
2 section 673(2) of the Omnibus Budget  
3 Reconciliation Act of 1981) applicable to a  
4 family of the size involved.

5 “(D) TREATMENT OF TERRITORIAL RESI-  
6 DENTS.—In the case of an individual who is not  
7 a resident of the 50 States or the District of  
8 Columbia, the individual is not eligible to be a  
9 low-income individual but may be eligible for fi-  
10 nancial assistance with prescription drug ex-  
11 penses under section 1935(e).

12 “(c) PREMIUM DISCOUNT AMOUNT.—The premium  
13 discount amount described in this subsection for an eligi-  
14 ble beneficiary residing in an area is an amount equal to—

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

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

24 “(d) RULES IN APPLYING COST-SHARING SUB-  
25 SIDIES.—

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

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

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

11           “(C) nothing in this part shall be con-  
12 strued as preventing a plan or provider from  
13 waiving or reducing the amount of cost-sharing  
14 otherwise applicable.

15           “(2) LIMITATION ON CHARGES.—In the case of  
16 a low-income individual receiving cost-sharing sub-  
17 sidies under subsection (b)(1)(B), the eligible entity  
18 may not charge more than a nominal amount in  
19 cases in which the cost-sharing subsidy is provided  
20 under such subsection.

21           “(e) ADMINISTRATION OF COST-SHARING PRO-  
22 GRAM.—The Commissioner shall provide a process where-  
23 by, in the case of a low-income individual who is eligible  
24 for reduced cost-sharing under subsection (b)(1)(B) and  
25 is enrolled in a Medicare Prescription Plus plan or a

1 Medicare+Choice plan under which qualified prescription  
2 drug coverage is provided—

3 “(1) the Commissioner provides for a notifica-  
4 tion of the eligible entity or Medicare+Choice orga-  
5 nization involved that the individual is eligible for  
6 such reduced cost-sharing;

7 “(2) the entity or organization involved reduces  
8 the cost-sharing pursuant to this section and sub-  
9 mits to the Commissioner information on the  
10 amount of such reduction; and

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

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

18 “(f) RELATION TO MEDICAID PROGRAM.—

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

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

1 “ADDITIONAL PRESCRIPTION DRUG SUBSIDIES THROUGH  
2 REINSURANCE

3 “SEC. 2232. (a) REINSURANCE SUBSIDY PAY-  
4 MENT.—In order to reduce premium levels applicable to  
5 qualified prescription drug coverage for all medicare bene-  
6 ficiaries, to reduce adverse selection among Medicare Pre-  
7 scription Plus plans and Medicare+Choice plans that pro-  
8 vide qualified prescription drug coverage, and to promote  
9 the participation of eligible entities under this part, the  
10 Commissioner shall provide in accordance with this section  
11 for payment to a qualifying entity (as defined in sub-  
12 section (b)) of the reinsurance payment amount (as de-  
13 fined in subsection (c)) for excess costs incurred in pro-  
14 viding qualified prescription drug coverage—

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

17 “(2) for individuals enrolled with a  
18 Medicare+Choice plan that provides qualified pre-  
19 scription drug coverage under part C of title XVIII;  
20 and

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

24 This section constitutes budget authority in advance of ap-  
25 propriations Acts and represents the obligation of the

1 Commissioner to provide for the payment of amounts pro-  
2 vided under this section.

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

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

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

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

15 “(c) REINSURANCE PAYMENT AMOUNT.—

16 “(1) IN GENERAL.—Subject to subsection (e)(2)  
17 and paragraph (4), the reinsurance payment amount  
18 under this subsection for a qualified beneficiary (as  
19 defined in subsection (f)(1)) for a coverage year (as  
20 defined in subsection (f)(2)) is an amount equal to  
21 80 percent of the allowable costs attributable to the  
22 portion of the individual’s gross covered prescription  
23 drug costs for the year that exceeds \$7,050.

24 “(2) ALLOWABLE COSTS.—For purposes of this  
25 section, the term ‘allowable costs’ means, with re-

1 spect to gross covered prescription drug costs under  
2 a plan described in subsection (b) offered by a quali-  
3 fying entity, the part of such costs that are actually  
4 paid under the plan, but in no case more than the  
5 part of such costs that would have been paid under  
6 the plan if the prescription drug coverage under the  
7 plan were standard coverage.

8 “(3) GROSS COVERED PRESCRIPTION DRUG  
9 COSTS.—For purposes of this section, the term  
10 ‘gross covered prescription drug costs’ means, with  
11 respect to an enrollee with a qualifying entity under  
12 a plan described in subsection (b) during a coverage  
13 year, the costs incurred under the plan for covered  
14 prescription drugs dispensed during the year, includ-  
15 ing costs relating to the deductible, whether paid by  
16 the enrollee or under the plan, regardless of whether  
17 the coverage under the plan exceeds standard cov-  
18 erage and regardless of when the payment for such  
19 drugs is made.

20 “(4) INDEXING DOLLAR AMOUNT.—

21 “(A) AMOUNT FOR 2003.—The dollar  
22 amount applied under paragraph (1) for 2003  
23 shall be the dollar amount specified in such  
24 paragraph.

