II

106TH CONGRESS
1ST SESSION

S. 1725

To amend title XVIII of the Social Security Act to modernize medicare supplemental policies so that outpatient prescription drugs are affordable and accessible for medicare beneficiaries.

IN THE SENATE OF THE UNITED STATES

OCTOBER 14, 1999

Mr. JEFFORDS 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 modernize medicare supplemental policies so that outpatient prescription drugs are affordable and accessible for 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 ''DrugGap Insurance for Seniors Act of 1999''.

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

Sec. 1. Short title; table of contents.
Sec. 2. Findings and purposes.
Sec. 3. Modernization of medicare supplemental benefit packages.

Sec. 4. Assistance to qualified low-income medicare beneficiaries.
Sec. 5. Grandfathering of current Medigap enrollees.
Sec. 6. Health insurance information, counseling, and assistance grants.
Sec. 7. NAIC study and report.

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress finds the following:

(1) Coverage of outpatient prescription drugs is the most important aspect of medical care not currently provided under the medicare program under title XVIII of the Social Security Act.

(2) The medicare program needs to be reformed, and should include provisions that provide access to outpatient prescription drugs for all medicare beneficiaries.

(3) Comprehensive medicare reform will require extensive time and effort, but Congress must act now to provide outpatient prescription drug coverage to the most vulnerable medicare beneficiaries until such time as the medicare program is reformed.

(4) Low-income medicare beneficiaries are the most vulnerable to the high cost of outpatient prescription drugs, since they are often not eligible to receive benefits under medicaid, yet have incomes too low to afford medicare supplemental policies that include coverage for outpatient prescription drugs.

(5) Medicare beneficiaries deserve meaningful choices among medicare supplemental policies, in-

cluding the option of purchasing affordable outpatient prescription drug-only medicare supplemental policies.

(6) Premiums for medicare supplemental policies have risen dramatically in recent years, and steps must be taken to keep premiums from rising out of the reach of medicare beneficiaries.

(7) Increased use of medicare supplemental policies does not represent sufficient structural medicare reform.

(b) PURPOSES.—The purposes of this Act are as follows:

(1) To provide medicare supplemental policies covering outpatient prescription drugs to low-income medicare beneficiaries at no cost.

(2) To provide expanded choice to all medicare beneficiaries by creating affordable drug-only medicare supplemental policies.

(3) To ensure that medicare supplemental policies are modernized in a manner that promotes competition and preserves affordability for all medicare beneficiaries.

SEC. 3. MODERNIZATION OF MEDICARE SUPPLEMENTAL BENEFIT PACKAGES.

(a) ADDITION OF DRUGGAP POLICIES AND MODIFICATION OF EXISTING MEDIGAP POLICIES.—Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following:

''(v) MODERNIZED BENEFIT PACKAGES FOR MEDICARE SUPPLEMENTAL POLICIES.—

''(1) PROMULGATION OF MODEL REGULATION.—

''(A) NAIC MODEL REGULATION.—If, within 9 months after the date of enactment of the DrugGap Insurance for Seniors Act of 1999, the National Association of Insurance Commissioners (in this subsection referred to as the ''NAIC'') changes the 1991 NAIC Model Regulation (described in subsection (p)) to incorporate—

''(i) limitations on the benefit packages that may be offered under a medicare supplemental policy consistent with paragraphs (2) and (3) of this subsection;

''(ii) an appropriate range of coverage options for outpatient prescription drugs, including at least a minimal level of coverage under each benefit package;

"(iii) a deductible for outpatient prescription drugs that is uniform across each benefit package;

"(iv) uniform language and definitions to be used with respect to such benefits;

"(v) uniform format to be used in the policy with respect to such benefits; and

"(vi) other standards to meet the additional requirements imposed by the amendments made by the DrugGap Insurance for Seniors Act of 1999;

subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy holders on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the '2000 NAIC Model Regulation').

