

107TH CONGRESS  
2D SESSION

# S. 2729

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

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## IN THE SENATE OF THE UNITED STATES

JULY 15, 2002

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

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## A BILL

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

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

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

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

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

7 (c) BIPA; SECRETARY.—In this Act:

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

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

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

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

#### TITLE I—MEDICARE VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

Sec. 101. Medicare voluntary prescription drug delivery program.

#### “PART D—VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

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

“Subpart 1—Establishment of Voluntary Prescription Drug Delivery Program

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

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

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

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

“Sec. 1860D–5. Beneficiary protections.

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

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

“Subpart 2—Prescription Drug Delivery System

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

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

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

TITLE II—OPTION FOR ENHANCED MEDICARE BENEFITS

- Sec. 201. Option for enhanced medicare benefits.

“PART E—ENHANCED MEDICARE BENEFITS

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

TITLE III—MEDICARE+CHOICE COMPETITION

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

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

# 1 **TITLE I—MEDICARE VOLUNTARY**

## 2 **PRESCRIPTION DRUG DELIV-**

## 3 **ERY PROGRAM**

### 4 **SEC. 101. MEDICARE VOLUNTARY PRESCRIPTION DRUG DE-**

### 5 **LIVERY PROGRAM.**

6 (a) ESTABLISHMENT.—Title XVIII (42 U.S.C. 1395

7 et seq.) is amended by redesignating part D as part F

8 and by inserting after part C the following new part:

9 “PART D—VOLUNTARY PRESCRIPTION DRUG DELIVERY

10 PROGRAM

11 “DEFINITIONS; TREATMENT OF REFERENCES TO

12 PROVISIONS IN MEDICARE+CHOICE PROGRAM

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

14 “(1) ADMINISTRATOR.—The term ‘Adminis-

15 trator’ means the Administrator of the Medicare

Competitive Agency as established under section 1860D-25.

“(2) COVERED DRUG.—

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

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

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

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

“(B) EXCLUSIONS.—

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

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

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

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

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

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

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

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

6 “(D) another entity; or

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

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

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

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

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

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

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

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

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

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



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

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

“(3) any reference to a contract under section 1857 included a reference to a contract under section 1860D–7(b); and

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

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

13 “ESTABLISHMENT OF VOLUNTARY PRESCRIPTION DRUG  
14 DELIVERY PROGRAM

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

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

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

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

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

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

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

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

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

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

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

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

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

14 “ENROLLMENT UNDER PROGRAM

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

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

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

5           “(b) SPECIAL ENROLLMENT PROCEDURES.—

6           “(1) LATE ENROLLMENT PENALTY.—

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

1 “(B) PERIODS TAKEN INTO ACCOUNT.—

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

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

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

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

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

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

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

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

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

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

the cost of prescription drugs the actuarial value of which (as defined by the Administrator) to the beneficiary equals or exceeds the actuarial value of standard coverage (as determined under section 1860D–6(f)), the Administrator shall determine a percentage of the period in which the beneficiary had such creditable prescription drug coverage that will be taken into account under subparagraph (B) (and not considered to be such creditable prescription drug coverage under clause (i)).

“(D) PERIODS TREATED SEPARATELY.—

Any increase in an eligible beneficiary’s monthly beneficiary obligation under subparagraph (A) with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which the beneficiary may have.

“(E) CONTINUOUS PERIOD OF ELIGIBILITY.—

“(i) IN GENERAL.—Subject to clause (ii), for purposes of this paragraph, an eligible beneficiary’s ‘continuous period of eligibility’ is the period that begins with the

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 of the policy terminates coverage under the  
2 policy.

3 “(c) PERIOD OF COVERAGE.—

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

10 “(2) OPEN AND SPECIAL ENROLLMENT.—

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

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

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

25 “(d) TERMINATION.—

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

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

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

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

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

25           “ELECTION OF A MEDICARE PRESCRIPTION DRUG PLAN

26           “SEC. 1860D–3. (a) IN GENERAL.—

1 “(1) PROCESS.—

2 “(A) ELECTION.—

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

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

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

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

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

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

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

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

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

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



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

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

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

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

20           “PROVIDING INFORMATION TO BENEFICIARIES

21           “SEC. 1860D–4. (a) ACTIVITIES.—

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

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

7           “(b) REQUIREMENTS.—

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

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

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

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

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

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

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

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

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

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

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

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

17          “BENEFICIARY PROTECTIONS

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

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

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

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

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

7           “(D) Grievance and appeals procedures.

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

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

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

comparable manner) and a notice of the benefits in relation to initial coverage limit and annual out-of-pocket limit for the current year, whenever prescription drug benefits are provided under this part (except that such notice need not be provided more often than monthly).

“(5) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—The provisions of section 1851(h) shall apply to marketing material and application forms under this part in the same manner as such provisions apply to marketing material and application forms under part C.

“(b) ACCESS TO COVERED DRUGS.—

“(1) ACCESS TO NEGOTIATED PRICES FOR PRESCRIPTION DRUGS.—An eligible entity offering a Medicare Prescription Drug plan shall issue such a card (or other technology) that may be used by an enrolled beneficiary to assure access to negotiated prices under section 1860D–6(e) for the purchase of prescription drugs for which coverage is not otherwise provided under the Medicare Prescription Drug plan.

“(2) ASSURING PHARMACY ACCESS.—

“(A) IN GENERAL.—An eligible entity offering a Medicare Prescription Drug plan shall

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

signed to assure, with respect to beneficiaries with chronic diseases (such as diabetes, asthma, hypertension, and congestive heart failure) or multiple prescriptions, that covered outpatient drugs under the prescription drug plan are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

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

“(i) enhanced beneficiary understanding of such appropriate use through beneficiary education, counseling, and other appropriate means;

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

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

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

1 with licensed and practicing pharmacists and  
 2 physicians.

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

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

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

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

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

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

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

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

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

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

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

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

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

3 “PRESCRIPTION DRUG BENEFITS

4 “SEC. 1860D–6. (a) REQUIREMENTS.—

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

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

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

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

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

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

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

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

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

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

5               “(1) DEDUCTIBLE.—

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

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

9                               or

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

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

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



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

3 “(3) INITIAL COVERAGE LIMIT.—

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

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

10 or

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

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

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

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

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

4 “(B) ANNUAL OUT-OF-POCKET LIMIT.—

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

8 “(I) for 2005, is equal to \$3,700;

9 or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19          “(e) ACCESS TO NEGOTIATED PRICES.—

20                 “(1) ACCESS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16           “(2) ASSUMPTION OF FINANCIAL RISK.—

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

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



1           “(3) SOLVENCY FOR UNLICENSED ENTITIES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 “(h) RELATION TO STATE LAWS.—

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

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

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

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

4                   “(A) Benefit requirements.

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

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

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

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

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

18          “Subpart 2—Prescription Drug Delivery System

19                   “ESTABLISHMENT OF SERVICE AREAS

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

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

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

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

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

12               “(A) maximizes the availability of Medi-  
 13      care Prescription Drug plans to eligible bene-  
 14      ficiaries; and

15               “(B) minimizes the ability of eligible enti-  
 16      ties offering such plans to favorably select eligi-  
 17      ble beneficiaries.

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

21           “PUBLICATION OF RISK ADJUSTERS

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

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

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

8 “(b) ESTABLISHMENT OF RISK ADJUSTERS.—

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

16 “APPROVAL OF PROPOSED MEDICARE PRESCRIPTION  
17 DRUG PLANS

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

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

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

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

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

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

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

20 “(d) ASSURING ACCESS.—

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

1           “(2) GUARANTEEING ACCESS TO COVERAGE.—

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

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

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

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

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

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

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

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

6 “COMPUTATION OF MONTHLY STANDARD COVERAGE

7 PREMIUMS

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

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

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

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

“(B) if determined appropriate by the Administrator, the monthly premium approved under section 1860D–13 for the year for the Medicare Prescription Drug plan that (as required under subparagraph (B) of such section)—

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

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

16 PREMIUM

17           “SEC. 1860D-15. (a) COMPUTATION.—

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

“**(2) WEIGHTED AVERAGE.**—The monthly national average premium computed under paragraph (1) shall be a weighted average, with the weight for

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

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

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

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

7 “COMPUTATION OF BENEFICIARY OBLIGATION

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

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

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

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

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

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



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

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

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

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

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

19 “COLLECTION OF BENEFICIARY OBLIGATION

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

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

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

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

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

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

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

23 “SEC. 1860D–19. (a) IN GENERAL.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In no case may the application of clause (i) result in a monthly beneficiary obligation that is below zero.

“(B) SUBSIDY PERCENT DEFINED.—For purposes of subparagraph (A)(i), the term ‘subsidy percent’ means a percent determined on a linear sliding scale ranging from 0 percent for individuals with incomes at 135 percent of such level to 55 percent for individuals with incomes at 150 percent of such level.

“(3) DETERMINATION OF ELIGIBILITY.—

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

“(i) is enrolled under this part, including an individual receiving qualified prescription drug coverage under a Medicare+Choice plan;

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

8           “(d) RELATION TO MEDICAID PROGRAM.—

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

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

16          “REINSURANCE PAYMENTS FOR QUALIFIED  
17          PRESCRIPTION DRUG COVERAGE

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

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

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

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

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

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

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

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

20           “(c) REINSURANCE PAYMENT AMOUNT.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12          “(e) PAYMENT METHODS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

12          “ESTABLISHMENT OF MEDICARE COMPETITIVE AGENCY

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

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

19                 “(1) ADMINISTRATOR.—

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

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

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

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

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

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

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

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

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

25 “(2) DEPUTY ADMINISTRATOR.—

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

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

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

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

trator shall be Acting Administrator of the Administration during the absence or disability of the Administrator and, unless the President designates another officer of the Government as Acting Administrator, in the event of a vacancy in the office of the Administrator.

“(3) SECRETARIAL COORDINATION OF PROGRAM ADMINISTRATION.—The Secretary shall ensure appropriate coordination between the Administrator and the Administrator of the Centers for Medicare & Medicaid Services in carrying out the programs under this title.

“(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

“(1) DUTIES.—

“(A) GENERAL DUTIES.—The Administrator shall carry out parts C and D, including—

“(i) negotiating, entering into, and enforcing, contracts with plans for the offering of Medicare+Choice plans under part C, including the offering of qualified prescription drug coverage under such plans; and

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

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

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

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

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

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

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

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

19 “(2) STAFF.—

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

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

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

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

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

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



Centers for Medicare & Medicaid Services and that are conducted by the Administrator by reason of this section, that exceeds the number of such full-time equivalent employees authorized to be employed by the Centers for Medicare & Medicaid Services to conduct such functions as of the date of enactment of this Act.