1           “(B) FOR 2004.—The dollar amount ap-  
2           plied under paragraph (1) for 2004 shall be the  
3           dollar amount specified in such paragraph in-  
4           creased by the annual percentage increase de-  
5           scribed in section 2225(d)(5) for 2004.

6           “(C) FOR SUBSEQUENT YEARS.—The dol-  
7           lar amount applied under paragraph (1) for a  
8           year after 2004 shall be the dollar amount  
9           (under this paragraph) applied under para-  
10          graph (1) for the preceding year increased by  
11          the annual percentage increase described in sec-  
12          tion 2225(d)(5) for the year involved.

13          “(D) ROUNDING.—Any amount, deter-  
14          mined under the preceding provisions of this  
15          paragraph for a year, which is not a multiple of  
16          \$5 shall be rounded to the nearest multiple of  
17          \$5.

18          “(d) PAYMENT METHODS.—

19               “(1) IN GENERAL.—Payments under this sec-  
20               tion shall be based on such a method as the Com-  
21               missioner determines. The Commissioner may estab-  
22               lish a payment method by which interim payments  
23               of amounts under this section are made during a  
24               year based on the Commissioner’s best estimate of

1 amounts that will be payable after obtaining all of  
2 the information.

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

6 “(e) QUALIFIED RETIREE PRESCRIPTION DRUG  
7 PLAN DEFINED.—

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

15 “(A) ASSURANCE.—The sponsor of the  
16 plan shall annually attest, and provide such as-  
17 surances as the Commissioner may require, that  
18 the coverage meets the requirements for quali-  
19 fied prescription drug coverage.

20 “(B) AUDITS.—The sponsor (and the plan)  
21 shall maintain, and afford the Commissioner  
22 access to, such records as the Commissioner  
23 may require for purposes of audits and other  
24 oversight activities necessary to ensure the ade-  
25 quacy of prescription drug coverage, the accu-

1 racy of payments made, and such other matters  
2 as may be appropriate.

3 “(C) OTHER REQUIREMENTS.—The spon-  
4 sor of the plan shall comply with such other re-  
5 quirements as the Commissioner finds nec-  
6 essary to administer the program under this  
7 section.

8 “(2) LIMITATION ON BENEFIT ELIGIBILITY.—  
9 No payment shall be provided under this section  
10 with respect to an individual who is enrolled under  
11 a qualified retiree prescription drug plan unless the  
12 individual is a medicare secondary payer eligible in-  
13 dividual who—

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

15 “(B) is eligible to obtain qualified prescrip-  
16 tion drug coverage under this part but did not  
17 elect such coverage (either through a Medicare  
18 Prescription Plus plan or through a  
19 Medicare+Choice plan).

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

21 “(A) EMPLOYMENT-BASED RETIREE  
22 HEALTH COVERAGE.—The term ‘employment-  
23 based retiree health coverage’ means health in-  
24 surance or other coverage of health care costs  
25 for medicare secondary payer eligible individ-

1 uals (or for such individuals and their spouses  
2 and dependents) based on their status as  
3 former employees or labor union members.

4 “(B) EMPLOYER.—The term ‘employer’  
5 has the meaning given such term by section  
6 3(5) of the Employee Retirement Income Secu-  
7 rity Act of 1974 (except that such term shall  
8 include only employers of 2 or more employees).

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

13 “(D) MEDICARE SECONDARY PAYER INDI-  
14 VIDUAL.—The term ‘medicare secondary payer  
15 eligible individual’ means, with respect to a  
16 plan, an individual who is covered under the  
17 plan and with respect to whom the plan is not  
18 a primary plan (as defined in section  
19 1862(b)(2)(A)).

20 “(f) GENERAL DEFINITIONS.—For purposes of this  
21 section:

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

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

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

4           “(C) is covered as a medicare secondary  
5           payer eligible individual under a qualified re-  
6           tiree prescription drug plan.

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

12          “PLAN FEES FOR ADMINISTRATIVE COSTS

13          “SEC. 2233. (a) IN GENERAL.—The Commissioner  
14          may levy on Medicare Prescription Plus plans and  
15          Medicare+Choice plans that provide drug coverage pursu-  
16          ant to this part an assessment sufficient to pay the esti-  
17          mated expenses of the Commissioner for administering the  
18          program under this part.

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

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

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

1           “MEDICARE PRESCRIPTION DRUG ACCOUNT

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

6           “(b) AMOUNTS IN ACCOUNT.—

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

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

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

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

19           “(c) PAYMENTS FROM ACCOUNT.—

20           “(1) IN GENERAL.—The Managing Trustee  
21 shall pay from time to time from the Medicare Pre-  
22 scription Drug Account such amounts as the Com-  
23 missioner certifies are necessary to make the pay-  
24 ments provided for by this part, and the payments

1 with respect to administrative expenses in accord-  
2 ance with section 201(g).

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

11 “(d) DEPOSITS INTO ACCOUNT.—

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

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

24 “(1) the amount transferred to the Ac-  
25 count under paragraph (1);

1           “(2) the beneficiary premiums collected  
2           and credited to the account under section  
3           2231(b)(2); and

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

6           “SECONDARY PAYER PROVISIONS

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

9           “DEFINITIONS; TREATMENT OF REFERENCES TO  
10          PROVISIONS IN MEDICARE + CHOICE PROGRAM

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

12           “(1) COMMISSIONER.—The term ‘Commis-  
13           sioner’ means the Commissioner of the Competitive  
14           Medicare Agency.

