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108TH CONGRESS
1ST SESSION

H. R. 1568

To amend part B of title XVIII of the Social Security Act to provide for a prescription drug benefit with a high deductible at no additional premium and access to discount prices on drugs and to provide for the operation of such benefit without a deductible for certain low-income Medicare beneficiaries.

IN THE HOUSE OF REPRESENTATIVES

APRIL 2, 2003

Mr. DOOLEY of California (for himself, Mrs. TAUSCHER, Mr. KIND, Mr. DAVIS of Florida, Mr. SMITH of Washington, Mr. STENHOLM, Mr. EMANUEL, Mr. COOPER, Mr. HILL, Mr. FORD, Mr. PETERSON of Minnesota, Mr. CARDOZA, Mr. CASE, Mr. CRAMER, Mr. MOORE, Ms. HARMAN, Mr. MILLER of North Carolina, Mr. DAVIS of Alabama, Mrs. MCCARTHY of New York, Mr. ISRAEL, Mr. WU, Mr. MARSHALL, Mr. LUCAS of Kentucky, Mr. MATHESON, and Mr. LARSEN of Washington) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend part B of title XVIII of the Social Security Act to provide for a prescription drug benefit with a high deductible at no additional premium and access to discount prices on drugs and to provide for the operation of such benefit without a deductible for certain low-income Medicare beneficiaries.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Rx Now Act of 2003''.

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

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

SEC. 2. PURPOSE.

The purpose of this Act is to provide for outpatient prescription drug benefits to medicare beneficiaries in the following manner:

(1) Medicare beneficiaries enrolled under medicare part B qualify for outpatient prescription drug

benefits after an annual deductible (initially set at $4,000) has been met. This benefit is available without any additional premium.

(2) There are fixed dollar copayments for this coverage, with the average of such copayments equal to 20 percent of the benefits and the amount of the copayments varying depending upon whether the drugs are generic, preferred brand-name, or non-preferred brand-name drugs.

(3) The benefits are provided through medicare-approved prescription drug plans. These plans may be current plans, such as Medicare+Choice plans, employer-based retiree coverage, medigap plans, State assistance programs, medicaid, drug discount card plans, and other qualified plans (as determined by the Secretary). All of these plans must offer, in addition to the high-deductible coverage, discounts for prescription drugs both while the annual deductible is being satisfied and after it is satisfied.

(4) To assure access to medicare-approved prescription drug plans for all medicare beneficiaries, the Secretary will solicit bids for prescription drug discount plans that will be available in all geographic regions to all medicare beneficiaries.

(5) All pharmacies that comply with electronic claims processing standards may provide drugs under the program.

(6) The Act also provides for the availability of additional benefits in the form of a waiver of the annual deductible, thereby providing immediate entitlement to prescription drug benefits, for medicare beneficiaries who have incomes under 200 percent of the poverty line and who are not eligible for medicaid prescription drug benefits.

TITLE I—PART B DRUG BENEFIT WITH HIGH DEDUCTIBLE AND NO PREMIUM

SEC. 101. INCLUSION OF HIGH-DEDUCTIBLE OUTPATIENT PRESCRIPTION DRUG BENEFIT UNDER PART B.

(a) COVERAGE.—Section 1832(a) (42 U.S.C. 1395k(a)) is amended—

(1) by striking ''and'' at the end of paragraph (1);

(2) by striking the period at the end of paragraph (2) and inserting ''; and''; and

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

''(3) entitlement to have payment made on his behalf (subject to the provisions of this part) for high-deductible outpatient prescription drug coverage under section 1845.''.

(b) DESCRIPTION OF HIGH-DEDUCTIBLE PRESCRIPTION DRUG BENEFIT.—Title XVIII is amended by inserting after section 1844 the following new section:

''OUTPATIENT PRESCRIPTION DRUG COVERAGE

''SEC. 1845. (a) HIGH-DEDUCTIBLE OUTPATIENT PRESCRIPTION DRUG COVERAGE DEFINED.—

''(1) IN GENERAL.—For purposes of this part, the term 'high-deductible outpatient prescription drug coverage' means payment of—

''(A) expenses for covered outpatient prescription drugs incurred in a year after the individual has incurred expenses for such drugs in the year of an amount equal to the annual deductible specified in paragraph (2); reduced by

''(B) cost-sharing described in paragraph (3).