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

“(A) IN GENERAL.—The Secretary, the Administrator, and the Administrator of the Centers for Medicare & Medicaid Services shall establish an appropriate transition of responsibility in order to redelegate the administration of part C from the Secretary and the Administrator of the Centers for Medicare & Medicaid Services to the Administrator as is appropriate to carry out the purposes of this section.

“(B) TRANSFER OF DATA AND INFORMATION.—The Secretary shall ensure that the Administrator of the Centers for Medicare & Medicaid Services transfers to the Administrator such information and data in the possession of the Administrator of the Centers for Medicare

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

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

13          “(d) OFFICE OF BENEFICIARY ASSISTANCE.—

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

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

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

“(i) Benefits, and limitations on payment (including cost-sharing, stop-loss provisions, and formulary restrictions) under parts C and D.

“(ii) Benefits, and limitations on payment under parts A, B, and E, including information on medicare supplemental policies under section 1882.

Such information shall be presented in a manner so that medicare beneficiaries may compare benefits under parts A, B, D, and E, and medicare supplemental policies with benefits under Medicare+Choice plans under part C.

“(B) DISSEMINATION OF APPEALS RIGHTS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries in the manner provided under subpara-

graph (A) a description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program under parts A and B (including beneficiaries who elect to receive enhanced medicare benefits under part E), the Medicare+Choice program under part C, and the voluntary prescription drug delivery program under part D.

“(3) MEDICARE OMBUDSMAN.—

“(A) IN GENERAL.—Within the Office of Beneficiary Assistance, there shall be a Medicare Ombudsman, appointed by the Secretary from among individuals with expertise and experience in the fields of health care and advocacy, to carry out the duties described in subparagraph (B).

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

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

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

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

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

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

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

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

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

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

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

24                   “(2) REPORTS.—

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

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

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

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

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

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

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

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

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

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



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

“(4) MEMBERSHIP.—

“(A) APPOINTMENT.—Subject to the succeeding provisions of this paragraph, the Board shall consist of 7 members to be appointed as follows:

“(i) Three members shall be appointed by the President.

“(ii) Two members shall be appointed by the Speaker of the House of Representatives, with the advice of the chairman and the ranking minority member of the Committees on Ways and Means and on Energy and Commerce of the House of Representatives.

“(iii) Two members shall be appointed by the President pro tempore of the Senate with the advice of the chairman and the ranking minority member of the Committee on Finance of the Senate.

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

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

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

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

15 “(6) TERMS OF OFFICE.—

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

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

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

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

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

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

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

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

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

21                  “(9) DIRECTOR AND STAFF.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 “(b) PAYMENTS FROM ACCOUNT.—

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

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

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

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

13      “(c) DEPOSITS INTO ACCOUNT.—

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16                   “(A) the gross domestic product;

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

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

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

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

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

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

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

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

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

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

15                       (A) in subsection (a)—

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

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

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

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

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

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

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

7       “SPECIAL PROVISIONS RELATING TO MEDICARE  
8                   PRESCRIPTION DRUG BENEFIT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

10 “(A) 2005 is 90 percent;

11 “(B) 2006 is 80 percent;

12 “(C) 2007 is 70 percent;

13 “(D) 2008 is 60 percent; or

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

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

19 “(d) ADDITIONAL PROVISIONS.—

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

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

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

9 (d) TREATMENT OF TERRITORIES.—

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

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

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

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

20 “(e) TREATMENT OF TERRITORIES.—

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

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

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

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

“(A) provides medical assistance with respect to the provision of covered drugs (as defined in section 1860D(a)(2)) to low-income medicare beneficiaries; and

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

“(3) INCREASED AMOUNT.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 (a) EXPANSION OF MEMBERSHIP.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

13 “PART E—ENHANCED MEDICARE BENEFITS

14 “ENTITLEMENT TO ELECT TO RECEIVE ENHANCED

15 MEDICARE BENEFITS

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

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

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

8       “SCOPE OF ENHANCED MEDICARE BENEFITS

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

13       “(b) UNIFIED DEDUCTIBLE.—

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

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

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

3           “(2) AMOUNT OF UNIFIED DEDUCTIBLE.—

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

7                   “(i) for 2005, \$300; or

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

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

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

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

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

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

13          “(c) SERIOUS ILLNESS PROTECTION.—

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

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

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

ditional out-of-pocket cost-sharing described in subparagraph (A) from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, in such proportion as the Secretary determines appropriate.

“(2) SERIOUS ILLNESS PROTECTION THRESHOLD.—

“(A) IN GENERAL.—The amount of the serious illness protection threshold under this subsection shall be—

“(i) for 2005, \$6,000; or

“(ii) for a subsequent year, the amount specified in this subparagraph for the preceding year increased by the percentage increase in the per capita actuarial value of benefits under parts A and B for such subsequent year.

“(B) ROUNDING.—If any amount determined under subparagraph (A) is not a multiple of \$1, such amount shall be rounded to the nearest multiple of \$1.

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

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

8       “(d) ENHANCED HOSPITAL BENEFITS.—

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

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

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

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

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

the application of the unified deductible under subsection (b), instead of imposing any coinsurance under the second sentence of section 1813(a)(1), the amount payable under part A for inpatient hospital services or inpatient critical access hospital services furnished to the eligible beneficiary during any year, shall be reduced by the amount of the inpatient hospital copayment specified in subparagraph (B) for each period of hospitalization and the beneficiary shall be responsible for payment of such amount for each such period.

“(B) AMOUNT OF INPATIENT HOSPITAL COPAYMENT.—

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

“(I) for 2005, \$400; or

“(II) for a subsequent year, the amount specified in this clause for the preceding year increased by the percentage increase in the per capita actuarial value of benefits under parts A and B for such subsequent year.

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25           “(i) for 2005, \$60; and

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

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

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

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

18           “(B) COPAYMENT AMOUNT.—

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

1 “(I) for 2005, \$10; and

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

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

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

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

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

3                   “PAYMENT OF BENEFITS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 “(4) CHANGES IN ELECTION.—

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

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



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

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

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

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

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

16          “PREMIUM ADJUSTMENTS; LATE ELECTION PENALTY

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

22          “(b) LATE ELECTION PENALTY.—

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

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

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

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

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

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

23 (b) PROVIDING INFORMATION TO BENEFICIARIES.—

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

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

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

7 (1) EFFECT OF PART E ON PART A PREMIUM.—

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

15 (2) EFFECT OF PART E ON PART B PREMIUM.—

16 Section 1839(a) (42 U.S.C. 1395r(a)) is amended—

17 (A) in paragraph (1)—

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

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

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

(C) in paragraph (3)—

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

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

(D) in paragraph (4)—

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

(ii) in the second sentence, by striking “under age 65 which” and inserting “under age 65 (including eligible beneficiaries who elect to receive enhanced medicare benefits under part E)”.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

3 “(B) COORDINATION.—The notice pro-  
 4 vided under subparagraph (A) shall be coordi-  
 5 nated with the notice required under subsection  
 6 (v)(4)(A)(i).

7 “(4) CLARIFICATION REGARDING ONE-TIME  
 8 AVAILABILITY OF A GUARANTEED ISSUE POLICY FOR  
 9 BENEFICIARIES WHO LOSE COVERAGE UNDER A  
 10 MEDICARE+CHOICE PLAN OF JANUARY 1, 2005, BE-  
 11 CAUSE THEY ELECT NOT TO RECEIVE ENHANCED  
 12 PART E BENEFITS.—In the case of a beneficiary who  
 13 is enrolled in a Medicare+Choice plan as of Decem-  
 14 ber 31, 2004, will not be eligible to be enrolled  
 15 under such plan as of January 1, 2005, because the  
 16 beneficiary has elected not to receive enhanced medi-  
 17 care benefits under part E—

18 “(A) such beneficiary shall be deemed to  
 19 be described in subsection (s)(3)(B)(ii); and

20 “(B) for purposes of (s)(3)(E)(ii), the date  
 21 of the termination of coverage shall be January  
 22 1, 2005.”.

23 (b) ESTABLISHMENT OF ENHANCED MEDICARE  
 24 FEE-FOR-SERVICE MEDIGAP POLICIES.—Section 1882  
 25 (42 U.S.C. 1395ss), as amended by subsection (a), is

1 amended by adding at the end the following new sub-  
 2 section:

3       “(w) ENHANCED MEDICARE FEE-FOR-SERVICE SUP-  
 4 PLEMENTAL POLICIES.—

5               “(1) ADDITIONAL BENEFIT PACKAGES.—

6                       “(A) ESTABLISHMENT.—

7                               “(i) IN GENERAL.—In addition to the  
 8 benefit packages classified under the  
 9 standards established by subsection (p)(2),  
 10 there shall be established benefit packages  
 11 that may only be purchased by bene-  
 12 ficiaries who have elected to receive en-  
 13 hanced medicare benefits under part E  
 14 that—

15                                       “(I) complement but do not du-  
 16 plicate enhanced medicare benefits de-  
 17 scribed in section 1860E-2;

18                                       “(II) do not provide for coverage  
 19 of the unified deductible under section  
 20 1860E-2(b);

21                                       “(III) subject to clause (ii), do  
 22 not provide coverage for more than 50  
 23 percent of the amount of coinsurance  
 24 and copayments applicable under sec-  
 25 tion 1860E-2;

1 “(IV) do not provide for coverage  
2 of expenses for prescription drugs;

3 “(V) provide a range of coverage  
4 options for beneficiaries; and

5 “(VI) use uniform language, defi-  
6 nitions, and format with respect to  
7 the coverage provided under a policy.

8 “(ii) ONE PACKAGE REQUIRED TO  
9 COVER ALL COST-SHARING.—

10 “(I) IN GENERAL.—One of the  
11 benefit packages established under  
12 clause (i) shall include coverage of all  
13 coinsurance and copayments applica-  
14 ble under section 1860E–2.

15 “(II) AVAILABILITY LIMITED TO  
16 BENEFICIARIES THAT ENROLLED IN  
17 PART E DURING CERTAIN PERIODS.—

18 The benefit package that includes the  
19 coverage described in subclause (II)  
20 shall only be made available to bene-  
21 ficiaries who elect to receive enhanced  
22 medicare benefits under part E during  
23 the beneficiary’s initial election period  
24 (as defined in paragraph (1)(B) of  
25 section 1860D–4(b)), during a special

1 election period described in paragraph  
2 (2) of such section, or during the  
3 transitional election period under  
4 paragraph (3) of such section.