15           “(2) COVERED OUTPATIENT DRUG.—

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

19           “(i) a drug that may be dispensed  
20           only upon a prescription and that is de-  
21           scribed in clause (i) or (ii) of section  
22           1927(k)(2)(A); or

23           “(ii) a biological product or insulin de-  
24           scribed in subparagraph (B) or (C) of such  
25           section.

26           “(B) EXCLUSIONS.—

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

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

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

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

6                   “(A) a pharmaceutical benefit management  
 7                   company;

8                   “(B) a wholesale or retail pharmacist deliv-  
 9                   ery system;

10                  “(C) an insurer (including an insurer that  
 11                  offers medicare supplemental policies under sec-  
 12                  tion 1882);

13                  “(D) another entity; or

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

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

21           “(6) MEDICARE+CHOICE ORGANIZATION;  
 22           MEDICARE+CHOICE PLAN.—The terms  
 23           ‘Medicare+Choice organization’ and  
 24           ‘Medicare+Choice plan’ have the meanings given  
 25           such terms in subsections (a)(1) and (b)(1), respec-

1       tively, of section 1859 (relating to definitions relat-  
2       ing to Medicare+Choice organizations and plans).

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

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

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

16           “(b) APPLICATION OF MEDICARE+CHOICE PROVI-  
17       SIONS UNDER THIS PART.—For purposes of applying pro-  
18       visions of part C of title XVIII under this part with re-  
19       spect to a Medicare Prescription Plus plan and an eligible  
20       entity, unless otherwise provided in this part such provi-  
21       sions shall be applied as if—

22           “(1) any reference to a Medicare+Choice plan  
23       included a reference to a Medicare Prescription Plus  
24       plan;



1           scription Drug Account established by section  
2           2234”;

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

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

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

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

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

6 “(j) AVAILABILITY OF PRESCRIPTION DRUG BENE-  
7 FITS.—

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

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

1 the Administrator determines that such require-  
 2 ments duplicate requirements otherwise applicable to  
 3 the organization or plan under this part.

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

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

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

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

22 “(5) SPECIFICATION OF SEPARATE AND STAND-  
 23 ARD PREMIUM.—

24 “(A) IN GENERAL.—For purposes of ap-  
 25 plying section 1854 and determining the pre-

1           mium discount under section 2231(c) with re-  
2           spect to qualified prescription drug coverage of-  
3           fered under this subsection under a plan, the  
4           Medicare+Choice organization shall compute  
5           and publish the following:

6                   “(i) SEPARATE PRESCRIPTION DRUG  
7                   PREMIUM.—A premium for prescription  
8                   drug benefits that constitutes qualified  
9                   prescription drug coverage that is separate  
10                  from other coverage under the plan.

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

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

22           The premium under clause (i) shall be com-  
23           puted without regard to any reduction in the  
24           premium permitted under subparagraph (B).

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

9           “(6) TRANSITION IN INITIAL ENROLLMENT PE-  
10          RIOD.—Notwithstanding any other provision of this  
11          part, the annual, coordinated election period under  
12          subsection (e)(3)(B) for 2003 shall be the 6-month  
13          period beginning with November 2002.

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

19          (b)        CONFORMING        AMENDMENTS.—Section  
20          1851(a)(1) of the Social Security Act (42 U.S.C. 1395w-  
21          21(a)(1)) is amended—

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

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

1           (3) by adding at the end the following flush lan-  
2           guage:

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

5           (c) EFFECTIVE DATE.—The amendments made by  
6           this section apply to coverage provided on or after January  
7           1, 2003.

8           **SEC. 204. MEDICAID AMENDMENTS.**

9           (a) DETERMINATIONS OF ELIGIBILITY FOR LOW-IN-  
10          COME SUBSIDIES.—

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

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

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

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

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

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

24                   (A) by redesignating section 1935 as sec-  
25                   tion 1936; and

1 (B) by inserting after section 1934 the fol-  
2 lowing new section:

3 “SPECIAL PROVISIONS RELATING TO MEDICARE

4 PRESCRIPTION DRUG BENEFIT

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

10 “(1) make determinations of eligibility for pre-  
11 mium and cost-sharing subsidies under (and in ac-  
12 cordance with) section 2231;

13 “(2) inform the Commissioner of the Competi-  
14 tive Medicare Agency of such determinations in  
15 cases in which such eligibility is established; and

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

19 “(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE  
20 COSTS.—

21 “(1) IN GENERAL.—The amounts expended by  
22 a State in carrying out subsection (a) are, subject to  
23 paragraph (2), expenditures reimbursable under the  
24 appropriate paragraph of section 1903(a); except  
25 that, notwithstanding any other provision of such  
26 section, the applicable Federal matching rates with

1       respect to such expenditures under such section shall  
2       be increased as follows:

3               “(A) For expenditures attributable to costs  
4               incurred during 2003, the otherwise applicable  
5               Federal matching rate shall be increased by 20  
6               percent of the percentage otherwise payable  
7               (but for this subsection) by the State.