''(2) ANNUAL DEDUCTIBLE.—

''(A) IN GENERAL.—The annual deductible under this paragraph—

''(i) for 2005 is equal to $4,000; and

''(ii) for a subsequent year is equal to the amount specified in subparagraph (B) for that year, except that, if the amount specified in such subparagraph is not a multiple of $10, it shall be rounded to the nearest multiple of $10.

''(B) INFLATIONARY ADJUSTMENT.—The amount specified in this subparagraph—

''(i) for 2005, is $4,000; or

''(ii) the amount specified in this subparagraph for a subsequent year is the amount specified in this subparagraph for the previous year increased by the annual percentage increase in average per capita aggregate expenditures for covered outpatient prescription drugs in the United States for medicare beneficiaries, as determined by the Secretary for the 12-month period ending in July of the previous year.

''(3) COST-SHARING.—

''(A) THREE-TIERED COPAYMENT STRUCTURE.—Subject to the succeeding provisions of this paragraph, in the case of a covered outpatient drug that is dispensed in a year to an eligible individual, the individual shall be re-

sponsible for a copayment for the drug in an amount equal to the following (or, if less, the price for the drug negotiated pursuant to subsection (c)(5)):

"(i) GENERIC DRUGS.—In the case of a generic covered outpatient drug, the base copayment amount specified in accordance with subparagraph (B) for each prescription (as defined by the Secretary) of such drug.

"(ii) PREFERRED BRAND NAME DRUGS.—In the case of a preferred brand name covered outpatient drug, 4 times the copayment amount applied under clause (i) for each prescription (as so defined) of such drug.

"(iii) NONPREFERRED BRAND NAME DRUG.—In the case of a nonpreferred brand name covered outpatient drug, 150 percent of the copayment amount applied under clause (ii) for each prescription (as so defined) of such drug.

"(B) ESTABLISHMENT OF BASE COPAYMENT AMOUNT CONSISTENT WITH 80:20 BENEFIT RATIO.—For each year beginning with

2005 the Secretary shall establish a base copayment amount in a manner consistent with the principle (subject to reasonable rounding rules) that the ratio of the aggregate amount of benefits provided under this section to the aggregate copayments under this paragraph for each year should be approximately equal to 80 to 20.

''(C) DISCOUNTS ALLOWED FOR NETWORK PHARMACIES.—A medicare-approved prescription drug plan may reduce copayments for its designees below the level otherwise provided under this paragraph, but in no case shall such a reduction result in an increase in payments made by the Secretary under this section to a plan.

''(D) TREATMENT OF MEDICALLY NECESSARY NONPREFERRED DRUGS.—A nonpreferred brand name drug shall be treated as a preferred brand name drug under this paragraph if such nonpreferred drug is determined (pursuant to procedures established under subsection (c)(6)) to be medically necessary.

''(E) REQUIREMENT FOR DESIGNATION OF PREFERRED BRAND NAME DRUGS.—Within each category of therapeutic-equivalent covered

outpatient prescription drugs (as defined by the Secretary), each medicare-approved prescription drug plan shall provide for the designation of at least one preferred brand name covered outpatient drug.

''(4) PAYMENT OF BENEFITS BEYOND DEDUCTIBLE.—

''(A) IN GENERAL.—There shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for covered outpatient prescription drugs with respect to which benefits are payable under this section, amounts equal to the amounts provided under paragraph (1).

''(B) COUNTING OF INCURRED EXPENSES.—Expenses with respect to covered outpatient prescription drugs under this section shall—

''(i) be treated as incurred regardless of whether they are reimbursed by a third-party payor;

''(ii) not be treated as incurred unless the expenses were incurred during a period

in which the individual was covered under this part; and

''(iii) not be treated as incurred unless information concerning the transaction giving rise to such expenses has been electronically transmitted by the pharmacy or other entity dispensing the covered outpatient prescription drugs to the medicare-approved prescription drug plan consistent with electronic claims standards established under subsection (c)(3).''.