5 “(B) MANNER OF ESTABLISHMENT.—The  
6 benefit packages established under this section  
7 shall be established in the manner described in  
8 subparagraph (E) of subsection (p)(1), except  
9 that for purposes of subparagraph (C) of such  
10 subsection, the standards established under this  
11 subsection shall take effect not later than Janu-  
12 ary 1, 2005.

13 “(2) CONSTRUCTION OF BENEFITS IN OTHER  
14 MEDICARE SUPPLEMENTAL POLICIES.—Nothing in  
15 this subsection shall be construed to affect the ben-  
16 efit packages classified as ‘A’ through ‘J’ under the  
17 standards established by subsection (p)(2) (including  
18 the benefit packages classified as ‘F’ and ‘J’ with a  
19 high deductible feature, as described in subsection  
20 (p)(11)).

21 “(3) GUARANTEED ISSUANCE AND RENEWAL  
22 OF ENHANCED MEDICARE FEE-FOR-SERVICE SUP-  
23 PLEMENTAL POLICIES.—The provisions of sub-  
24 sections (q) and (s), including provisions of sub-  
25 section (s)(3) (relating to special enrollment periods

1 in cases of termination or disenrollment), shall apply  
 2 to medicare supplemental policies established under  
 3 this subsection in a similar manner as such provi-  
 4 sions apply to medicare supplemental policies issued  
 5 under the standards established under subsection  
 6 (p).

7 “(4) OPPORTUNITY OF CURRENT POLICY-  
 8 HOLDERS TO PURCHASE ENHANCED MEDICARE FEE-  
 9 FOR-SERVICE SUPPLEMENTAL POLICIES.—

10 “(A) REQUIREMENTS FOR ISSUERS OF  
 11 POLICIES WITH RESPECT TO CURRENT POLICY-  
 12 HOLDERS.—No medicare supplemental policy of  
 13 an issuer with a benefit package that is estab-  
 14 lished under paragraph (1) shall be deemed to  
 15 meet the standards in subsection (c) unless the  
 16 issuer does all of the following:

17 “(i) NOTICE TO CURRENT POLICY-  
 18 HOLDERS.—Provide written notice during  
 19 the 60-day period immediately preceding  
 20 the period established under section  
 21 1860E-4(b)(1), to each individual who is a  
 22 policyholder or certificate holder of a medi-  
 23 care supplemental policy issued by that  
 24 issuer (at the most recent available address  
 25 of that individual) of the offer described in

1 clause (ii) and of the fact that, so long as  
 2 such individual retains coverage under  
 3 such policy, the individual shall be ineli-  
 4 gible to elect enhanced medicare benefits  
 5 under part E.

6 “(ii) OFFER FOR CURRENT POLICY-  
 7 HOLDERS.—Offer the policyholder or cer-  
 8 tificate holder under the terms described in  
 9 subparagraph (C), during at least the pe-  
 10 riod established under section 1860E-  
 11 4(b)(1), a medicare supplemental policy es-  
 12 tablished under paragraph (1) with the  
 13 benefit package that the Secretary deter-  
 14 mines is most comparable to the policy in  
 15 which the individual is enrolled with cov-  
 16 erage effective as of the effective date of  
 17 the election of the individual under part E.

18 “(iii) OFFER FOR INDIVIDUALS COV-  
 19 ERED UNDER POLICIES ISSUED BY OTHER  
 20 ISSUERS IF THAT ISSUER IS NOT GOING TO  
 21 OFFER ENHANCED MEDICARE FEE-FOR-  
 22 SERVICE SUPPLEMENTAL POLICIES.—Offer  
 23 an individual described in subparagraph  
 24 (B), under the terms described in subpara-  
 25 graph (C), and during at least the period

1           established under section 1860E–4(b)(1), a  
 2           medicare supplemental policy established  
 3           under paragraph (1) with the benefit pack-  
 4           age that the Secretary determines is most  
 5           comparable to the policy in which the indi-  
 6           vidual is enrolled with coverage effective as  
 7           of the effective date of the election of the  
 8           individual under part E.

9           The notice provided under clause (i) shall be co-  
 10          ordinated with the notice required under sub-  
 11          section (v)(3)(A).

12           “(B) INDIVIDUAL DESCRIBED.—An indi-  
 13          vidual described in this subparagraph is an in-  
 14          dividual who is a policyholder or certificate  
 15          holder of a medicare supplemental policy issued  
 16          by an issuer who is not going to offer a policy  
 17          with a benefit package established under para-  
 18          graph (1).

19           “(C) TERMS OF OFFER DESCRIBED.—The  
 20          terms described in this subparagraph are terms  
 21          which do not—

22           “(i) deny or condition the issuance or  
 23          effectiveness of a medicare supplemental  
 24          policy described in subparagraph (A)(ii)



that is offered and is available for issuance  
to new enrollees by such issuer;

“(ii) discriminate in the pricing of  
such policy because of health status, claims  
experience, receipt of health care, or med-  
ical condition; or

“(iii) impose an exclusion of benefits  
based on a preexisting condition under  
such policy.

“(5) PROHIBITION OF SALE OF ENHANCED  
POLICIES TO ORIGINAL MEDICARE FEE-FOR-SERVICE  
ENROLLEES; PROHIBITION OF SALE OF ORIGINAL  
POLICIES TO ENHANCED MEDICARE FEE-FOR-SERV-  
ICE ENROLLEES.—

“(A) PROHIBITION.—No person may sell,  
issue, or renew a medicare supplemental policy  
with—

“(i) a benefit package established  
under this subsection to an individual who  
has not elected to receive enhanced medi-  
care benefits under part E; or

“(ii) a benefit package classified as  
‘A’ through ‘J’ under the standards estab-  
lished by subsection (p)(2) (including the  
benefit packages classified as ‘F’ and ‘J’

1 with a high deductible feature, as described  
2 in subsection (p)(11)) to an individual who  
3 has elected to receive enhanced medicare  
4 benefits under part E.

5 “(B) PENALTY.—Any person who violates  
6 the provisions of subparagraph (A) shall be  
7 subject to a civil money penalty in an amount  
8 that does not exceed \$25,000 (or \$15,000 in  
9 the case of a seller who is not an issuer of a  
10 policy) for each such violation. The provisions  
11 of section 1128A (other than the first sentence  
12 of subsection (a) and other than subsection (b))  
13 shall apply to a civil money penalty under the  
14 previous sentence in the same manner as such  
15 provisions apply to a penalty or proceeding  
16 under section 1128A(a).

17 “(6) OTHER PROHIBITIONS AND PENALTIES.—  
18 Each penalty under this section shall apply with re-  
19 spect to policies established under this subsection as  
20 if such policies were issued under the standards es-  
21 tablished under subsection (p), including the pen-  
22 alties under subsections (a), (d), (p)(8), (p)(9),  
23 (q)(5), (r)(6)(A), (s)(4), and (t)(2)(D).”.

1     **TITLE III—MEDICARE+CHOICE**  
 2                     **COMPETITION**

3     **SEC. 301. ANNUAL CALCULATION OF BENCHMARK**  
 4                     **AMOUNTS BASED ON FLOOR RATES AND**  
 5                     **LOCAL FEE-FOR-SERVICE RATES.**

6             (a) ANNUAL CALCULATION OF BENCHMARK  
 7 AMOUNTS BASED ON FLOOR RATES AND LOCAL FEE-  
 8 FOR-SERVICE RATES.—Section 1853(a) (42 U.S.C.  
 9 1395w-23(a)) is amended by adding at the end the fol-  
 10 lowing new paragraph:

11                 “(4) ANNUAL CALCULATION OF BENCHMARK  
 12 AMOUNTS.—For each year, the Secretary shall cal-  
 13 culate a benchmark amount for each  
 14 Medicare+Choice payment area for each month for  
 15 such year with respect to coverage of enhanced  
 16 medicare benefits under part E equal to the greatest  
 17 of the following amounts:

18                     “(A) MINIMUM AMOUNT.— $\frac{1}{12}$  of the an-  
 19 nual Medicare+Choice capitation rate deter-  
 20 mined under subsection (c)(1)(B) for the pay-  
 21 ment area for the year; or

22                     “(B) LOCAL FEE-FOR-SERVICE RATE.—  
 23 The local fee-for-service rate for such area for  
 24 the year (as calculated under paragraph (5)).”.

1 (b) ANNUAL CALCULATION OF LOCAL FEE-FOR-  
 2 SERVICE RATES.—Section 1853(a) (42 U.S.C. 1395w-  
 3 23(a)), as amended by subsection (a), is amended by add-  
 4 ing at the end the following new paragraph:

5 “(5) ANNUAL CALCULATION OF LOCAL FEE-  
 6 FOR-SERVICE RATES.—

7 “(A) IN GENERAL.—Subject to subpara-  
 8 graphs (B) and (C), the term ‘local fee-for-serv-  
 9 ice rate’ means the amount of payment for a  
 10 month in a Medicare+Choice payment area for  
 11 benefits under this title and associated claims  
 12 processing costs for an individual who has elect-  
 13 ed to receive enhanced medicare benefits under  
 14 part E (but, if the Medicare+Choice plan offers  
 15 prescription drug coverage, excluding any costs  
 16 associated with part D), and not enrolled in a  
 17 Medicare+Choice plan under this part. The  
 18 Secretary shall annually calculate such amount  
 19 in a manner similar to the manner in which the  
 20 Secretary calculated the adjusted average per  
 21 capita cost under section 1876, except that  
 22 such calculation shall include in such amount,  
 23 to the extent practicable, any amounts that  
 24 would have been paid under this title if individ-  
 25 uals entitled to benefits under this title had not

received services from facilities of the Department of Veterans Affairs or the Department of Defense.

“(B) REMOVAL OF MEDICAL EDUCATION COSTS FROM CALCULATION OF LOCAL FEE-FOR-SERVICE RATE.—

“(i) IN GENERAL.—In calculating the local fee-for-service rate under subparagraph (A) for a year, the amount of payment described in such subparagraph shall be adjusted to exclude from such payment the payment adjustments described in clause (ii).

“(ii) PAYMENT ADJUSTMENTS DESCRIBED.—

“(I) IN GENERAL.—Subject to subclause (II), the payment adjustments described in this subparagraph are payment adjustments that the Secretary estimates were payable during each month for direct graduate medical education costs under section 1886(h).