8               “(B) For expenditures attributable to costs  
9               incurred during 2004, the otherwise applicable  
10              Federal matching rate shall be increased by 40  
11              percent of the percentage otherwise payable  
12              (but for this subsection) by the State.

13              “(C) For expenditures attributable to costs  
14              incurred during 2005, the otherwise applicable  
15              Federal matching rate shall be increased by 60  
16              percent of the percentage otherwise payable  
17              (but for this subsection) by the State.

18              “(D) For expenditures attributable to costs  
19              incurred during 2006, the otherwise applicable  
20              Federal matching rate shall be increased by 80  
21              percent of the percentage otherwise payable  
22              (but for this subsection) by the State.

23              “(E) For expenditures attributable to costs  
24              incurred after 2006, the otherwise applicable

1 Federal matching rate shall be increased to 100  
2 percent.

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

8 (b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID  
9 RESPONSIBILITY FOR PREMIUM AND COST-SHARING SUB-  
10 SIDIES FOR DUALY ELIGIBLE INDIVIDUALS.—

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

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

20 “(c) FEDERAL ASSUMPTION OF MEDICAID PRE-  
21 SCRIPTION DRUG COSTS FOR DUALY ELIGIBLE BENE-  
22 FICIARIES.—

23 “(1) IN GENERAL.—For purposes of section  
24 1903(a)(1), for a State that is 1 of the 50 States  
25 or the District of Columbia for a calendar quarter

1 in a year (beginning with 2003) the amount com-  
2 puted under this subsection is equal to the product  
3 of the following:

4 “(A) MEDICARE SUBSIDIES.—The total  
5 amount of payments made in the quarter under  
6 section 2231 (relating to premium and cost-  
7 sharing prescription drug subsidies for low-in-  
8 come medicare beneficiaries) that are attrib-  
9 utable to individuals who are residents of the  
10 State and are entitled to benefits with respect  
11 to prescribed drugs under the State plan under  
12 this title (including such a plan operating under  
13 a waiver under section 1115).

14 “(B) STATE MATCHING RATE.—A propor-  
15 tion computed by subtracting from 100 percent  
16 the Federal medical assistance percentage (as  
17 defined in section 1905(b)) applicable to the  
18 State and the quarter.

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

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

25 “(A) 2003 is 90 percent;

1 “(B) 2004 is 80 percent;

2 “(C) 2005 is 70 percent;

3 “(D) 2006 is 60 percent; or

4 “(E) a year after 2006 is 50 percent.”.

5 (c) MEDICAID PROVIDING WRAP-AROUND BENE-  
6 FITS.—Section 1935 of the Social Security Act, as so in-  
7 serted and amended, is further amended by adding at the  
8 end the following new subsection:

9 “(d) ADDITIONAL PROVISIONS.—

10 “(1) MEDICAID AS SECONDARY PAYOR.—In the  
11 case of an individual dually entitled to qualified pre-  
12 scription drug coverage under a Prescription Plus  
13 Plan under part B of title XXII (or under a  
14 Medicare+Choice plan under part C of such title)  
15 and medical assistance for prescribed drugs under  
16 this title, medical assistance shall continue to be pro-  
17 vided under this title for prescribed drugs to the ex-  
18 tent payment is not made under the Medicare Pre-  
19 scription Plus plan or the Medicare+Choice plan se-  
20 lected by the individual.

21 “(2) CONDITION.—A State may require, as a  
22 condition for the receipt of medical assistance under  
23 this title with respect to prescription drug benefits  
24 for an individual eligible to obtain qualified prescrip-  
25 tion drug coverage described in paragraph (1), that

1 the individual elect qualified prescription drug cov-  
2 erage under the program under part B of title  
3 XXII.”.

4 (d) TREATMENT OF TERRITORIES.—

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

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

10 (B) in subsection (e)(1), by inserting “sub-  
11 ject to subsection (e),” after “1903(a)”;

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

14 “(e) TREATMENT OF TERRITORIES.—

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

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

20 “(B) if the State establishes a plan de-  
21 scribed in paragraph (2) (for providing medical  
22 assistance with respect to the provision of pre-  
23 scription drugs to medicare beneficiaries), the  
24 amount otherwise determined under section  
25 1108(f) (as increased under section 1108(g))

1 for the State shall be increased by the amount  
2 specified in paragraph (3).

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

5 “(A) provides medical assistance with re-  
6 spect to the provision of covered outpatient  
7 drugs (as defined in section 2236(2)) to low-in-  
8 come medicare beneficiaries; and

9 “(B) assures that additional amounts re-  
10 ceived by the State that are attributable to the  
11 operation of this subsection are used only for  
12 such assistance.

13 “(3) INCREASED AMOUNT.—

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

17 “(i) the aggregate amount specified in  
18 subparagraph (B); and

19 “(ii) the amount specified in section  
20 1108(g)(1) for that State, divided by the  
21 sum of the amounts specified in such sec-  
22 tion for all such States.

23 “(B) AGGREGATE AMOUNT.—The aggre-  
24 gate amount specified in this subparagraph  
25 for—

1 “(i) 2003, is equal to \$20,000,000; or

2 “(ii) a subsequent year, is equal to the  
3 aggregate amount specified in this sub-  
4 paragraph for the previous year increased  
5 by the annual percentage increase specified  
6 in section 2225(d)(5) for the year involved.