"(B) REGULATION BY THE SECRETARY.—If the NAIC does not make the changes in the 1991 NAIC Model Regulation within the 9-month period specified in subparagraph (A), the Secretary shall promulgate, not later than 9

months after the end of such period, a regulation and subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy holders on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation as changed by the Secretary under this subparagraph (such changed regulation referred to in this section as the '2000 Federal Regulation').

''(C) DATE SPECIFIED.—

''(i) IN GENERAL.—Subject to clause (ii), the date specified in this subparagraph for a State is the date the State adopts the 2000 NAIC Model Regulation or 2000 Federal Regulation or 1 year after the date the NAIC or the Secretary first adopts such standards, whichever is earlier.

''(ii) STATES REQUIRING REVISIONS TO STATE LAW.—In the case of a State which the Secretary identifies, in consultation with the NAIC, as—

''(I) requiring State legislation (other than legislation appropriating

funds) in order for medicare supplemental policies to meet the 2000 NAIC Model Regulation or 2000 Federal Regulation; but

"(II) having a legislature which is not scheduled to meet in 2001 in a legislative session in which such legislation may be considered;

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 2000. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

"(D) CONSULTATION WITH WORKING GROUP.—In promulgating standards under this paragraph, the NAIC or Secretary shall consult with a working group composed of representatives of issuers of medicare supplemental policies, consumer groups, medicare beneficiaries, and other qualified individuals. Such represent-

atives shall be selected in a manner so as to assure balanced representation among the interested groups.

''(E) MODIFICATION OF STANDARDS IF MEDICARE BENEFITS CHANGE.—If benefits (including deductibles and coinsurance) under this title are changed and the Secretary determines, in consultation with the NAIC, that changes in the 2000 NAIC Model Regulation or 2000 Federal Regulation are needed to reflect such changes, the preceding provisions of this paragraph shall apply to the modification of standards previously established in the same manner as they applied to the original establishment of such standards.

''(2) CORE GROUP OF BENEFITS AND NUMBER OF BENEFIT PACKAGES.—The benefits under the 2000 NAIC Model Regulation or 2000 Federal Regulation shall provide—

''(A) for such groups or packages of benefits as may be appropriate taking into account the considerations specified in paragraph (3) and the requirements of the succeeding subparagraphs;

"(B) for identification of a core group of basic benefits common to all policies other than the medicare supplemental policies described in paragraph (12)(B); and

"(C) that, subject to paragraph (4)(B), the total number of different benefit packages (counting the core group of basic benefits described in subparagraph (B) and each other combination of benefits that may be offered as a separate benefit package) that may be established in all the States and by all issuers shall not exceed 10 plus the 2 benefit packages described in paragraph (11) and the 3 policies described in paragraph (12)(B).

"(3) BALANCE OF OBJECTIVES.—The benefits under paragraph (2) shall, to the extent possible, balance the objectives of—

"(A) ensuring that medicare supplemental policies are affordable for beneficiaries under this title, and that the policies modernized under this subsection do not have premiums higher than the medicare supplemental policies available on the date of enactment of the DrugGap Insurance for Seniors Act of 1999;

''(B) facilitating comparisons among policies;

''(C) avoiding adverse selection;

''(D) providing consumer choice;

''(E) providing market stability;

''(F) promoting competition;

''(G) including some drug coverage, however limited, in each of the 10 benefit packages described in paragraph (2)(C); and

''(H) ensuring that beneficiaries under this title receive the benefit of prices for outpatient prescription drugs negotiated by issuers of medicare supplemental policies under this section.

''(4) STATES MAY OFFER NEW OR INNOVATIVE SUPPLEMENTAL BENEFITS.—

''(A) COMPLIANCE WITH APPLICABLE 2000 NAIC MODEL REGULATION OR 2000 FEDERAL REGULATION REQUIRED.—

''(i) STATES.—Except as provided in subparagraph (B) or paragraph (6), no State with a regulatory program approved under subsection (b)(1) may provide for or permit the grouping of benefits (or language or format with respect to such bene-

fits) under a medicare supplemental policy unless such grouping meets the applicable 2000 NAIC Model Regulation or 2000 Federal Regulation.