“(II) TREATMENT OF PAYMENTS COVERED UNDER STATE HOSPITAL

1 REIMBURSEMENT SYSTEM.—To the  
 2 extent that the Secretary estimates  
 3 that the amount of the local fee-for-  
 4 service rates reflects payments to hos-  
 5 pitals reimbursed under section  
 6 1814(b)(3), the Secretary shall esti-  
 7 mate a payment adjustment that is  
 8 comparable to the payment adjust-  
 9 ment that would have been made  
 10 under clause (i) if the hospitals had  
 11 not been reimbursed under such sec-  
 12 tion.

13 “(C) SPECIAL RULE FOR RURAL AREAS.—

14 “(i) IN GENERAL.—Subject to clause  
 15 (ii), in calculating the local fee-for-service  
 16 rates under subparagraph (A) for a year,  
 17 the Secretary shall calculate such costs for  
 18 rural areas (as defined in section  
 19 1886(d)(2)(D)) of a State as if each rural  
 20 area were part of a single  
 21 Medicare+Choice payment area.

22 “(ii) LIMITATION.—Payment amounts  
 23 determined under subparagraph (A) may  
 24 not be less than the amounts that would  
 25 have been paid if clause (i) did not apply.”.

1       (c) CPI INCREASES IN FLOOR PAYMENT RATES.—  
2 Section 1853(c)(1)(B) (42 U.S.C. 1395w-23(c)(1)(B)) is  
3 amended—

4           (1) in clause (iv), by striking “and each suc-  
5 ceeding year,” and inserting “, 2003, and 2004,”;  
6 and

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

9                   “(v) For 2005 and each succeeding  
10 year, the minimum amount specified in  
11 this clause (or clause (iv)) for the pre-  
12 ceding year increased by the percentage in-  
13 crease in the Consumer Price Index for all  
14 urban consumers (U.S. urban average) for  
15 the 12-month period ending with June of  
16 the previous year.”.

17       (d) FURNISHING OF CLAIMS DATA BY VA AND  
18 DoD.—Upon the request of the Secretary of Health and  
19 Human Services, the Secretary of Veterans Affairs and  
20 the Secretary of Defense shall provide such claims data  
21 as the Secretary of Health and Human Services may re-  
22 quire to determine the amount that would have been paid  
23 under the medicare program under title XVIII of the So-  
24 cial Security Act if individuals entitled to benefits under  
25 such program had not received services from facilities of

1 the Department of Veterans Affairs or the Department  
 2 of Defense for purposes calculating the amounts under  
 3 section 1853(a)(5) of such Act (as added by subsection  
 4 (b)) and section 1853(c)(8) of such Act (as added by sec-  
 5 tion 312(b)).

6 **SEC. 302. APPLICATION OF COMPREHENSIVE RISK ADJUST-**  
 7 **MENT METHODOLOGY.**

8 Section 1853(a)(3) is amended to read as follows:

9 “(3) COMPREHENSIVE RISK ADJUSTMENT  
 10 METHODOLOGY.—

11 “(A) APPLICATION OF METHODOLOGY.—

12 The Secretary shall apply the comprehensive  
 13 risk adjustment methodology described in sub-  
 14 paragraph (B) to 100 percent of the amount of  
 15 the plan bids under section 1853(d)(1) and the  
 16 weighted service area benchmark amounts cal-  
 17 culated under section 1853(d)(3).

18 “(B) COMPREHENSIVE RISK ADJUSTMENT  
 19 METHODOLOGY DESCRIBED.—The comprehen-  
 20 sive risk adjustment methodology described in  
 21 this subparagraph is the risk adjustment meth-  
 22 odology that would apply with respect to  
 23 Medicare+Choice plans offered by  
 24 Medicare+Choice organizations in 2004, except  
 25 that if such methodology does not apply to



1 groups of beneficiaries who are aged or disabled  
 2 and groups of beneficiaries who have end-stage  
 3 renal disease, the Secretary shall revise such  
 4 methodology to apply to such groups.

5 “(C) UNIFORM APPLICATION TO ALL  
 6 TYPES OF PLANS.—Subject to section  
 7 1859(e)(4), the comprehensive risk adjustment  
 8 methodology established under this paragraph  
 9 shall be applied uniformly without regard to the  
 10 type of plan.

11 “(D) DATA COLLECTION.—In order to  
 12 carry out this paragraph, the Secretary shall re-  
 13 quire Medicare+Choice organizations to submit  
 14 such data and other information as the Sec-  
 15 retary deems necessary.

16 “(E) IMPROVEMENT OF PAYMENT ACCU-  
 17 RACY.—Notwithstanding any other provision of  
 18 this paragraph, the Secretary may revise the  
 19 comprehensive risk adjustment methodology de-  
 20 scribed in subparagraph (B) from time to time  
 21 to improve payment accuracy.”.

22 **SEC. 303. ANNUAL ANNOUNCEMENT OF BENCHMARK**  
 23 **AMOUNTS AND OTHER PAYMENT FACTORS.**

24 Section 1853(b) (42 U.S.C. 1395w-23(b)), as  
 25 amended by section 532(d)(1) of the Public Health Secu-

1 rity and Bioterrorism Preparedness and Response Act of  
 2 2002 (Public Law 107–188; 116 Stat. 696), is amended—

3 (1) in the heading, by striking “PAYMENT  
 4 RATES” and inserting “PAYMENT FACTORS”;

5 (2) by striking paragraph (1) and inserting the  
 6 following:

7 “(1) ANNUAL ANNOUNCEMENT.—Beginning in  
 8 2004, at the same time as the Secretary publishes  
 9 the risk adjusters under section 1860D–11, the Sec-  
 10 retary shall annually announce (in a manner in-  
 11 tended to provide notice to interested parties) the  
 12 following payment factors:

13 “(A) The benchmark amount for each  
 14 Medicare+Choice payment area (as calculated  
 15 under subsection (a)(4)) for the year.

16 “(B) The factors to be used for adjusting  
 17 payments under the comprehensive risk adjust-  
 18 ment methodology described in subsection  
 19 (a)(3)(B) with respect to each  
 20 Medicare+Choice payment area for the year.”;

21 (3) in paragraph (3), by striking “monthly ad-  
 22 justed” and all that follows before the period at the  
 23 end and inserting “each payment factor described in  
 24 paragraph (1)”;

25 (4) by striking paragraph (4).

1 **SEC. 304. SUBMISSION OF BIDS BY MEDICARE+CHOICE OR-**  
 2 **GANIZATIONS.**

3 Section 1854(a) (42 U.S.C. 1395w-24(a)), as  
 4 amended by section 532(b)(1) of the Public Health Secu-  
 5 rity and Bioterrorism Preparedness and Response Act of  
 6 2002 (Public Law 107-188; 116 Stat. 696), is amended  
 7 to read as follows:

8 “(a) SUBMISSION OF BIDS BY MEDICARE+CHOICE  
 9 ORGANIZATIONS.—

10 “(1) IN GENERAL.—Not later than the second  
 11 Monday in September (or July 1 of each year before  
 12 2002) and except as provided in paragraph (3), each  
 13 Medicare+Choice organization shall submit to the  
 14 Secretary, in such form and manner as the Sec-  
 15 retary may specify, for each Medicare+Choice plan  
 16 that the organization intends to offer in a service  
 17 area in the following year—

18 “(A) notice of such intent and information  
 19 on the service area of the plan;

20 “(B) the plan type for each plan;

21 “(C) if the Medicare+Choice plan is a co-  
 22 ordinated care plan (as described in section  
 23 1851(a)(2)(A)) or a private fee-for-service plan  
 24 (as described in section 1851(a)(2)(C)), the in-  
 25 formation described in paragraph (2) with re-  
 26 spect to each payment area;

1 “(D) the enrollment capacity (if any) in re-  
 2 lation to the plan and each payment area;

3 “(E) the expected mix, by health status, of  
 4 enrolled individuals; and

5 “(F) such other information as the Sec-  
 6 retary may specify.

7 “(2) INFORMATION REQUIRED FOR COORDI-  
 8 NATED CARE PLANS AND PRIVATE FEE-FOR-SERVICE  
 9 PLANS.—For a Medicare+Choice plan that is a co-  
 10 ordinated care plan (as described in section  
 11 1851(a)(2)(A)) or a private fee-for-service plan (as  
 12 described in section 1851(a)(2)(C)), the information  
 13 described in this paragraph is as follows:

14 “(A) INFORMATION REQUIRED WITH RE-  
 15 SPECT TO BENEFITS UNDER PART E.—Informa-  
 16 tion relating to the coverage of benefits under  
 17 part E as follows:

18 “(i) The plan bid, which shall consist  
 19 of a dollar amount that represents the  
 20 total amount that the plan is willing to ac-  
 21 cept (after the application of the com-  
 22 prehensive risk adjustment methodology  
 23 under section 1853(a)(3)) for providing  
 24 coverage of the benefits under part E to an

1 individual enrolled in the plan that resides  
 2 in the service area of the plan for a month.

3 “(ii) For the supplemental benefits  
 4 package offered (if any)—

5 “(I) the adjusted community rate  
 6 (as defined in subsection (g)(3)) of  
 7 the package;

8 “(II) the Medicare+Choice  
 9 monthly supplemental beneficiary pre-  
 10 mium (as defined in subsection  
 11 (b)(2)(C));

12 “(III) a description of any cost-  
 13 sharing; and

14 “(IV) such other information as  
 15 the Secretary considers necessary.

16 “(iii) The assumptions that the  
 17 Medicare+Choice organization used in pre-  
 18 paring the plan bid with respect to num-  
 19 bers, in each payment area, of enrolled in-  
 20 dividuals and the mix, by health status, of  
 21 such individuals.

22 “(B) INFORMATION REQUIRED WITH RE-  
 23 SPECT TO PART D.—If the Medicare+Choice  
 24 organization elects to offer prescription drug  
 25 coverage, the information required to be sub-

mitted by an eligible entity under section 1860D–12, including the monthly premiums for standard coverage and any other qualified prescription drug coverage available to individuals enrolled under part D.

“(3) REQUIREMENTS FOR MSA PLANS.—For an MSA plan described in section 1851(a)(2)(B), the information described in this paragraph is the information that such a plan would have been required to submit under this part if the 21st Century Medicare Act had not been enacted.

“(4) REVIEW.—

“(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall review the adjusted community rates (as defined in section 1854(g)(3)), the amounts of the Medicare+Choice monthly basic and supplemental beneficiary premiums filed under this subsection and shall approve or disapprove such rates and amounts so submitted. The Chief Actuary of the Medicare Competitive Agency shall review the actuarial assumptions and data used by the Medicare+Choice organization with respect to such rates and amounts so submitted

1 to determine the appropriateness of such as-  
 2 sumptions and data.