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

11 (2) CONFORMING AMENDMENT.—Section  
12 1108(f) of the Social Security Act (42 U.S.C.  
13 1308(f)) is amended by inserting “and section  
14 1935(e)(1)(B)” after “Subject to subsection (g)”.

15 **SEC. 205. MEDIGAP PROVISIONS.**

16 (a) IN GENERAL.—Notwithstanding any other provi-  
17 sion of law, no new medicare supplemental policy that pro-  
18 vides coverage of expenses for prescription drugs may be  
19 issued under section 1882 of the Social Security Act on  
20 or after January 1, 2003, to an individual unless it re-  
21 places a medicare supplemental policy that was issued to  
22 that individual and that provided some coverage of ex-  
23 penses for prescription drugs.

1 (b) ISSUANCE OF SUBSTITUTE POLICIES IF OBTAIN-  
2 ING PRESCRIPTION DRUG COVERAGE THROUGH MEDI-  
3 CARE.—

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

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

15 (B) may not discriminate in the pricing of  
16 such policy, because of health status, claims ex-  
17 perience, receipt of health care, or medical con-  
18 dition; and

19 (C) may not impose an exclusion of bene-  
20 fits based on a preexisting condition under such  
21 policy,

22 in the case of an individual described in paragraph  
23 (2) who seeks to enroll under the policy not later  
24 than 63 days after the date of the termination of en-  
25 rollment described in such paragraph and who sub-

1 mits evidence of the date of termination or  
2 disenrollment along with the application for such  
3 medicare supplemental policy.

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

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

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

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

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

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

5 (1) in subsection (d)(3)—

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

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

14 (B) in subparagraph (B)(iii)—

15 (i) in subclause (I), by striking “(II)  
 16 and (III)” and inserting “(II), (III), and  
 17 (IV)”;

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

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

22 “(III) If the statement required by clause (i) is ob-  
 23 tained and indicates that the individual is enrolled in 1  
 24 medicare supplemental policy or 1 Medicare Prescription  
 25 Plus plan, the sale of another policy or plan is not in viola-

1 tion of clause (i) if such other policy or plan does not du-  
2 plicate health benefits under the policy or plan in which  
3 the individual is enrolled.”;

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

7 (3) in subsection (s)(3)—

8 (A) in subparagraph (B)—

9 (i) in clause (ii), by inserting “is en-  
10 rolled with an eligible entity under a Medi-  
11 care Prescription Plus plan under part B  
12 of title XXII or” after “section 1851(e)(4)  
13 or the individual”;

14 (ii) in clause (v)(II), by inserting  
15 “with any eligible entity under a Medicare  
16 Prescription Plus plan under part B of  
17 title XXII,” after “under part C,”; and

18 (iii) in clause (vi), by inserting “, in  
19 a Medicare Prescription Plus plan under  
20 part B of title XXII,” after “under part  
21 C”; and

22 (B) in subparagraph (E)—

23 (i) in clause (i), by inserting “(or, in  
24 the case of an individual enrolled under a  
25 Medicare Prescription Plus plan, the date

1 on which the individual was notified by the  
2 eligible entity of the impending termination  
3 or discontinuance of the Medicare Pre-  
4 scription Plus plan) after “it offers in the  
5 area”; and

6 (ii) in clause (ii), by inserting “or  
7 Medicare Prescription Plus plan” after  
8 “Medicare+Choice plan”.

9 **SEC. 206. GAO REPORT ON PART B PAYMENT FOR DRUGS**  
10 **AND BIOLOGICALS AND RELATED SERVICES.**

11 (a) IN GENERAL.—The Comptroller General of the  
12 United States shall conduct a study to quantify the extent  
13 to which reimbursement for drugs and biologicals under  
14 the current medicare payment methodology (provided  
15 under section 1842(o) of the Social Security Act (42  
16 U.S.C. 1395u(o)) overpays for the cost of such drugs and  
17 biologicals compared to the average acquisition cost paid  
18 by physicians or other suppliers of such drugs.

19 (b) ELEMENTS.—The study shall also assess the con-  
20 sequences of changing the current medicare payment  
21 methodology to a payment methodology that is based on  
22 the average acquisition cost of the drugs. The study shall,  
23 at a minimum, assess the effects of such a reduction on—

24 (1) the delivery of health care services to medi-  
25 care beneficiaries with cancer;

1           (2) total medicare expenditures, including an  
2 estimate of the number of patients who would, as a  
3 result of the payment reduction, receive chemo-  
4 therapy in a hospital rather than in a physician's of-  
5 fice;

6           (3) the delivery of dialysis services;

7           (4) the delivery of vaccines;

8           (5) the administration in physician offices of  
9 drugs other than cancer therapy drugs; and

10          (6) the effect on the delivery of drug therapies  
11 by hospital outpatient departments of changing the  
12 average wholesale price as the basis for medicare  
13 pass-through payments to such departments, as in-  
14 cluded in the Medicare, Medicaid, and SCHIP Bal-  
15 anced Budget Refinement Act of 1999.