''(ii) FEDERAL GOVERNMENT.—Except as provided in subparagraph (B), the Secretary may not provide for or permit the grouping of benefits (or language or format with respect to such benefits) under a medicare supplemental policy seeking approval by the Secretary unless such grouping meets the applicable 2000 NAIC Model Regulation or 2000 Federal Regulation.

''(B) ADDITIONAL BENEFITS.—The issuer of a medicare supplemental policy may offer the benefits described in subsection (p)(3)(B) under the circumstances described in such subsection as if each reference to '1991' were a reference to '2000'.

''(5) STATES MAY NOT RESTRICT CORE BENEFITS.—

''(A) MEDICARE SUPPLEMENTAL POLICIES SUBJECT TO STATE REGULATION.—Except as provided in subparagraph (B), this subsection shall not be construed as preventing a State

from restricting the groups of benefits that may be offered in medicare supplemental policies in the State.

''(B) MUST MAKE CORE BENEFITS AVAILABLE.—A State with a regulatory program approved under subsection (b)(1) may not restrict under subparagraph (A) the offering of a medicare supplemental policy consisting only of the core group of benefits described in paragraph (2)(B).

''(6) STATE ALTERNATIVE SIMPLIFICATION PROGRAMS.—The Secretary may waive the application of standards described in clauses (i) through (vi) of paragraph (1)(A) in those States that on the date of enactment of the DrugGap Insurance for Seniors Act of 1999 had in place an alternative simplification program.

''(7) DISCOUNTS FOR ITEMS AND SERVICES NOT COVERED UNDER MEDICARE SUPPLEMENTAL POLICIES.—This subsection shall not be construed as preventing an issuer of a medicare supplemental policy who otherwise meets the requirements of this section from providing, through an arrangement with a vendor, for discounts from that vendor to policy holders or certificate holders for the purchase of

items or services not covered under its medicare supplemental policies or under this title, including the issuance of drug discount cards.

''(8) CIVIL PENALTY FOR VIOLATION OF THE MODEL REGULATION.—Except as provided in paragraph (10), any person who sells or issues a medicare supplemental policy, on and after the effective date specified in paragraph (1)(C), in violation of the applicable 2000 NAIC Model Regulation or 2000 Federal Regulation insofar as such regulation relates to the requirements of subsection (o) or (q) or clauses (i) through (vi) of paragraph (1)(A) is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a seller who is not an issuer of a policy) for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

''(9) REQUIREMENTS OF SELLERS.—

''(A) CORE BENEFIT PACKAGE.—Anyone who sells a medicare supplemental policy to an individual shall make available for sale to the

individual a medicare supplemental policy with only the core group of basic benefits (described in paragraph (2)(B)).

''(B) OUTLINE OF COVERAGE.—Anyone who sells a medicare supplemental policy to an individual shall provide the individual, before the sale of the policy, an outline of coverage which describes the benefits under the policy. Such outline shall be on a standard form approved by the State regulatory program or the Secretary (as the case may be) consistent with the 2000 NAIC Model Regulation or 2000 Federal Regulation under this subsection.

''(C) PENALTIES.—Whoever sells a medicare supplemental policy in violation of this paragraph is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a seller who is not the issuer of the policy) for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(D) EFFECTIVE DATE.—Subject to paragraph (10), this paragraph shall apply to sales of policies occurring on or after the effective date specified in paragraph (1)(C).

"(10) SAFE HARBOR FOR SELLERS.—No penalty may be imposed under paragraph (8) or (9) in the case of a seller who is not the issuer of a policy until the Secretary has published a list of the groups of benefit packages that may be sold or issued consistent with paragraph (1)(A)(i).

"(11) ADDITION OF HIGH DEDUCTIBLE MEDICARE SUPPLEMENTAL POLICIES.—For purposes of paragraph (2), the benefit packages described in this paragraph are the benefit packages modernized under this subsection that the Secretary determines are most comparable to the benefit packages described in subsection (p)(11).