SEC. 102. PROVISION OF BENEFITS THROUGH MEDICARE APPROVED PRESCRIPTION DRUG PLANS.

(a) IN GENERAL.—Section 1845 of the Social Security Act, as inserted by section 101(a), is further amended by adding at the end the following:

''(b) PROVISION OF BENEFITS THROUGH A MEDICARE APPROVED PRESCRIPTION DRUG PLAN.—

''(1) IN GENERAL.—In the case of an individual entitled to benefits for high-deductible outpatient prescription drug coverage under this section, the individual shall obtain such benefits through a medicare-approved prescription drug plan that is designated under this subsection.

''(2) DESIGNATION PROCESS.—The Secretary shall provide for a process for designation of medicare-approved prescription drug plans consistent with the following:

''(A) FREQUENCY OF DESIGNATIONS.—The Secretary shall permit individuals, on an annual basis and at such other times during a year as the Secretary may specify, to change the plan designated.

''(B) DISSEMINATION OF INFORMATION.—The Secretary shall provide for the dissemination of information on designation of plans under this subsection. Such dissemination may be coordinated with the dissemination of information on Medicare+Choice plan selection under part C.

''(C) DEFAULT ASSIGNMENT.—In the case of an individual who is enrolled under this part who has not otherwise designated a medicare-approved prescription drug plan, the Secretary shall assign the individual to an appropriate prescription drug discount card plan serving the area in which the individual resides.

''(D) DEEMED DESIGNATION.—The Secretary may deem an individual who is enrolled

in a medicare-approved prescription drug plan described in subparagraph (A) through (E) of subsection (c)(2) as having designated such plan, but shall permit the individual to designate a prescription drug discount card plan instead. The Secretary shall establish rules in cases where an individual is enrolled in more than one such plan.

''(3) DESIGNEE DEFINED.—In this section, the term 'designee' means such an individual who makes such a designation and, with respect to a plan, an individual who has designated that plan under this subsection.

''(c) MEDICARE-APPROVED PRESCRIPTION DRUG PLANS.—

''(1) IN GENERAL.—For purposes of this part, the term 'medicare-approved prescription drug plan' means a health plan or program described in paragraph (2) that—

''(A) provides at least high-deductible outpatient prescription drug coverage to designees of that plan or program;

''(B) meets the applicable requirements of paragraph (3) and succeeding paragraphs of this subsection with respect to such designees;

''(C) has entered into an agreement with the Secretary to provide and exchange electronically such information as the Secretary may require for the administration of the program of benefits under this section; and

''(D) meets such additional requirements as the Secretary may specify, including requiring the provision of appropriate periodic audits.

''(2) TYPES OF PLANS AND PROGRAMS THAT MAY QUALIFY.—The types of plans and programs that may qualify as a medicare-approved prescription drug plan are the following:

''(A) A Medicare+Choice plan.

''(B) A group health plan, including a retirement health benefits plan, that provides prescription drug coverage.

''(C) A State plan under title XIX.

''(D) A health benefits plan under the Federal employees' health benefits program under chapter 89 of title 5, United States Code.

''(E) A medicare supplemental policy.

''(F) State pharmaceutical assistance program.

''(G) A prescription drug discount card plan (described in subsection (d)).

"(H) Any other prescription drug plan that is determined to meet such requirements as the Secretary establishes.

"(3) ADMINISTRATION THROUGH CARD-BASED ELECTRONIC MECHANISM.—

"(A) USE OF MEDICARE PRESCRIPTION DRUG CARD.—Claims for benefits under this section under a medicare-approved prescription drug plan may only be made electronically through the use of an electronic prescription card system (in this paragraph referred to as the 'system').

"(B) STANDARDS FOR ELECTRONIC PRESCRIPTION CARD SYSTEM.—The Secretary shall establish standards for the system, including the following:

"(i) CARDS.—Standards for claims cards to be used by designees under the system.