16          (c) PAYMENT FOR RELATED PROFESSIONAL SERV-  
17 ICES.—The study shall also include a review of the extent  
18 to which other payment methodologies under part B of  
19 the medicare program, if any, intended to reimburse phy-  
20 sician and other suppliers of drugs and biologicals de-  
21 scribed in subsection (a) for costs incurred in handling,  
22 storing, and administering such drugs and biologicals are  
23 inadequate to cover such costs and whether an additional  
24 payment would be required to cover these costs under the  
25 average acquisition cost methodology.

1 (d) CONSIDERATION OF ISSUES IN IMPLEMENTING  
2 AN AVERAGE ACQUISITION COST METHODOLOGY.—The  
3 study shall assess possible means by which a payment  
4 method based on average acquisition cost could be imple-  
5 mented, including at least the following:

6 (1) Identification of possible bases for deter-  
7 mining the average acquisition cost of drugs, such as  
8 surveys of wholesaler catalog prices, and determina-  
9 tion of the advantages, disadvantages, and costs (to  
10 the government and the public) of each possible ap-  
11 proach.

12 (2) The impact on individual providers and  
13 practitioners if average or median prices are used as  
14 the payment basis.

15 (3) Methods for updating and keeping current  
16 the prices used as the payment basis.

17 (e) COORDINATION WITH BBRA STUDY.—The  
18 Comptroller General of the United States shall conduct  
19 the study under this section in coordination with the study  
20 provided for under section 213(a) of the Medicare, Med-  
21 icaid, and SCHIP Balanced Budget Refinement Act of  
22 1999 (113 Stat. 1501A–350), as enacted into law by sec-  
23 tion 1000(a)(6) of Public Law 106–113.

24 (f) REPORT.—Not later than 6 months after the date  
25 of enactment of this Act, the Comptroller General of the

1 United States shall submit to Congress a report on the  
 2 study conducted under this section, as well as the study  
 3 referred to in subsection (e). Such report shall include rec-  
 4 ommendations regarding such changes in the medicare re-  
 5 imbursement policies described in subsections (a) and (c)  
 6 as the Comptroller General deems appropriate, as well as  
 7 the recommendations described in section 213(b) of the  
 8 Medicare, Medicaid, and SCHIP Balanced Budget Refine-  
 9 ment Act of 1999.

10 **TITLE III—MEDICARE+CHOICE**  
 11 **REFORMS**

12 **SEC. 301. INCREASE IN NATIONAL PER CAPITA**  
 13 **MEDICARE+CHOICE GROWTH PERCENTAGE**  
 14 **IN 2001 AND 2002.**

15 Section 1853(c)(6)(B) of the Social Security Act (42  
 16 U.S.C. 1395w-23(c)(6)(B)) is amended—

17 (1) by striking clauses (iv) and (v);

18 (2) by redesignating clause (vi) as clause (iv);

19 and

20 (3) in clause (iv) (as so redesignated), by strik-  
 21 ing “2002” and inserting “2000”.

22 **SEC. 302. REMOVING APPLICATION OF BUDGET NEU-**  
 23 **TRALITY BEGINNING IN 2002.**

24 Section 1853(c) of the Social Security Act (42 U.S.C.  
 25 1395w-23(c)) is amended—

1 (1) in paragraph (1)(A), in the matter following  
2 clause (ii), by inserting “(for years other than  
3 2002)” after “multiplied”; and

4 (2) in paragraph (5), by inserting “(other than  
5 2002)” after “for each year”.

6 **SEC. 303. MEDICARE+CHOICE COMPETITION PROGRAM.**

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

9 (1) MONTHLY PAYMENTS.—Section  
10 1853(a)(1)(A) of the Social Security Act (42 U.S.C.  
11 1395w-23(a)(1)(A)) is amended by adding at the  
12 end the following new sentences: “For each year (be-  
13 ginning with 2003), under a contract under section  
14 1857, the Commissioner shall make to each  
15 Medicare+Choice organization, with respect to cov-  
16 erage of an individual for a month under this part  
17 in a Medicare+Choice payment area, monthly pay-  
18 ments with respect to benefits under parts A and B  
19 combined in accordance with subsection (c)(8). For  
20 rules relating to payment of the Medicare+Choice  
21 monthly supplemental beneficiary premium or any  
22 prescription drug premium, see section 1854(j).”.

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

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

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

9 “(A) The benchmark amount (as defined  
10 in paragraph (5)(A)).

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

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

16 “(D) The ESRD adjustment (as defined in  
17 paragraph (5)(D)).

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

20 (ii) in paragraph (3), by striking  
21 “monthly adjusted” and all that follows be-  
22 fore the period at the end and inserting  
23 “the payment rates under this part for  
24 each individual enrolled in the  
25 Medicare+Choice plan offered by the

1 Medicare+Choice organization for the  
2 year”; and

3 (iii) by adding at the end the fol-  
4 lowing new paragraph:

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

9 “(A) BENCHMARK AMOUNT.—

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

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

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

21 “(ii) PHASE-OUT OF MINIMUM  
22 AMOUNT AND BLENDED CAPITATION  
23 RATE.—If the amount calculated under  
24 clause (i)(I) for a year for all payment  
25 areas is equal to either the minimum

1 amount or the blended capitation rate, for  
2 all subsequent years the Commissioner  
3 shall not calculate the rates described in  
4 that clause and the amount under such  
5 clause instead shall be equal to the county-  
6 specific monthly per capita costs.