3 “(B) EXCEPTION.—The Secretary shall  
 4 not review, approve, or disapprove the amounts  
 5 submitted under paragraph (3).”.

6 **SEC. 305. ADJUSTMENT OF PLAN BIDS; COMPARISON OF**  
 7 **ADJUSTED BID TO BENCHMARK; PAYMENT**  
 8 **AMOUNT.**

9 (a) IN GENERAL.—Section 1853 (42 U.S.C. 1395w–  
 10 23) is amended—

11 (1) by redesignating subsections (d) through (i)  
 12 as subsections (e) through (j), respectively; and

13 (2) by inserting after subsection (c) the fol-  
 14 lowing new subsection:

15 “(d) SECRETARY’S DETERMINATION OF PAYMENT  
 16 AMOUNT FOR ENHANCED MEDICARE BENEFITS.—

17 “(1) ADJUSTMENT OF PLAN BIDS.—The Sec-  
 18 retary shall adjust each plan bid submitted under  
 19 section 1854(a) for the coverage of benefits under  
 20 part E using the comprehensive risk adjustment  
 21 methodology applicable under subsection (a)(3)  
 22 based on the assumptions described in section  
 23 1854(a)(2)(A)(iii) that the plan used with respect to  
 24 numbers of enrolled individuals.

1           “(2) DETERMINATION OF WEIGHTED SERVICE  
 2       AREA BENCHMARK AMOUNTS.—The Secretary shall  
 3       calculate a weighted service area benchmark amount  
 4       for enhanced medicare benefits under part E for  
 5       each plan equal to the weighted average of the  
 6       benchmark amounts for enhanced medicare benefits  
 7       under such part for the payment areas included in  
 8       the service area of the plan using the assumptions  
 9       described in section 1854(a)(2)(A)(iii) that the plan  
 10      used with respect to numbers of enrolled individuals.

11           “(3) DETERMINATION OF PLAN BENCHMARK.—  
 12      The Secretary shall calculate the plan benchmark  
 13      amount by adjusting the weighted service area  
 14      benchmark amount determined under paragraph (1)  
 15      using—

16           “(A) the comprehensive risk adjustment  
 17           methodology applicable under subsection (a)(3);  
 18           and

19           “(B) the assumptions contained in the  
 20           plan bid that the plan used with respect to  
 21           numbers of enrolled individuals.

22           “(4) COMPARISON TO BENCHMARK.—The Sec-  
 23      retary shall determine the difference between each  
 24      plan bid (as adjusted under paragraph (1)) and the



1 plan benchmark amount (as determined under para-  
 2 graph (3)) for purposes of determining—

3 “(A) the payment amount under para-  
 4 graph (5); and

5 “(B) the part E premium reductions and  
 6 Medicare+Choice monthly basic beneficiary  
 7 premiums.

8 “(5) DETERMINATION OF PAYMENT AMOUNT.—  
 9 The Secretary shall determine the payment amount  
 10 for plans as follows:

11 “(A) BIDS THAT EQUAL OR EXCEED THE  
 12 BENCHMARK.—The amount of each monthly  
 13 payment to a Medicare+Choice organization  
 14 with respect to each individual enrolled in a  
 15 plan shall be the plan benchmark amount.

16 “(B) BIDS BELOW THE BENCHMARK.—  
 17 The amount of each monthly payment to a  
 18 Medicare+Choice organization with respect to  
 19 each individual enrolled in a plan shall be the  
 20 plan benchmark amount reduced by 25 percent  
 21 of the difference between the bid and the bench-  
 22 mark amount and further reduced by the  
 23 amount of any premium reduction elected by  
 24 the plan under section 1854(d)(1)(A)(i).

1           “(6) FACTORS USED IN ADJUSTING BIDS AND  
 2           BENCHMARKS FOR MEDICARE+CHOICE ORGANIZA-  
 3           TIONS AND IN DETERMINING ENROLLEE PRE-  
 4           MIUMS.—Subject to paragraph (7), the Secretary  
 5           shall use, for purposes of adjusting plan bids and  
 6           calculating plan benchmarks under this subsection—

7                   “(A) with respect to benefits under part  
 8           E—

9                           “(i) the benchmark amount for the  
 10                          Medicare+Choice payment area announced  
 11                          under section 1854(a)(1)(A); and

12                           “(ii) the health status and other de-  
 13                          mographic adjustment factors for the  
 14                          Medicare+Choice payment area announced  
 15                          under section 1854(a)(1)(B); and

16                          “(B) if the Medicare+Choice organization  
 17                          elects to offer prescription drug coverage, the  
 18                          risk adjusters published under section 1860D–  
 19                          11 applicable with respect to such coverage.

20           “(7) ADJUSTMENT FOR NATIONAL COVERAGE  
 21           DETERMINATIONS AND LEGISLATIVE CHANGES IN  
 22           BENEFITS.—If the Secretary makes a determination  
 23           with respect to coverage under this title or there is  
 24           a change in benefits required to be provided under  
 25           this part that the Secretary projects will result in a

1 significant increase in the costs to Medicare+Choice  
 2 organizations of providing benefits under contracts  
 3 under this part (for periods after any period de-  
 4 scribed in section 1852(a)(5)), the Secretary shall  
 5 appropriately adjust the benchmark amounts or pay-  
 6 ment amounts (as determined by the Secretary).  
 7 Such projection and adjustment shall be based on an  
 8 analysis by the Chief Actuary of the Competitive  
 9 Medicare Agency of the actuarial costs associated  
 10 with the new benefits.”.

11 (b) CONFORMING AMENDMENT.—Section 1853(c)(7)  
 12 (42 U.S.C. 1395w–23(c)(7)) is repealed.

13 **SEC. 306. DETERMINATION OF PREMIUM REDUCTIONS, RE-**  
 14 **DUCE COST-SHARING, ADDITIONAL BENE-**  
 15 **FITS, AND BENEFICIARY PREMIUMS.**

16 (a) CALCULATION OF BENEFICIARY PREMIUMS.—  
 17 Section 1854 (42 U.S.C. 1395–24) is amended by—

18 (1) redesignating subsections (d) through (h) as  
 19 subsections (e) through (i), respectively; and

20 (2) inserting after subsection (c) the following  
 21 new subsection:

22 “(d) DETERMINATION OF PREMIUM REDUCTIONS,  
 23 REDUCED COST-SHARING, ADDITIONAL BENEFITS, AND  
 24 BENEFICIARY PREMIUMS.—

25 “(1) BIDS BELOW THE BENCHMARK.—

“(A) IN GENERAL.—If the Secretary determines under section 1853(d)(4) that the plan benchmark amount exceeds the plan bid, the Secretary shall require the plan to return 75 percent of such excess to the enrollee in the form of, at the option of the organization offering the plan—

“(i) subject to subparagraph (B), a monthly medicare premium reduction for individuals enrolled in the plan;

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

“(iii) subject to subparagraph (C), such additional benefits as the organization may specify; or

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

“(B) LIMITATION ON PREMIUM REDUCTIONS.—The amount of the reduction under subparagraph (A)(i) with respect to any enrollee in a Medicare+Choice plan—

“(i) may not exceed the premium described in section 1839(a)(3), as adjusted under section 1860E–5; and

1 “(ii) shall apply uniformly to each en-  
 2 rollee of the Medicare+Choice plan to  
 3 which such reduction applies.

4 “(C) REQUIREMENT OF ENROLLMENT IN  
 5 PART D TO RECEIVE PRESCRIPTION DRUG BEN-  
 6 EFITS.—An organization may not specify any  
 7 additional benefit that provides for the coverage  
 8 of any prescription drug (other than that re-  
 9 quired under part E).

10 “(2) BIDS ABOVE THE BENCHMARK.—If the  
 11 Secretary determines under section 1853(d)(4) that  
 12 the plan bid (as adjusted under section 1853(d)(1))  
 13 exceeds the plan benchmark amount (determined  
 14 under section 1853(d)(3)), the amount of such ex-  
 15 cess shall be the Medicare+Choice monthly basic  
 16 beneficiary premium (as defined in section  
 17 1854(b)(2)(A)).”.

18 (b) CONFORMING PART E PREMIUM REDUCTION  
 19 AMENDMENTS.—

20 (1) ADJUSTMENT AND PAYMENT OF PART E  
 21 PREMIUMS.—Section 1860E–5 (as added by section  
 22 201) is amended—

23 (A) in subsection (a), by inserting “, ex-  
 24 cept as reduced by the amount of any reduction

1           elected under section 1854(d)(1)(A)(i)” before  
 2           the period at the end; and

3                   (B) by adding at the end the following new  
 4           subsection:

5           “(c) MEDICARE+CHOICE PREMIUM REDUCTIONS.—  
 6   In the case of an individual enrolled in a Medicare+Choice  
 7   plan, the Secretary shall reduce (but not below zero) the  
 8   amount of the monthly beneficiary premium to reflect any  
 9   reduction elected under section 1854(d)(1)(A)(i). Such  
 10   premium adjustment may be provided in such manner as  
 11   the Secretary may specify.”.

12                   (2) TREATMENT OF REDUCTION FOR PURPOSES  
 13   OF DETERMINING GOVERNMENT CONTRIBUTION  
 14   UNDER PART E.—Section 1844(c) (42 U.S.C.  
 15   1395w) is amended by striking “section  
 16   1854(f)(1)(E)” and inserting “section  
 17   1854(d)(1)(A)(i)”.

18           (c) SUNSET OF SPECIFIC REQUIREMENTS FOR ADDI-  
 19   TIONAL BENEFITS.—Section 1854(g) (as redesignated by  
 20   subsection (a)(1)) is amended—

21                   (1) in paragraph (1)(A), by striking “Each  
 22   Medicare+Choice organization” and inserting “For  
 23   years before 2005, each Medicare+Choice organiza-  
 24   tion”; and

(2) in paragraph (2), by striking “A Medicare+Choice organization” and inserting “For years before 2005, a Medicare+Choice organization”.