"(ii) COORDINATION OF ELECTRONIC INFORMATION.—Standards for the real-time transmittal among pharmacies, medicare-approved prescription drug plans, and the Secretary (including an appropriate data clearinghouse operated by or under

contract with the Secretary) of information on expenses incurred for covered outpatient prescription drugs by designees.

''(iii) CONFIDENTIALITY.—Standards that assure the confidentiality of individually identifiable information of designees and that are consistent with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

''(4) ACCEPTANCE OF CLAIMS THROUGH ALL QUALIFYING PHARMACIES.—A medicare-approved prescription drug plan shall provide for acceptance and process of claims for designees from any pharmacy that meets standards the Secretary has established under paragraph (3) to carry out real-time transmittal of claims to such plans and that provides for disclosure, in the case of dispensing of a brand name drug to a designee, of information on the availability of generic equivalents at reduced cost to the designee.

''(5) REQUIREMENT TO NEGOTIATE DISCOUNTS AND GENERIC EQUIVALENTS.—A medicare-approved prescription drug plan shall provide designees of the plan with the following:

''(A) NEGOTIATED PRICES.—Access to negotiated prices (including applicable discounts) used for payment for covered outpatient drugs, regardless of the fact that no benefits or only partial benefits may be payable with respect to such drugs because of the application of the deductible under subsection (a)(2) or copayment under subsection (a)(3).

''(B) GENERIC EQUIVALENTS.—Information on the availability of generic equivalents at reduced cost to such designees.

''(6) TREATMENT OF NONPREFERRED BRAND NAME DRUGS.—

''(A) PROCEDURES REGARDING THE DETERMINATION OF DRUGS THAT ARE MEDICALLY NECESSARY.—

''(i) IN GENERAL.—A medicare-approved prescription drug plan shall have in place procedures on a case-by-case basis to treat a nonpreferred brand name drug as a preferred brand name drug for purposes of subsection (a) if the nonpreferred brand name drug is determined—

''(I) to be not as effective for the designee in preventing or slowing the

deterioration of, or improving or maintaining, the health of the individual; or

"(II) to have a significant adverse effect on the individual.

"(ii) REQUIREMENT.—The procedures under clause (i) shall require that determinations under such clause are based on professional medical judgment, the medical condition of the enrollee, and other medical evidence.

"(B) PROCEDURES REGARDING APPEAL RIGHTS WITH RESPECT TO DENIALS OF CARE.—Such a plan shall have in place procedures to ensure a timely internal review (and timely independent external review) for resolution of denials of coverage in accordance with the medical exigencies of the case in accordance with requirements established by the Secretary that are comparable to such requirements for Medicare+Choice organizations under part C and to ensure notice to designees regarding such procedures. A designee shall have the further right to an appeal of such a denial of coverage in the same manner as is provided under

section 1852(g)(5) in the case of a failure to receive health services under a Medicare+Choice plan.

''(7) PROMPT PAYMENT OF PHARMACIES FOR COVERED BENEFITS.—Medicare-approved prescription drug plans shall provide for payment to qualifying pharmacies of benefits under subsection (a)(4) promptly in accordance with rules no less generous than the rules applicable under section 1842(c)(2)(B).

''(8) EDUCATION.—Medicare-approved prescription drug plans shall apply methods to identify and educate providers, pharmacists, and designees regarding—

''(A) instances or patterns concerning the unnecessary or inappropriate prescribing or dispensing of covered outpatient prescription drugs;

''(B) instances or patterns of substandard care;

''(C) potential adverse reactions to covered outpatient prescription drugs;

''(D) inappropriate use of antibiotics;

''(E) appropriate use of generic products; and

''(F) the importance of using covered outpatient prescription drugs in accordance with the instruction of prescribing providers.