7 “(B) COUNTY-SPECIFIC MONTHLY PER  
8 CAPITA COSTS.—

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

1 to benefits under this title had not received  
2 services from facilities of the Department  
3 of Veterans Affairs or the Department of  
4 Defense.

5 “(ii) EXCLUSION OF GME COSTS.—

6 The calculation of costs under clause (i)  
7 shall not take into account any amounts  
8 attributable to—

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

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

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

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

7           “(E) HEALTH STATUS ADJUSTMENT FAC-  
8           TOR.—The term ‘health status adjustment fac-  
9           tor’ means the health status adjustment imple-  
10          mented under subsection (a)(3)(C) until such  
11          time as the Commissioner develops a health sta-  
12          tus adjustment factor that takes into account  
13          the specific health care needs of  
14          Medicare+Choice eligible individuals who do  
15          not have end-stage renal disease based on the  
16          delivery of care in all settings, which method-  
17          ology shall be phased in equally over a 10-year  
18          period, beginning with 2004, or (if later) the  
19          date on which such factor is developed.

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

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

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

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

7 “(A) IN GENERAL.—For each year (begin-  
 8 ning with 2003), each Medicare+Choice organi-  
 9 zation shall submit to the Commissioner, in a  
 10 form and manner specified by the Commis-  
 11 sioner and for each Medicare+Choice plan  
 12 which it intends to offer in a service area in the  
 13 following year—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20                 “(B) DETERMINATION OF BENCHMARK  
21                 PER COUNTY.—For each year (beginning with  
22                 2003), the Commissioner shall determine the  
23                 benchmark amount (as defined in subparagraph  
24                 (A) of subsection (b)(5)) for each  
25                 Medicare+Choice payment area and shall ad-

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

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

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

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

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

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

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

22 (b) PREMIUMS.—

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

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

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

6 “(1) IN GENERAL.—Notwithstanding subsection  
7 (b) and subject to paragraph (2), for each year (be-  
8 ginning with 2003), the Commissioner shall deter-  
9 mine the difference between the organization’s bid  
10 (submitted under subsection (a)(6) and adjusted  
11 under section 1853(c)(8)(A)) and the plan’s bench-  
12 mark amount (as adjusted under 1853(c)(8)(B)) to  
13 determine the amount of any medicare premium re-  
14 duction, prescription drug premium reduction, re-  
15 duction in plan cost-sharing, or additional benefits  
16 required under paragraph (2)(A), or the  
17 Medicare+Choice monthly supplemental beneficiary  
18 premium for plan enrollees.

19 “(2) ADJUSTMENT.—

20 “(A) BIDS BELOW THE BENCHMARK.—  
21 Notwithstanding subsection (f), if the organiza-  
22 tion’s bid is lower than the plan’s benchmark  
23 amount, 75 percent of the difference deter-  
24 mined under paragraph (1) shall be returned to

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

3 “(i) a monthly medicare premium re-  
4 duction for individuals enrolled in the plan  
5 (up to the entire amount of the premium  
6 for part B);

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

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

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

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

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

23 “(j) RULES RELATING TO PREMIUMS OWED BY  
24 MEDICARE+CHOICE ENROLLEES.—In the case of any  
25 Medicare+Choice monthly supplemental beneficiary pre-

1 mium under subsection (i)(2)(B) or any prescription drug  
2 premium under section 1851(j) that an individual is re-  
3 sponsible for under a Medicare+Choice plan in which the  
4 individual is enrolled, the following rules shall apply:

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

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

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

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

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

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

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

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

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

1           mentary Medical Insurance Trust Fund under  
2           section 1840.

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

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

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

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

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

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

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

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

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

17 “(ii) for 2003 and each subsequent year,  
18 at plan option, the reductions and benefits de-  
19 scribed in section 1854(i)(2)(A).”.

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

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

4 (e) CONFORMING AMENDMENTS.—

5 (1) PREMIUM REDUCTIONS UNDER PART B.—

6 (A) AMOUNT OF PREMIUMS.—Section  
7 1839(a)(2) of the Social Security Act (42  
8 U.S.C. 1395r(a)(2)) is amended by striking  
9 “shall” and all that follows and inserting the  
10 following: “shall be the amount determined  
11 under paragraph (3), adjusted as required in  
12 accordance with subsections (b), (c), and (f),  
13 and thereafter further modified as required to  
14 comply with section 1854(i)(2)(A).”.

15 (B) PAYMENT OF PREMIUMS.—Section  
16 1840 of the Social Security Act (42 U.S.C.  
17 1395s) is amended by adding at the end the fol-  
18 lowing new clause:

19 “(i) The Commissioner shall provide for necessary  
20 adjustments of the medicare premium for  
21 Medicare+Choice enrollees determined under section  
22 1854(i)(2)(A)(i). This premium adjustment may be pro-  
23 vided directly or as an adjustment to Social Security, Rail-  
24 road Retirement and Civil Service Retirement benefits, as  
25 appropriate, as the Commissioner of the Competitive

1 Medicare Agency determines feasible with the concurrence  
2 of such agencies.”.

3 (2) APPROPRIATIONS FOR GOVERNMENT CON-  
4 TRIBUTION.—Section 1844(a)(1) of the Social Secu-  
5 rity Act (42 U.S.C. 1395w(a)(1)) is amended by  
6 adding at the end the following new subparagraph:

7 “(C) an adjustment for the Government con-  
8 tribution to reflect the savings to the Trust Fund  
9 from enrollment in Medicare+Choice plans by bene-  
10 ficiaries who receive monthly medicare premium re-  
11 ductions in accordance with section 1854(i)(2)(A)(i);  
12 plus”.