(d) LIMITATION ON ENROLLEE LIABILITY.—

(1) FOR BENEFITS UNDER PART E.—Section 1854(f)(1) (as redesignated by subsection (a)(1)) is amended to read as follows:

“(1) FOR ENHANCED MEDICARE BENEFITS.—

The sum of—

“(A) the Medicare+Choice monthly basic beneficiary premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments (taking into account any reductions in cost-sharing described in subsection (d)(1)(A)(ii)) applicable on average to individuals enrolled under this part with a Medicare+Choice plan described in subparagraph (A) or (C) of section 1851(a)(2) of an organization with respect to required benefits described in section 1852(a)(1)(A) and any additional benefits described in subsection (a)(2)(A)(iii) for a year; must equal

“(B) the actuarial value of the deductibles, coinsurance, and copayments that would be ap-

1           plicable on average to individuals who have  
 2           elected to receive enhanced medicare benefits  
 3           under part E if they were not members of a  
 4           Medicare+Choice organization for the year (ad-  
 5           justed as determined appropriate by the Sec-  
 6           retary to account for geographic differences and  
 7           for plan cost and utilization differences).”.

8           (2) FOR SUPPLEMENTAL BENEFITS.—Section  
 9           1854(f)(2) (as so redesignated) is amended to read  
 10          as follows:

11           “(2) FOR SUPPLEMENTAL BENEFITS.—If the  
 12          Medicare+Choice organization provides to its mem-  
 13          bers enrolled under this part in a Medicare+Choice  
 14          plan described in subparagraph (A) or (C) of section  
 15          1851(a)(2) with respect to supplemental benefits re-  
 16          lating to benefits under part E described in section  
 17          1852(a)(3)(A), the sum of the Medicare+Choice  
 18          monthly supplemental beneficiary premium (multi-  
 19          plied by 12) charged and the actuarial value of its  
 20          deductibles, coinsurance, and copayments charged  
 21          with respect to such benefits for a year must equal  
 22          the adjusted community rate (as defined in sub-  
 23          section (g)(3)) for such benefits for the year.”.



1 (e) PREMIUMS CHARGED; PREMIUM TERMI-  
 2 NOLOGY.—Section 1854(b) (42 U.S.C. 1395w–24) is  
 3 amended to read as follows:

4 “(b) MONTHLY PREMIUMS CHARGED.—

5 “(1) IN GENERAL.—

6 “(A) COORDINATED CARE AND PRIVATE  
 7 FEE-FOR-SERVICE PLANS.—The monthly  
 8 amount of the premium charged to an indi-  
 9 vidual enrolled in a Medicare+Choice plan  
 10 (other than an MSA plan) offered by a  
 11 Medicare+Choice organization shall be equal to  
 12 the sum of the following:

13 “(i) The Medicare+Choice monthly  
 14 basic beneficiary premium (if any).

15 “(ii) The Medicare+Choice monthly  
 16 supplemental beneficiary premium (if any).

17 “(iii) The Medicare+Choice monthly  
 18 obligation for qualified prescription drug  
 19 coverage (if any).

20 “(B) MSA PLANS.—The rules under this  
 21 section that would have applied with respect to  
 22 an MSA plan if the 21st Century Medicare Act  
 23 had not been enacted shall continue to apply to  
 24 MSA plans after the date of enactment of such  
 25 Act.

1           “(2) PREMIUM TERMINOLOGY.—For purposes  
2 of this part:

3           “(A) MEDICARE+CHOICE MONTHLY BASIC  
4 BENEFICIARY PREMIUM.—The term  
5 ‘Medicare+Choice monthly basic beneficiary  
6 premium’ means, with respect to a  
7 Medicare+Choice plan, the amount required to  
8 be charged under subsection (d)(2) for the plan.

9           “(B) MEDICARE+CHOICE MONTHLY OBLI-  
10 GATION FOR QUALIFIED PRESCRIPTION DRUG  
11 COVERAGE.—The term ‘Medicare+Choice  
12 monthly obligation for qualified prescription  
13 drug coverage’ means, with respect to a  
14 Medicare+Choice plan, the amount determined  
15 under section 1853(k)(3).

16           “(C) MEDICARE+CHOICE MONTHLY SUP-  
17 PLEMENTAL BENEFICIARY PREMIUM.—The  
18 term ‘Medicare+Choice monthly supplemental  
19 beneficiary premium’ means, with respect to a  
20 Medicare+Choice plan, the amount required to  
21 be charged under subsection (f)(2) for the plan,  
22 or, in the case of an MSA plan, the amount  
23 filed under subsection (a)(3).

24           “(D) MEDICARE+CHOICE MONTHLY MSA  
25 PREMIUM.—The term ‘Medicare+Choice

1           monthly MSA premium’ means, with respect to  
 2           a Medicare+Choice plan, the amount of such  
 3           premium filed under subsection (a)(3) for the  
 4           plan.”.

5           (f) CONFORMING AMENDMENTS.—

6           (1) Section 1851(d)(2)(D) (42 U.S.C. 1395w–  
 7           21(d)(2)(D)) is amended by inserting “and  
 8           Medicare+Choice monthly obligation for qualified  
 9           prescription drug coverage” after “Medicare+Choice  
 10          monthly basic and supplemental beneficiary pre-  
 11          miums”.

12          (2) Section 1851(g)(3)(B)(i) (42 U.S.C.  
 13          1395w–21(g)(3)(B)(i)) is amended by striking “any  
 14          Medicare+Choice monthly basic and supplemental  
 15          beneficiary premiums” and inserting “any  
 16          Medicare+Choice monthly basic beneficiary pre-  
 17          mium, Medicare+Choice monthly obligation for  
 18          qualified prescription drug coverage,  
 19          Medicare+Choice monthly supplemental beneficiary  
 20          premium,”.

21          (3) Section 1852(c)(1)(F) (42 U.S.C. 1395w–  
 22          22(c)(1)(F)) is amended to read as follows:

23                       “(F) SUPPLEMENTAL BENEFITS.—Supple-  
 24                       mental benefits available from the organization  
 25                       offering the plan, including the supplemental

1           benefits covered and the Medicare+Choice  
2           monthly supplemental beneficiary premium for  
3           such benefits.”.

4           (4) Section 1853(f)(1) (as redesignated by sec-  
5           tion 305(1)) is amended by striking “(as defined in  
6           section 1854(b)(2)(C))” and inserting “(as defined  
7           in section 1854(b)(2)(D))”.

8           (5) Section 1854(c) (42 U.S.C. 1395w–24(c)) is  
9           amended by striking “The Medicare+Choice month-  
10          ly basic and supplemental beneficiary premium” and  
11          inserting “The Medicare+Choice monthly basic ben-  
12          eficiary premium, the Medicare+Choice monthly ob-  
13          ligation for qualified prescription drug coverage, or  
14          the Medicare+Choice monthly supplemental bene-  
15          ficiary premium”.

16          (6) Section 1854(e) (as redesignated by sub-  
17          section (a)(1)) is amended by inserting “and the  
18          Medicare+Choice monthly obligation for qualified  
19          prescription drug coverage” after “Medicare+Choice  
20          monthly basic and supplemental beneficiary pre-  
21          miums”.

22          (7) Section 1859(c)(4) (42 U.S.C. 1395w–  
23          28(c)(4)) is amended to read as follows:

24                 “(4) MEDICARE+CHOICE MONTHLY BASIC BEN-  
25                 EFICIARY PREMIUM; MEDICARE+CHOICE MONTHLY

1 OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG  
 2 COVERAGE; MEDICARE+CHOICE MONTHLY SUPPLE-  
 3 MENTAL BENEFICIARY PREMIUM.—The terms  
 4 ‘Medicare+Choice monthly basic beneficiary pre-  
 5 mium’, ‘Medicare+Choice monthly obligation for  
 6 qualified prescription drug coverage’, and  
 7 ‘Medicare+Choice monthly supplemental beneficiary  
 8 premium’ are defined in section 1854(b)(2).”.

9 **SEC. 307. ELIGIBILITY, ELECTION, AND ENROLLMENT IN**  
 10 **COMPETITIVE MEDICARE+CHOICE PLANS.**

11 (a) ELIGIBILITY.—Section 1851(a)(3) is amended to  
 12 read as follows:

13 “(3) MEDICARE+CHOICE ELIGIBLE INDIVIDUAL.—In this title, the term ‘Medicare+Choice  
 14 eligible individual’ means an individual who—  
 15

16 “(A) is entitled to benefits under part A  
 17 and enrolled under part B; and

18 “(B) has elected to receive enhanced medi-  
 19 care benefits under part E.”.

20 (b) ELECTIONS.—

21 (1) IN GENERAL.—Section 1851(a)(1)(A) is  
 22 amended by inserting “(including through the elec-  
 23 tion of enhanced medicare benefits under part E)  
 24 and, if elected by the beneficiary and offered by the  
 25 Medicare+Choice plan, through the voluntary pre-

1       scription drug delivery program under part D” after  
2       “parts A and B”.

3               (2) DEFAULT ELECTION.—Section 1851(c)(3)  
4       (42 U.S.C. 1395w–21(c)(3)) is amended by inserting  
5       “to receive enhanced medicare benefits under part E  
6       of the” after “deemed to have chosen”.

7               (3) COVERAGE ELECTION PERIODS.—Section  
8       1851(e)(1) (42 U.S.C. 1395w–21(e)(1)) is amended  
9       by striking “entitled to benefits under part A and  
10       enrolled under part B” and inserting “eligible to  
11       elect to receive enhanced medicare benefits under  
12       part E”.

13              (4) GUARANTEED ISSUANCE AND RENEWAL.—  
14       Section 1851(g)(3)(C) (42 U.S.C. 1395w–  
15       21(g)(3)(C)) is amended—

16              (A) in clause (i), by inserting “elected to  
17       receive enhanced medicare benefits under part  
18       E of the” after “deemed to have”; and

19              (B) in clause (ii), by striking “deemed to  
20       have chosen to change coverage to” and insert-  
21       ing “deemed to have elected to receive enhanced  
22       medicare benefits under part E through the”.

23              (5) EFFECT OF ELECTION OF  
24       MEDICARE+CHOICE PLAN OPTION.—Section 1851(i)  
25       (42 U.S.C. 1395w–21(i)) is amended—

1 (A) in paragraph (1)—

2 (i) by striking “1853(g), 1853(h)”

3 and inserting “1853(h), 1853(i)”; and

4 (ii) by inserting “(as modified under  
5 part E)” after “parts A and B”; and

6 (B) in paragraph (2), by striking  
7 “1853(e), 1853(g), 1853(h)” and inserting  
8 “1853(f), 1853(h), 1853(i)”.