''(9) NOT AT FINANCIAL RISK.—The entity offering a medicare-approved prescription drug plan shall not be at financial risk for the provision of high-deductible prescription drug coverage under the plan to designees, but there shall be performance incentives (based on risk corridors negotiated between the entity and the Secretary and subject to audit) in relation to the administration of the contract and the entity's ability to reduce costs through appropriate incentive mechanisms.

''(10) PROVISION OF DATA.—The entity offering such a plan shall provide the Secretary with such information as is required to make payments to the entity under this section.

''(d) PRESCRIPTION DRUG DISCOUNT CARD PLANS.—

''(1) SOLICITATION OF BIDS.—The Secretary shall solicit bids from entities to offer prescription drug discount card plans to individuals enrolled under this part either nationwide or in large geographic areas. The Secretary shall award bids in a manner so that such plans are offered in all areas

of the United States. The Secretary may not award a contract based on such a bid to an entity with respect to a plan unless the entity and plan meet the applicable requirements to be a medicare-approved prescription drug plan under this section.

''(2) LIMITATION ON BENEFITS.—The entity offering a prescription drug discount card plan shall not offer (or charge for) benefits to designees of the plan in addition to high-deductible prescription drug coverage, access to negotiated prices, and other benefits required under this section and, in the case of subsidy eligible individuals, benefits under subsection (h).

''(e) PAYMENT OF PLANS.—

''(1) IN GENERAL.—The Secretary shall provide, in the contract entered into between the Secretary and entities that offer medicare-approved prescription drug plans, for payment to the plans for high-deductible prescription drug coverage offered through the plan, including expanded coverage for low-income individuals under subsection (g) and taking into account performance incentives described in paragraph (2). In addition, in the case of prescription drug discount card plans, the Secretary shall provide for payment of administrative costs in car-

rying out the contract (taking into account the performance incentives described in paragraph (2)), based on rates negotiated between the Secretary and the entity in the solicitation process under subsection (d).

''(2) INCENTIVES FOR COST AND UTILIZATION MANAGEMENT AND QUALITY IMPROVEMENT.—The Secretary shall include in the contract such financial or other performance incentives for cost and utilization management and quality improvement as the Secretary may deem appropriate.

''(f) COVERED OUTPATIENT PRESCRIPTION DRUGS DEFINED.—

''(1) IN GENERAL.—Except as provided in this subsection, for purposes of this section, the term 'covered outpatient prescription drug' means—

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

''(B) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section or insulin described in subparagraph (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)).

''(2) EXCLUSIONS.—

''(A) IN GENERAL.—Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3), as the Secretary may specify and does not include such other medicines, classes, and uses as the Secretary may specify consistent with the goals of providing quality care and containing costs under this section.

''(B) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered outpatient prescription drug under this section shall not be so considered if payment for such drug is available under part A or under this part (other than under this section).''.

(b) NO EFFECT ON PART B PREMIUM.—

(1) IN GENERAL.—Section 1839(a) (42 U.S.C. 1395r(a)) is amended by adding at the end the following new paragraph:

''(5) Notwithstanding the previous provisions of this subsection, in computing actuarial rates there shall not be taken into account benefits and administrative costs that are attributable to the prescription drug coverage provided under section 1845.''.

(2) GOVERNMENT CONTRIBUTION.—Section 1844(a)(1) (42 U.S.C. 1395w(a)(1)) is amended—

(A) by striking ''plus'' at the end of subparagraph (A);

(B) by striking ''; plus'' at the end of subparagraph (B) and inserting '', plus''; and

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

''(C) a Government contribution equal to the aggregate amounts expended from the Trust Fund for benefits and administrative expenses attributable to the prescription drug coverage provided under section 1845; plus''.

(c) MEDICARE AS PRIMARY PAYOR.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended by adding at the end the following new paragraph:

''(7) EXCEPTION FOR OUTPATIENT PRESCRIPTION DRUG BENEFIT.—The previous provisions of this subsection shall not apply to benefits provided under section 1845.''.

TITLE II—BENEFITS FOR LOW-INCOME BENEFICIARIES

SEC. 201. BENEFITS FOR LOW-INCOME BENEFICIARIES.