"(12) DRUGGAP MEDICARE SUPPLEMENTAL POLICIES.—

"(A) ESTABLISHMENT OF DRUG-ONLY MEDICARE SUPPLEMENTAL POLICIES.—

"(i) IN GENERAL.—There are established 3 benefit packages, consistent with the benefit packages described in subparagraph (B), that—

"(I) consist of only outpatient prescription drug benefits;

"(II) may be designed to incorporate the utilization management techniques described in subparagraph (C);

"(III) do not include benefits for prescription drugs otherwise available under part A or B; and

"(IV) do not include benefits for any prescription drug excluded by the State in which the medicare supplemental policy is issued or sold under section 1927(d).

"(ii) DEFINITION.—In this section, the term 'DrugGap medicare supplemental policy' means a medicare supplemental policy (as defined in subsection (g)(1)) that has 1 of the benefit packages described in subparagraph (B).

"(B) BENEFIT PACKAGES DESCRIBED.—The benefit packages for DrugGap medicare supplemental policies described in this paragraph are as follows:

"(i) STANDARD DRUGGAP BENEFIT PACKAGES.—

"(I) STANDARD DRUGGAP.—A Standard DrugGap medicare supplemental policy that provides a deductible not to exceed $250, coinsurance not to exceed 20 percent, and a $5,000 maximum benefit.

"(II) LOW-COST STANDARD DRUGGAP.—A Low-Cost Standard DrugGap medicare supplemental policy that provides a deductible not to exceed $750, coinsurance not to exceed 30 percent, and a $5,000 maximum benefit.

"(ii) STOP-LOSS DRUGGAP BENEFIT PACKAGE.—A Stop-Loss DrugGap medicare supplemental policy that provides a stop-loss coverage benefit that limits the application of any beneficiary cost-sharing during a year after the beneficiary incurs out-of-pocket covered expenditures in excess of $5,000, or, in the case that the beneficiary owns a DrugGap medicare supplemental policy described in clause (i),

such beneficiary reaches the maximum benefit under such policy.

''(iii) MAXIMUM BENEFIT DEFINED.—In this paragraph, the term 'maximum benefit' means the total amount paid for covered outpatient prescription drugs, including any amounts paid by the issuer of the DrugGap medicare supplemental policy and any cost-sharing paid by the policyholder.

''(C) USE OF UTILIZATION MANAGEMENT TECHNIQUES.—

''(i) FORMULARIES.—An issuer may use a formulary to contain costs under any benefit package established under subparagraph (A)(i) only if the issuer—

''(I) includes in the formulary at least 1 drug from each therapeutic class and provides at least 1 generic equivalent, if available; and

''(II) provides for coverage of otherwise covered nonformulary drugs when a nonformulary alternative is medically necessary and appropriate.

''(ii) OTHER UTILIZATION MANAGEMENT TECHNIQUES.—Nothing in this part shall be construed as preventing an issuer offering DrugGap medicare supplemental policies from using reasonable utilization management techniques, including generic drug substitution, consistent with applicable law.''.

(b) DRUGGAP MEDIGAP POLICIES DO NOT DUPLICATE OTHER MEDIGAP POLICIES.—Section 1882(d)(3) of the Social Security Act (42 U.S.C. 1395ss(d)(3)) is amended—

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

''(ix) Nothing in this subparagraph shall be construed as preventing the sale of a DrugGap policy to an individual, provided that the sale is of a DrugGap policy that does not duplicate any health benefits under a medicare supplemental policy owned by the individual.'';

(2) in subparagraph (B)(ii)(I), by inserting ''and one DrugGap medicare supplemental policy'' before the comma; and

(3) in subparagraph (B)(iii)—

(A) in subclause (I), by striking ''(II) and (III)'' and inserting ''(II), (III), and (IV)'';

(B) by redesignating subclause (III) as subclause (IV); and

(C) by inserting after subclause (II) the following:

''(III) If the statement required by clause (i) is obtained and indicates that the individual is enrolled in 1 or more medicare supplemental policies, the sale of a DrugGap policy is not in violation of clause (i) if such DrugGap policy does not duplicate health benefits under any policy in which the individual is enrolled.''.