9 (c) PROVIDING INFORMATION TO PROMOTE IN-  
10 FORMED CHOICE.—

11 (1) GENERAL INFORMATION ON BENEFITS.—

12 Section 1851(d)(3) (42 U.S.C. 1395w–21(d)(3)) is  
13 amended—

14 (A) by striking subparagraph (A) and in-  
15 serting the following:

16 “(A) BENEFITS UNDER ENHANCED MEDI-  
17 CARE FEE-FOR-SERVICE PROGRAM OPTION.—A  
18 general description of the enhanced medicare  
19 benefits covered under the original medicare  
20 fee-for-service program under parts A and B  
21 for individuals who have elected to receive such  
22 benefits under part E, including—

23 “(i) covered items and services;

1 “(ii) beneficiary cost-sharing, such as  
 2 deductibles, coinsurance, and copayment  
 3 amounts; and

4 “(iii) any beneficiary liability for bal-  
 5 ance billing.”;

6 (B) by redesignating subparagraphs (B)  
 7 through (E) as subparagraphs (C) through (F),  
 8 respectively;

9 (C) by inserting after subparagraph (A)  
 10 the following new subparagraph:

11 “(B) OUTPATIENT PRESCRIPTION DRUG  
 12 COVERAGE BENEFITS.—For Medicare+Choice  
 13 eligible individuals who are enrolled under part  
 14 D, the information required under section  
 15 1860D–4 if the Medicare+Choice organization  
 16 elects to offer prescription drug coverage.”; and

17 (D) in subparagraph (D) (as redesignated  
 18 by subparagraph (B)), by inserting “(with the  
 19 enhanced medicare benefits under part E)”  
 20 after “the original medicare fee-for-service pro-  
 21 gram”.

22 (2) INFORMATION COMPARING PLAN OP-  
 23 TIONS.—Section 1851(d)(4) (42 U.S.C. 1395w–  
 24 21(d)(4)) is amended—



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

“(ix) For Medicare+Choice eligible individuals who are enrolled under part D, the comparative information described in section 1860D–4(b)(2) if the Medicare+Choice organization elects to offer prescription drug coverage.”; and

(B) in subparagraph (D), by inserting “with respect to eligible beneficiaries who elect to receive enhanced medicare benefits under part E” after “under parts A and B”.

**SEC. 308. BENEFITS AND BENEFICIARY PROTECTIONS  
UNDER COMPETITIVE MEDICARE+CHOICE  
PLANS.**

(a) BASIC BENEFITS.—Section 1852(a) (42 U.S.C. 1395w–22(a)(1)(A)) is amended—

(1) in paragraph (1)—

(A) by striking subparagraph (A) and inserting the following new subparagraph:

“(A) those items and services (other than hospice care) for which benefits are available under parts A and B to individuals residing in the area served by the plan and who have elect-

1 ed to receive enhanced medicare benefits under  
2 part E;”;

3 (B) by redesignating subparagraph (B) as  
4 subparagraph (C);

5 (C) by inserting after subparagraph (A)  
6 the following new subparagraph:

7 “(B) if the Medicare+Choice organization  
8 elects to offer prescription drug coverage, pre-  
9 scription drug coverage under part D to individ-  
10 uals who are enrolled under that part and who  
11 reside in the area served by the plan; and”;

12 (D) in subparagraph (C) (as redesignated  
13 by paragraph (2)), by striking “1854(f)(1)(A)”  
14 and inserting “1854(d)(1)”;

15 (2) in paragraph (2), by striking “parts A and  
16 B (including any balance billing permitted under  
17 such parts” and inserting “part E (including any  
18 balance billing permitted under such part”;

19 (3) in paragraph (3), by adding at the end the  
20 following new subparagraph:

21 “(D) REQUIREMENT OF ENROLLMENT IN  
22 PART D TO RECEIVE PRESCRIPTION DRUG BEN-  
23 EFITS.—Notwithstanding the preceding provi-  
24 sions of this paragraph, the Secretary may not  
25 approve any supplemental health care benefit

1           that provides for the coverage of any prescrip-  
 2           tion drug (other than that required under part  
 3           E).”; and

4           (4) in paragraph (5), by striking “Health Care  
 5           Financing Administration” and inserting “Medicare  
 6           Competitive Agency” in the flush matter following  
 7           subparagraph (B).

8           (b)        ESRD        ANTIDISCRIMINATION.—Section  
 9   1852(b)(1) (42 U.S.C. 1395w–22(b)(1)) is amended to  
 10 read as follows:

11           “(1) BENEFICIARIES.—A Medicare+Choice or-  
 12           ganization may not deny, limit, or condition the cov-  
 13           erage or provision of benefits under this part, for in-  
 14           dividuals permitted to be enrolled with the organiza-  
 15           tion under this part, based on any health status-re-  
 16           lated factor described in section 2702(a)(1) of the  
 17           Public Health Service Act.”.

18           (c)        DISCLOSURE        REQUIREMENTS.—Section  
 19   1852(c)(1)(B) (42 U.S.C. 1395w–22(c)(1)(B)) is amend-  
 20 ed by striking “section 1851(d)(3)(A)” and inserting  
 21 “subparagraphs (A) and (B) of section 1851(d)(3)”.

22           (d)        ASSURING   ACCESS   TO   SERVICES   IN  
 23 MEDICARE+CHOICE   PRIVATE   FEE-FOR-SERVICE  
 24 PLANS.—Section 1852(d)(4)(A) is amended by striking  
 25 “part A, part B, or both, for such services, or” and insert-

1 ing “part E for such services (and, if the  
 2 Medicare+Choice organization elects to offer prescription  
 3 drug coverage, that are not less than the payment rates  
 4 provided under part D for such services for  
 5 Medicare+Choice eligible individuals enrolled under that  
 6 part); or”.

7 (e) INFORMATION ON BENEFICIARY LIABILITY FOR  
 8 MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE  
 9 PLANS.—Section 1852(k)(2)(C)(i) (42 U.S.C. 1395w–  
 10 22(k)(2)(C)(i)) is amended by striking “parts A and B”  
 11 and inserting “part E, under part D for individuals en-  
 12 rolled under that part (if the Medicare+Choice organiza-  
 13 tion elects to offer prescription drug coverage),”.

14 **SEC. 309. PAYMENTS TO MEDICARE+CHOICE ORGANIZA-**  
 15 **TIONS FOR ENHANCED MEDICARE BENEFITS**  
 16 **UNDER PART E BASED ON RISK-ADJUSTED**  
 17 **BIDS.**

18 (a) IN GENERAL.—Section 1853(a)(1)(A) (42 U.S.C.  
 19 1395w–23(a)(1)(A)) is amended to read as follows:

20 “(1) MONTHLY PAYMENTS.—Under a contract  
 21 under section 1857 and subject to subsections (f),  
 22 (h), and (j) and section 1859(e)(4), the Secretary  
 23 shall make, to each Medicare+Choice organization,  
 24 with respect to coverage of an individual for a month

1 under this part in a Medicare+Choice payment area,  
 2 separate monthly payments with respect to—

3 “(A) enhanced medicare benefits under  
 4 part E in accordance with subsection (d); and

5 “(B) if the Medicare+Choice organization  
 6 elects to offer prescription drug coverage, bene-  
 7 fits under part D in accordance with subsection  
 8 (k) for individuals enrolled under that part.”.

9 (b) CONFORMING AMENDMENT.—Section  
 10 1853(g)(1)(A) (42 U.S.C. 1395w–23(g)(1)(A)) is amend-  
 11 ed by inserting “as part of the enhanced medicare benefits  
 12 elected under part E of” before “the original medicare fee-  
 13 for-service program option”.

14 **SEC. 310. SEPARATE PAYMENTS TO MEDICARE+CHOICE OR-**  
 15 **GANIZATIONS FOR PART D BENEFITS.**

16 (a) IN GENERAL.—Section 1853 (42 U.S.C. 1395w–  
 17 27) is amended by adding at the end the following new  
 18 subsection:

19 “(k) AVAILABILITY OF PRESCRIPTION DRUG BENE-  
 20 FITS.—

21 “(1) SCOPE OF PRESCRIPTION DRUG BENE-  
 22 FITS.—

23 “(A) AVAILABILITY OF STANDARD COV-  
 24 ERAGE.—If a Medicare+Choice organization  
 25 elects to offer prescription drug coverage under

1 a Medicare+Choice plan, such organization  
2 shall make such coverage (other than that re-  
3 quired under part E) available to each enrollee  
4 under that plan who is also enrolled under part  
5 D that includes only standard coverage and  
6 that meets the requirements of this subsection.

7 “(B) ADDITIONAL QUALIFIED PRESCRIP-  
8 TION DRUG COVERAGE.—In addition to the  
9 standard coverage option made available to  
10 each enrollee under paragraph (1), a  
11 Medicare+Choice plan may make available to  
12 each enrollee that is also enrolled under part D,  
13 other qualified prescription drug coverage  
14 (other than that required under part E) that  
15 meets the requirements of this subsection under  
16 a Medicare+Choice plan offered under this  
17 part.

18 “(C) REQUIREMENT OF ENROLLMENT IN  
19 PART D TO RECEIVE PRESCRIPTION DRUG BEN-  
20 EFITS.—A Medicare+Choice organization may  
21 not provide for the coverage of any prescription  
22 drugs (other than that required under part E)  
23 to an enrollee unless that enrollee is also en-  
24 rolled under part D.

1           “(2) PAYMENT OF FULL AMOUNT OF PREMIUM  
2           TO ORGANIZATIONS FOR QUALIFIED PRESCRIPTION  
3           DRUG COVERAGE.—For each year (beginning with  
4           2005), the Secretary shall pay to each  
5           Medicare+Choice organization offering a  
6           Medicare+Choice plan that provides qualified pre-  
7           scription drug coverage in which a Medicare+Choice  
8           eligible individual is enrolled, an amount equal to the  
9           full amount of the monthly premium submitted  
10          under section 1854(a)(2)(B) on behalf of each such  
11          individual enrolled in such plan for the year, as ad-  
12          justed using the risk adjusters that apply to the  
13          standard coverage under section 1853(b)(4)(B).

14          “(3) AMOUNT OF MEDICARE+CHOICE MONTHLY  
15          OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG  
16          COVERAGE.—In the case of a Medicare+Choice eligi-  
17          ble individual receiving qualified prescription drug  
18          coverage under a Medicare+Choice plan, the obliga-  
19          tion for qualified prescription drug coverage of such  
20          individual in a year shall be determined as follows:

21                 “(A) PREMIUMS EQUAL TO THE MONTHLY  
22                 NATIONAL AVERAGE.—If the amount of the  
23                 monthly premium for qualified prescription  
24                 drug coverage submitted under section  
25                 1854(a)(2)(B) for the plan for the year is equal

1 to the monthly national average premium (as  
 2 computed under section 1860D–15) for the  
 3 year, the monthly obligation of the individual in  
 4 that year shall be an amount equal to the appli-  
 5 cable percent (as defined in section 1860D–  
 6 17(c)) of the amount of the monthly national  
 7 average premium.