(a) IN GENERAL.—Section 1845, as inserted by section 101(b), is amended by adding at the end the following new subsection:

''(g) FIRST DOLLAR COVERAGE FOR CERTAIN LOW-INCOME INDIVIDUALS.—

''(1) IN GENERAL.—In the case of a subsidy eligible individual (as defined in paragraph (2)), this section shall be applied as if the annual deductible were equal to zero but, with respect to costs incurred before the amount of the annual deductible otherwise applicable, the following copayment amounts shall apply:

''(A) 20 PERCENT COPAYMENT FOR INDIVIDUALS WITH INCOMES UP TO 135 PERCENT OF POVERTY.—For subsidy eligible individuals with income that does not exceed 135 percent of the poverty line, the copayment amounts shall be the copayments amounts specified in

subsection (a)(3), which reflects an average benefit percentage of 80 percent.

''(B) 30 PERCENT COPAYMENT FOR INDIVIDUALS WITH INCOMES BETWEEN 135 AND 150 PERCENT OF POVERTY.—For subsidy eligible individuals with income that exceeds 135 percent (but does not exceed 150 percent) of the poverty line, the copayment amounts shall be the copayments amounts specified in subsection (a)(3) increased by 50 percent, which reflects an average benefit percentage of 70 percent.

''(C) 50 PERCENT COPAYMENT FOR INDIVIDUALS WITH INCOMES ABOVE 150 PERCENT OF POVERTY.—For subsidy eligible individuals with income that exceeds 150 percent of the poverty line, the copayment amounts shall be the copayments amounts specified in subsection (a)(3) increased by 150 percent, which reflects an average benefit percentage of 50 percent.

''(2) DETERMINATION OF ELIGIBILITY.—

''(A) SUBSIDY ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this subsection, subject to subparagraph (D), the term 'subsidy eligible individual' means an individual who—

''(i) is enrolled under this part;

"(ii) has income below 150 percent (or such higher percent, not to exceed 200 percent, as a State may specify under subparagraph (B)) of the Federal poverty line; and

"(iii) is not eligible for medical assistance with respect to prescription drugs under title XIX.

For purposes of this section, an individual shall not be treated as eligible for medical assistance with respect to prescription drugs under title XIX (including under a waiver under section 1115) only if, with respect to such assistance, the individual is charged a copayment greater than a nominal amount (as described in section 1916(a)(3)) and there is no monthly or similar dollar limit established for the amount of such assistance over any period of time.

"(B) COVERAGE OF INDIVIDUALS WITH INCOME UP TO 200 PERCENT OF POVERTY AT STATE OPTION.—One of the 50 States or the District of Columbia may, at its option and subject to section 1935(c), specify a percent of income, that exceeds 150 percent but does not exceed 200 percent, that will apply for purposes

of this subsection to individuals residing in the State.

''(C) DETERMINATIONS.—The determination of whether an individual residing in a State is a subsidy eligible individual shall be determined under the State medicaid plan for the State under section 1935(a) or by the Social Security Administration. There are authorized to be appropriated to the Social Security Administration such sums as may be necessary for the determination of eligibility under this subparagraph.

''(D) INCOME DETERMINATIONS.—For purposes of applying this subsection—

''(i) income shall be determined in the manner no less restrictive than the manner described in section 1905(p)(1)(B); and

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

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

"(3) ADMINISTRATION OF SUBSIDY PROGRAM.—The Secretary shall provide a process whereby, in the case of an individual who is determined to be a subsidy eligible individual and who is enrolled in a medicare-approved prescription drug plan—

"(A) the Secretary provides for a notification of the entity offering the plan that the individual is eligible for a subsidy under paragraph (1);

"(B) such entity adjusts the benefits for prescription drug coverage accordingly and submits to the Secretary information on the amount of such benefits provided; and

"(C) the Secretary periodically and on a timely basis reimburses the entity for the amount of such benefits (including reasonable related administrative costs) that are provided

only because of the application of this subsection.