(c) ENROLLMENT IN CASE OF INVOLUNTARY TERMINATIONS OF COVERAGE.—Section 1882(s)(3)(C)(i) of the Social Security Act (42 U.S.C. 1395ss(s)(3)(C)(i)) is amended by striking ''under subsection (p)(2)'' and inserting ''under subsection (v)(2), a Standard DrugGap medicare supplemental policy under the standards established under subsection (v)(12)(B)(i), and a Stop-Loss DrugGap medicare supplemental policy under the standards established under subsection (v)(12)(B)(ii)''.

(d) SPECIAL ENROLLMENT PERIOD.—Section 1882(n) of the Social Security Act (42 U.S.C. 1395ss(n)) is amended by adding at the end the following:

''(7)(A) No medicare supplemental policy of the issuer shall be deemed to meet the standards in subsection (c) unless the issuer—

''(i) provides written notice, within a 60-day period specified in the modernization of the medicare supplemental policies under subsection (v), to the policyholder or certificate holder (at the most recent available address) of the offer described in clause (ii); and

''(ii) offers the individual under the terms described in subparagraph (B), during a period of 180 days beginning on the date specified in subparagraph (C), institution of coverage effective as of the date specified in the modernization described in clause (i) for such purpose, for any policy described under subsection (v).

''(B) The terms described under this subparagraph are terms which do not—

''(i) deny or condition the issuance or effectiveness of a medicare supplemental 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 medical condition; or

''(iii) impose an exclusion of benefits based on a preexisting condition under such policy.

''(C) The date specified in this subparagraph for a policy issued in a State is such date as the Secretary, in consultation with the NAIC, specifies (taking into account the method used under paragraph (4) for establishing a date under this subsection).''.

(e) CONFORMING AMENDMENTS.—Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended—

(1) in subsection (a)(2)—

(A) in the matter preceding subparagraph (A), by striking ''(p)'' and inserting ''(v)'';

(B) in subparagraph (A)—

(i) by striking ''1991'' each place it appears and inserting ''2000''; and

(ii) by striking ''(p)'' and inserting ''(v)''; and

(C) in the matter following subparagraph (B), by striking ''(p)'' and inserting ''(v)'';

(2) in subsection (o)—

(A) in paragraph (1), by striking ''(p)'' and inserting ''(v)''; and

(B) in paragraph (2), by striking ''(p)'' and inserting ''(v)''; and

(3) in subsection (r)—

(A) in paragraph (1)—

(i) in the matter preceding subparagraph (A), by striking ''(p)'' and inserting ''(v)''; and

(ii) in the matter following subparagraph (B), by striking ''(p)'' and inserting ''(v)''; and

(B) in paragraph (2)(A)—

(i) by striking ''(p)'' and inserting ''(v)''; and

(ii) by striking ''the date specified in section 171(m)(4) of the Social Security Act Amendments of 1994'' and inserting ''the date of enactment of the DrugGap Insurance for Seniors Act of 1999''.

SEC. 4. ASSISTANCE TO QUALIFIED LOW-INCOME MEDICARE BENEFICIARIES.

(a) IN GENERAL.—Part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) is amended by adding at the end the following:

''SEC. 1849. ASSISTANCE TO QUALIFIED LOW-INCOME MEDICARE BENEFICIARIES.

''(a) QUALIFIED LOW-INCOME MEDICARE BENEFICIARY DEFINED.—For purposes of this part, the term 'qualified low-income medicare beneficiary' means an individual—

''(1) who is—

''(A) entitled to benefits under part A;

''(B) enrolled under this part; and

''(C) who does not have coverage for outpatient prescription drugs through enrollment in a Medicare+Choice plan offered by a Medicare+Choice organization under part C or in a group health plan;

''(2) who would be eligible for medical assistance under title XIX but for the fact that the individual's income exceeds the income level (expressed as a percentage of the poverty line) established by the State for eligibility for medical assistance under such title, including at least the care and services listed in paragraphs (1) through (5), (17), and (21) of section 1905(a), but does not exceed the lesser of—