13 (3) CONTINUATION OF ENROLLMENT PER-  
14 MITTED.—Section 1851(b)(1)(B) of the Social Secu-  
15 rity Act (42 U.S.C. 1395w–21(b)(1)(B)) is amended  
16 by striking “section 1852(a)(1)(A)” and inserting  
17 “section 1852(a)(1)”.

18 (4) INFORMATION COMPARING PLAN PRE-  
19 MIUMS.—Section 1851(d)(4)(B) of the Social Secu-  
20 rity Act (42 U.S.C. 1395w–21(d)(4)(B)) is  
21 amended—

22 (A) by striking “PREMIUMS.—The” and in-  
23 serting “PREMIUMS.—

24 “(i) IN GENERAL.—The”;

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

3 “(ii) REDUCTIONS.—The reduction in  
4 the part B premiums, if any.”.

5 (5) NATIONAL COVERAGE DETERMINATIONS.—  
6 Section 1852(a)(5) of the Social Security Act (42  
7 U.S.C. 1395w–22(a)(5)) is amended by inserting  
8 “(or, for 2003 and each subsequent fiscal year, the  
9 county-specific monthly per capita costs)” after “the  
10 annual Medicare+Choice capitation rate”.

11 (6) DISCLOSURE REQUIREMENTS.—Section  
12 1852(c)(1)(F) of the Social Security Act (42 U.S.C.  
13 1395w–22(c)(1)(F)) is amended by striking clause  
14 (i) and redesignating clauses (ii) and (iii) as clauses  
15 (i) and (ii), respectively.

16 (7) GEOGRAPHIC ADJUSTMENT.—Section  
17 1853(d)(3)(B) of the Social Security Act (42 U.S.C.  
18 1395w–23(e)(3)(B)) is amended—

19 (A) in the heading, by striking “BUDGET  
20 NEUTRALITY”;

21 (B) by striking “adjust the payment rates”  
22 and all that follows through “that would have  
23 been made” and inserting “adjust the bench-  
24 mark amounts otherwise established under this  
25 section for Medicare+Choice payment areas in

1 the State in a manner so that the weighted av-  
2 erage of the benchmark amounts under this  
3 section in the State equals the weighted average  
4 of benchmark amounts that would have been  
5 applicable”.

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

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

16 “(3) COMMISSIONER.—The term ‘Commis-  
17 sioner’ means the Commissioner of the Competitive  
18 Medicare Agency appointed under section  
19 2202(a)(1).”.

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



1 (b) EFFECTIVE DATE.—The amendment made by  
 2 this section shall take effect on the date of enactment of  
 3 this Act.

4 **TITLE IV—MEDICARE BENE-**  
 5 **FICIARY OUTREACH AND**  
 6 **EDUCATION**

7 **SEC. 401. MEDICARE CONSUMER COALITIONS.**

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

11 “PART C—MEDICARE CONSUMER COALITIONS

12 “ESTABLISHMENT OF MEDICARE CONSUMER COALITIONS

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

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

24 “(c) REQUEST FOR PROPOSALS; SELECTION OF  
 25 MEDICARE CONSUMER COALITIONS.—If the Commis-

1 sioner elects to establish Medicare Consumer Coalitions  
2 under subsection (a), the Commissioner shall—

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

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

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

16 “(1) in conducting the information programs  
17 under subsection (c); and

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

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

1 of such section (relating to beneficiary education pro-  
2 grams). If the Commissioner selects a Medicare Consumer  
3 Coalition to conduct such programs, the programs shall  
4 include the following:

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

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

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

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

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

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

24           “(2) INFORMATION STANDARDS.—If the Com-  
25 missioner establishes Medicare Consumer Coalitions,

1 the Commissioner shall develop standards to ensure  
2 that the information provided to eligible beneficiaries  
3 under the information programs is complete, accu-  
4 rate, and uniform.

5 “(3) REVIEW OF INFORMATION.—

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

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

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

1       “(f) REPORT.—If the Commissioner establishes  
2 Medicare Consumer Coalitions under this section, not  
3 later than December 31, 2003, the Commissioner shall  
4 submit to the appropriate committees of Congress a report  
5 on the performance of any Medicare Consumer Coalitions,  
6 including an assessment of the effectiveness of the out-  
7 reach efforts conducted under this section.

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

11       “(h) EFFECTIVE DATE.—If the Commissioner estab-  
12 lishes Medicare Consumer Coalitions, the Commissioner  
13 should establish the such Coalitions under this section in  
14 a manner that ensures that the information programs con-  
15 ducted by Medicare Consumer Coalitions begin not later  
16 than January 1, 2003.”.

○