''(4) RELATION TO MEDICAID PROGRAM.—

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

''(B) COORDINATION.—The Secretary shall develop and implement a plan for the coordination of prescription drug benefits under this part with the benefits provided under the medicaid program under title XIX, with particular attention to insuring coordination of payments and prevention of fraud and abuse. In developing and implementing such plan, the Secretary shall involve the States, the data processing industry, pharmacists, and pharmaceutical manufacturers, and other experts and representatives of low-income medicare beneficiaries.

''(C) EXEMPTION.—Section 1902(n) shall not apply with respect to coverage of cost-sharing imposed under paragraph (1) or under subsection (a)(3).''.

(b) MEDICAID AMENDMENTS.—

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

(A) REQUIREMENT.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

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

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

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

''(66) provide for making eligibility determinations under sections 1845(g) and 1935(a).''.

(2) NEW SECTION.—Title XIX of such Act is further amended—

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

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

''SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

''SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGIBILITY DETERMINATIONS FOR LOW-INCOME SUBSIDY.—

''(1) IN GENERAL.—As a condition of its State plan under this title under section 1902(a)(66) and

receipt of any Federal financial assistance under section 1903(a), a State shall—

"(A) make determinations of eligibility for subsidies under (and in accordance with) section 1845(g);

"(B) inform the Secretary of such determinations in cases in which such eligibility is established; and

"(C) otherwise provide the Secretary with such information as may be required to carry out section 1845.

"(2) STATE OPTION FOR COVERAGE OF ADDITIONAL LOW-INCOME INDIVIDUALS.—A State may elect under paragraph (2)(B) of section 1845(g) to cover additional low-income medicare beneficiaries under the prescription drug subsidy program provided under such subsection, subject to contribution under subsection (c).

"(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE COSTS.—

"(1) IN GENERAL.—The amounts expended by a State in carrying out subsection (a) are, subject to paragraph (2), expenditures reimbursable under the appropriate paragraph of section 1903(a); except that, notwithstanding any other provision of such

section, the applicable Federal matching rates with respect to such expenditures under such section shall be increased as follows (but in no case shall the rate as so increased exceed 100 percent):

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

"(B)(i) For expenditures attributable to costs incurred during 2006 and each subsequent year through 2013, the otherwise applicable Federal matching rate shall be increased by the applicable percent (as defined in clause (ii)) of the percentage otherwise payable (but for this subsection) by the State.

"(ii) For purposes of clause (i), the 'applicable percent' for—

"(I) 2006 is 20 percent; or

"(II) a subsequent year is the applicable percent under this clause for the previous year increased by 10 percentage points.

"(C) For expenditures attributable to costs incurred after 2013, the otherwise applicable

Federal matching rate shall be increased to 100 percent.

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

''(c) STATE CONTRIBUTION AT SCHIP MATCHING RATE TOWARDS ADDITIONAL LOW-INCOME SUBSIDIES FOR OPTIONAL SUBSIDY ELIGIBLE INDIVIDUALS COVERED UNDER STATE OPTION.—In the case of a State that specifies a percent of income under section 1845(g)(2)(B) for a quarter, the amount of payment made to the State under section 1903(a)(1) for the quarter shall be reduced by the product of—

''(1) 100 percent less the enhanced FMAP described in section 2105(b) for that State and quarter; and

''(2) the additional amount of payment made under section 1845 because of the application of such specification.''.

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

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

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

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

"(1) IN GENERAL.—For purposes of section 1903(a)(1), for a State that is one of the 50 States or the District of Columbia for a calendar quarter in a year (beginning with 2005) the amount computed under this subsection is equal to the product of the following:

"(A) MEDICARE BENEFITS FOR MEDICAID ELIGIBLES.—The total amount of payments made in the quarter because of the operation of section 1845 that are attributable to individuals who are residents of the State and are eligible for medical assistance with respect to prescription drugs under this title.

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

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

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

''(A) 2005 is 90 percent;

''(B) a subsequent year before 2014, is the phase-out proportion for calendar quarters in the previous year decreased by 10 percentage points; or

''(C) a year after 2013 is 0 percent.''.