''(A) 50 percentage points above such income level; or

''(B) 200 percent of the poverty line; and

''(3) who is enrolled in—

''(A) a Standard DrugGap medicare supplemental policy and a Stop-Loss DrugGap medicare supplemental policy as such policies

are described in clauses (i)(I) and (ii) of section 1882(v)(12)(B), respectively; or

''(B) a Low-Cost Standard DrugGap medicare supplemental policy and a Stop-Loss DrugGap medicare supplemental policy as such policies are described in clauses (i)(II) and (ii) of section 1882(v)(12)(B), respectively.

''(b) PROGRAM ADMINISTERED BY THE STATES.—

''(1) IN GENERAL.—The Secretary shall establish an arrangement with each State (as defined under section 1861(x)) under which the State performs the functions described in paragraphs (2) through (4).

''(2) ANNUAL ELIGIBILITY.—The State shall determine whether a beneficiary under this title in the State is a qualified low-income medicare beneficiary. A determination that such an individual is a qualified low-income medicare beneficiary shall remain valid for a period of 12 months but is conditioned upon continuing enrollment in medicare supplemental policies described in subsection (a)(4).

''(3) COMPUTATION OF STATE WEIGHTED AVERAGE PREMIUM FOR STANDARD DRUGGAP AND STOP-LOSS DRUGGAP MEDICARE SUPPLEMENTAL POLICIES.—For each year, the State shall compute

a State weighted average premium equal to the weighted average of the premiums for medicare supplemental policies described in clause (i)(I) of section 1882(v)(12)(B) and the medicare supplemental policies described in clause (ii) of such section for the State, with the weight for each medicare supplemental policy being equal to the average number of beneficiaries under this title enrolled under such policy in the previous year. In the initial year that such medicare supplemental policies are available, the State shall estimate the State weighted average premium for each type of policy.

''(4) PAYMENT BY STATES ON BEHALF OF QUALIFIED LOW-INCOME MEDICARE BENEFICIARIES.—The State shall provide for payment to the appropriate entity on behalf of a qualified low-income medicare beneficiary for a year in an amount equal to—

''(A) for the medicare supplemental policy described under clause (i) of section 1882(v)(12)(B) in which such beneficiary is enrolled, the lesser of—

''(i) the amount of the State weighted average premium (as computed under

paragraph (3)) for the policies described under subclause (I) of such clause; or

''(ii) the full quoted premium for the policy;

''(B) for the medicare supplemental policy described under clause (ii) of section 1882(v)(12)(B) in which such beneficiary is enrolled, the lesser of—

''(i) the amount of the State weighted average premium (as computed under paragraph (3)) for the policies described under such clause; or

''(ii) the full quoted premium for the policy; and

''(C) such beneficiary out-of-pocket expenses related to the supplemental benefits provided under the policies described in subparagraphs (A) and (B) as the State determines is appropriate.

''(c) PAYMENTS TO STATES.—

''(1) REIMBURSEMENT FROM FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—Each calendar quarter in a fiscal year, the Secretary shall pay to each State from the Federal Supplementary Medical Insurance Trust Fund under sec-

tion 1841 an amount equal to the amount paid by the State under subsection (b)(4).

''(2) EXCLUSION OF ADDITIONAL PART B COSTS FROM DETERMINATION OF PART B PREMIUM.—In estimating the benefits and administrative costs that will be payable from the Federal Supplementary Medical Insurance Trust Fund for a year for purposes of determining the monthly premium rate under section 1839(a)(3), the Secretary shall exclude an estimate of any benefits and administrative costs attributable to the application of this section.

''(3) CONSTRUCTION RELATIVE TO OTHER BENEFITS.—Nothing in this section shall be construed as requiring a State, under its plan under title XIX, to be responsible for any portion of the subsidy or beneficiary cost-sharing provided under this section to qualified low-income medicare beneficiaries.