8 “(B) PREMIUMS THAT ARE LESS THAN  
 9 THE MONTHLY NATIONAL AVERAGE.—If the  
 10 amount of the monthly premium for qualified  
 11 prescription drug coverage submitted under sec-  
 12 tion 1854(a)(2)(B) for the plan for the year is  
 13 less than the monthly national average premium  
 14 (as computed under section 1860D–15) for the  
 15 year, the monthly obligation of the individual in  
 16 that year shall be an amount equal to—

17 “(i) the applicable percent (as defined  
 18 in section 1860D–17(c)) of the amount of  
 19 the monthly national average premium;  
 20 minus

21 “(ii) the amount by which the month-  
 22 ly national average premium exceeds the  
 23 amount of the premium submitted under  
 24 section 1854(a)(2)(B).



1           “(C) PREMIUMS THAT ARE GREATER THAN  
 2           THE MONTHLY NATIONAL AVERAGE.—If the  
 3           amount of the monthly premium for qualified  
 4           prescription drug coverage submitted under sec-  
 5           tion 1854(a)(2)(B) for the plan for the year ex-  
 6           ceeds the monthly national average premium  
 7           (as computed under section 1860D–15) for the  
 8           year, the monthly obligation of the individual in  
 9           that year shall be an amount equal to the sum  
 10          of—

11                   “(i) the applicable percent (as defined  
 12                   in section 1860D–17(c)) of the amount of  
 13                   the monthly national average premium;  
 14                   plus

15                   “(ii) the amount by which the pre-  
 16                   mium submitted under section  
 17                   1854(a)(2)(B) exceeds the amount of the  
 18                   monthly national average premium.

19           “(4) COLLECTION OF MEDICARE+CHOICE  
 20           MONTHLY OBLIGATION FOR QUALIFIED PRESCRIP-  
 21           TION DRUG COVERAGE.—The provisions of section  
 22           1860D–18, including subsection (b) of such section,  
 23           shall apply to the amount of the monthly premium  
 24           required to be paid by a Medicare+Choice eligible  
 25           individual receiving qualified prescription drug cov-

1 erage under a Medicare+Choice plan (as determined  
 2 under paragraph (3)) in the same manner as such  
 3 provisions apply to the monthly beneficiary obliga-  
 4 tion required to be paid by an eligible beneficiary en-  
 5 rolled in a Medicare Prescription Drug plan.

6 “(5) COMPLIANCE WITH ADDITIONAL BENE-  
 7 FICIARY PROTECTIONS.—With respect to the offer-  
 8 ing of qualified prescription drug coverage by a  
 9 Medicare+Choice organization under a  
 10 Medicare+Choice plan, the organization and plan  
 11 shall meet the requirements of section 1860D–5, in-  
 12 cluding requirements relating to information dis-  
 13 semination and grievance and appeals, in the same  
 14 manner as they apply to an eligible entity and a  
 15 Medicare Prescription Drug plan under part D. The  
 16 Secretary shall waive such requirements to the ex-  
 17 tent the Secretary determines that such require-  
 18 ments duplicate requirements otherwise applicable to  
 19 the organization or plan under this part.

20 “(6) COVERAGE OF PRESCRIPTION DRUGS FOR  
 21 ENROLLEES IN PLANS THAT DO NOT OFFER PRE-  
 22 SCRIPTIION DRUG COVERAGE.—If an individual who  
 23 is enrolled under part D is enrolled in a  
 24 Medicare+Choice plan that does not offer prescrip-  
 25 tion drug coverage, such individual shall be per-

mitted to enroll for prescription drug coverage under such part in the same manner as if such individual was not enrolled in a Medicare+Choice plan.

“(7) AVAILABILITY OF PREMIUM SUBSIDY AND COST-SHARING REDUCTIONS FOR LOW-INCOME ENROLLEES.—For provisions—

“(A) providing premium subsidies and cost-sharing reductions for low-income individuals receiving qualified prescription drug coverage through a Medicare+Choice plan, see section 1860D–19; and

“(B) providing a Medicare+Choice organization with insurance subsidy payments for providing qualified prescription drug coverage through a Medicare+Choice plan, see section 1860D–20.

“(8) QUALIFIED PRESCRIPTION DRUG COVERAGE; STANDARD COVERAGE.—For purposes of this part, the terms ‘qualified prescription drug coverage’ and ‘standard coverage’ have the meanings given such terms in paragraphs (9) and (10), respectively, of section 1860D.”.

(b) SANCTIONS FOR IMPROPER PRESCRIPTION DRUG COVERAGE.—Section 1857(g)(1) (42 U.S.C. 1395w–27(g)(1)) is amended—

1 (1) in subparagraph (F), by striking “or” after  
 2 the semicolon at the end;

3 (2) in subparagraph (G), by adding “or” after  
 4 the semicolon at the end; and

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

7 “(H) charges any individual an amount in  
 8 excess of the Medicare+Choice monthly obliga-  
 9 tion for qualified prescription drug coverage  
 10 under section 1853(k)(3), provides coverage for  
 11 prescription drugs that is not qualified prescrip-  
 12 tion drug coverage (as defined in section  
 13 1853(k)(7)), offers prescription drug coverage,  
 14 but does not make standard prescription drug  
 15 coverage available (as defined in such section),  
 16 or provides coverage for prescription drugs  
 17 (other than those covered under part E) to an  
 18 individual who is not enrolled under part D;”.

19 **SEC. 311. ADMINISTRATION BY THE MEDICARE COMPETI-**  
 20 **TIVE AGENCY.**

21 On and after January 1, 2005, the Medicare+Choice  
 22 program under part C of title XVIII of the Social Security  
 23 Act shall be administered by the Medicare Competitive  
 24 Agency in accordance with subpart 3 of part D of such  
 25 title (as added by section 101), and, in accordance with

1 section 1860D–25(c)(3)(C) of such Act (as added by sec-  
 2 tion 101), each reference to the Secretary made in this  
 3 title, or the amendments made by this title, shall be  
 4 deemed to be a reference to the Administrator of the Medi-  
 5 care Competitive Agency.

6 **SEC. 312. CONTINUED CALCULATION OF ANNUAL**  
 7 **MEDICARE+CHOICE CAPITATION RATES.**

8 (a) CONTINUED CALCULATION.—

9 (1) IN GENERAL.—Section 1853(c) (as amend-  
 10 ed by subsection (b)) is amended by adding at the  
 11 end the following new paragraph:

12 “(7) TRANSITION TO MEDICARE+CHOICE COM-  
 13 PETITION.—

14 “(A) IN GENERAL.—For each year (begin-  
 15 ning with 2005) payments to Medicare+Choice  
 16 plans shall not be computed under this sub-  
 17 section, but instead shall be based on the pay-  
 18 ment amount determined under subsection (d).

19 “(B) CONTINUED CALCULATION OF CAPI-  
 20 TATION RATES.—For each year (beginning with  
 21 2004) the Secretary shall calculate and publish  
 22 the annual Medicare+Choice capitation rates  
 23 under this subsection and shall use the annual  
 24 Medicare+Choice capitation rate determined  
 25 under subsection (c)(1)(B) for purposes of de-

1           termining the benchmark amount under sub-  
2           section (a)(4).”.

3           (2)     CONFORMING     AMENDMENT.—Section  
4           1853(c)(1) (42 U.S.C. 1395w–23(c)(1)) is amended  
5           by striking “For purposes of this part, subject to  
6           paragraphs (6)(C) and (7),” and inserting “For pur-  
7           poses of making payments under this part for years  
8           before 2004 and for purposes of calculating the an-  
9           nual Medicare+Choice capitation rates under para-  
10          graph (7) beginning with such year, subject to para-  
11          graph (6)(C),” in the matter preceding subpara-  
12          graph (A).

13          (b) INCLUSION OF COSTS OF VA AND DoD MILITARY  
14          FACILITY SERVICES IN CONTINUED CALCULATION.—Sec-  
15          tion 1853(c) (42 U.S.C. 1395w–23(c)), as amended by  
16          subsection (a)(1), is amended by adding at the end the  
17          following new paragraph:

18                 “(8) INCLUSION OF COSTS OF VA AND DoD  
19          MILITARY FACILITY SERVICES TO MEDICARE-ELIGI-  
20          BLE BENEFICIARIES.—For purposes of determining  
21          the blended capitation rate under subparagraph (A)  
22          of paragraph (1) and the minimum percentage in-  
23          crease under subparagraph (C) of such paragraph  
24          for a year, the annual per capita rate of payment for  
25          1997 determined under section 1876(a)(1)(C) shall

1 be adjusted to include in such rate, to the extent  
 2 practicable, the Secretary's estimate, on a per capita  
 3 basis, of the amount of additional payments that  
 4 would have been made in the area involved under  
 5 this title if individuals entitled to benefits under this  
 6 title had not received services from facilities of the  
 7 Department of Veterans Affairs or the Department  
 8 of Defense.”.

9 **SEC. 313. FIVE-YEAR EXTENSION OF MEDICARE COST CON-**  
 10 **TRACTS.**

11 (a) IN GENERAL.—Section 1876(h)(5)(C) (42 U.S.C.  
 12 1395mm(h)(5)(C)), as redesignated by section 634(1) of  
 13 BIPA (114 Stat. 2763A–568), is amended by striking  
 14 “2004” and inserting “2009”.

15 (b) EFFECTIVE DATE.—The amendment made by  
 16 subsection (a) shall take effect on the date of enactment  
 17 of this Act.

18 **SEC. 314. EFFECTIVE DATE.**

19 (a) IN GENERAL.—Except as provided in section  
 20 306(b)(1)(B), section 313(b), and subsection (b), the  
 21 amendments made by this title shall apply to plan years  
 22 beginning on and after January 1, 2005.

23 (b) MEDICARE+CHOICE MSA PLANS.—Notwith-  
 24 standing any provision of this title, the Secretary shall  
 25 apply the payment and other rules that apply with respect

1 to an MSA plan described in section 1851(a)(2)(B) of the  
2 Social Security Act (42 U.S.C. 1395w-21(a)(2)(B)) as if  
3 this title had not been enacted.