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

''(e) MEDICAID AS SECONDARY PAYOR.—In the case of an individual who is entitled to benefits under part B of title XVIII and is eligible for medical assistance with respect to prescribed drugs under this title, medical assist-

ance shall continue to be provided under this title for prescribed drugs to the extent payment is not made under such part B, without regard to section 1902(n)(2).''.

(d) TREATMENT OF TERRITORIES.—

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

(A) in subsection (a) in the matter preceding paragraph (1), by inserting ''subject to subsection (f)'' after ''section 1903(a)'';

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

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

''(f) TREATMENT OF TERRITORIES.—

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

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

''(B) if the State establishes a plan described in paragraph (2) (for providing medical assistance with respect to the provision of prescription drugs to medicare beneficiaries under section 1845(g)), 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 under section 1845(g) with respect to the provision of covered outpatient drugs to low-income medicare beneficiaries whose income does not exceed an income level specified under the plan; and

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

''(3) INCREASED AMOUNT.—

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

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

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

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

''(i) 2005, is equal to $25,000,000; or

''(ii) a subsequent year, is equal to the aggregate amount specified in this subparagraph for the previous year increased by annual percentage increase specified in section 1845(a)(2)(B) for the year involved.

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

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

SEC. 202. IMPROVING ENROLLMENT PROCESS UNDER MEDICAID.

(a) AUTOMATIC REENROLLMENT WITHOUT NEED TO REAPPLY.—

(1) IN GENERAL.—Section 1905(p) (42 U.S.C. 1396d(p)) is amended—

(A) by redesignating paragraph (6) as paragraph (9); and

(B) by inserting after paragraph (5), the following new paragraph:

''(6) In the case of an individual who has been determined to qualify as a qualified medicare beneficiary or to be eligible for benefits under section 1902(a)(10)(E)(iii), the individual shall be deemed to continue to be so qualified or eligible without the need for any annual or periodic application unless and until the individual notifies the State that the individual's eligibility conditions have changed so that the individual is no longer so qualified or eligible.''.

(2) CONFORMING AMENDMENT.—Section 1902(e)(8) (42 U.S.C. 1396a(e)(8)) is amended by striking the second sentence.

(b) USE OF SIMPLIFIED APPLICATION PROCESS.—Such section 1905(p) is further amended by adding at the end the following new paragraph:

''(7) A State shall permit individuals to apply to qualify as a qualified medicare beneficiary or for benefits under section 1902(a)(10)(E)(iii) through the use of the simplified application form developed under section 1905(p)(5)(A) and shall permit such an application to be made over the telephone, the Internet, or by mail, without

the need for an interview in person by the applicant or a representative of the applicant.''.

(c) ROLE OF SOCIAL SECURITY OFFICES.—

(1) ENROLLMENT AND PROVISION OF INFORMATION AT SOCIAL SECURITY OFFICES.—Such section is further amended by adding at the end the following new paragraph:

''(8) The Commissioner of Social Security shall provide, through local offices of the Social Security Administration—

''(A) for the enrollment under State plans under this title for appropriate medicare cost-sharing benefits for individuals who qualify as a qualified medicare beneficiary or for benefits under section 1902(a)(10)(E)(iii); and

''(B) for providing oral and written notice of the availability of such benefits.''.

(2) CLARIFYING AMENDMENT.—Section 1902(a)(5) (42 U.S.C. 1396a(a)(5)) is amended by inserting ''as provided in section 1905(p)(10)'' before ''except''.

(d) OUTSTATIONING OF STATE ELIGIBILITY WORKERS AT SSA FIELD OFFICES.—Section 1902(a)(55) (42 U.S.C. 1396a(a)(55)) is amended—

(1) by striking ''subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX)'' and inserting ''paragraph (10)(A)(i)(IV), (10)(A)(i)(VI), (10)(A)(i)(VII), (10)(A)(ii)(IX), or (10)(E)''; and

(2) in subparagraph (A), by inserting ''and in the case of applications of individuals for medical assistance under paragraph (10)(E), at locations that include field offices of the Social Security Administration''.

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