''(d) MAINTENANCE OF STATE EFFORT REQUIREMENT.—In the case of any State in which the income level (expressed as a percentage of the poverty line) established by the State for eligibility for medical assistance under title XIX (that includes at least the care and services listed in paragraphs (1) through (5), (17), and (21) of section 1905(a)) is less than 150 percent of the poverty line appli-

cable to a family of the size involved in a calendar quarter in a fiscal year—

''(1) no payment may be made to such State under section 1849(c) for a calendar quarter in a fiscal year unless the State demonstrates to the satisfaction of the Secretary that the expenditures of the State for any State-funded prescription drug program for which individuals entitled to benefits under this section are eligible during the fiscal year is not less than the level of such expenditures for fiscal year 1999; and

''(2) payments shall not be made under this section for coverage of prescription drugs to the extent that—

''(A) payment is made under such a program; or

''(B) the Secretary determines payment would be made under such a program as in effect on the date of enactment of the DrugGap Insurance for Seniors Act of 1999.

''(e) POVERTY LINE DEFINED.—The term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.''.

(b) CONFORMING AMENDMENT.—Section 1839(a)(3) of the Social Security Act (42 U.S.C. 1395r(a)(3)), as amended by section 5101(e) of the Tax and Trade Relief Extension Act of 1998 (contained in division J of Public Law 105–277), is amended by striking ''except as provided in subsection (g)'' and inserting ''except as provided in subsection (g) or section 1849(d)''.

SEC. 5. GRANDFATHERING OF CURRENT MEDIGAP ENROLLEES.

(a) IN GENERAL.—The amendments made by this Act shall take effect on the date of enactment of this Act, and shall apply to medicare supplemental policies issued or sold after the date specified in subsection (b), but shall not apply to the renewal of medicare supplemental policies that are in existence on such date.

(b) DATE SPECIFIED.—The date specified in this subsection for each State is the date specified under section 1882(n)(7)(C) of the Social Security Act (42 U.S.C. 1395ss(n)(7)(C)) (as added by section 3(d) of this Act).

SEC. 6. HEALTH INSURANCE INFORMATION, COUNSELING, AND ASSISTANCE GRANTS.

(a) IN GENERAL.—Section 4360(b)(2)(A)(ii) of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1395b–4(b)(2)(A)(ii)) is amended by striking ''and information'' and inserting '', providing specific information re-

garding any DrugGap benefit medicare supplemental policy described under section 1882(v) of the Social Security Act (42 U.S.C. 1395ss(v)), and information''.

(b) AUTHORIZATION OF APPROPRIATIONS.—In addition to any amounts otherwise appropriated, there are authorized to be appropriated $50,000,000 for each fiscal year, beginning with the first year in which a DrugGap medicare supplemental policy described in section 1882(v)(12) is available, for the purpose of carrying out the provisions of section 4360 of the Omnibus Budget Reconciliation Act of 1990 (as amended by subsection (a)).

SEC. 7. NAIC STUDY AND REPORT.

(a) STUDY.—The Secretary of Health and Human Services shall contract with the National Association of Insurance Commissioners (referred to in this section as the ''NAIC'') to conduct a study of medicare supplemental policies offered under section 1882 of the Social Security Act (42 U.S.C. 1395ss) in order to identify—

(1) areas that are the cause of increasing medicare supplemental insurance claims costs (such as outpatient expenses) that affect the affordability of medicare supplemental policies;

(2) changes to Federal law (if any) required to address the issues identified under paragraph (1) to

make medicare supplemental policies more affordable for beneficiaries under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.); and

(3) methods of encouraging additional issuers to offer such policies and to reduce the cost of premiums for such policies.

(b) REPORT.—Not later than November 1, 2001, the NAIC shall submit a report to the Secretary of Health and Human Services on the study conducted under subsection (a) that contains a detailed statement of the findings and conclusions of the NAIC together with recommendations for such legislation and administrative actions as the NAIC considers appropriate.

(c) TRANSMISSION TO CONGRESS.—Not later than January 1, 2002, the Secretary of Health and Human Services shall transmit the report submitted under subsection (b) to Congress together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

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