I

107TH CONGRESS
1ST SESSION

H. R. 2632

To amend title XVIII of the Social Security Act to provide Medicare beneficiaries with access to affordable outpatient prescription drugs.

IN THE HOUSE OF REPRESENTATIVES

JULY 25, 2001

Mr. FOLEY (for himself, Mrs. CAPITO, and Mr. TERRY) 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 title XVIII of the Social Security Act to provide Medicare beneficiaries with access to affordable outpatient prescription drugs.

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 Drug Discount and Security Act of 2001''.

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

SEC. 2. VOLUNTARY MEDICARE OUTPATIENT PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by redesignating part D as part E and by inserting after part C the following new part:

''PART D—VOLUNTARY MEDICARE OUTPATIENT PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM

''DEFINITIONS

''SEC. 1860. In this part:

''(1) COMMISSIONER.—The term 'Commissioner' means the Commissioner of Medicare Prescription Drugs appointed under section 1860S(a).

''(2) COVERED OUTPATIENT DRUG.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'covered outpatient 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.

''(B) EXCLUSIONS.—

''(i) IN GENERAL.—The term 'covered outpatient 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 those restricted under subparagraph (E) of such section (relating to smoking cessation agents).

''(ii) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this part shall not be considered to be such a drug if payment for the drug is available under part A or B (but such drug shall be so considered if such payment is not available because the eligible beneficiary has exhausted benefits under part A or B), without regard to whether the individual is entitled to benefits under part A or enrolled under part B.

''(3) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual who is—

''(A) eligible for benefits under part A or enrolled under part B; and

''(B) not eligible for prescription drug coverage under a medicaid plan under title XIX.

''(4) ELIGIBLE ENTITY.—The term 'eligible entity' means any entity that the Commissioner determines to be appropriate to provide the benefits under this part, including—

''(A) pharmaceutical benefit management companies;

''(B) wholesale and retail pharmacy delivery systems;

''(C) insurers;

''(D) Medicare+Choice organizations;

''(E) other entities; or

''(F) any combination of the entities described in subparagraphs (A) through (E).

''(5) POVERTY LINE.—The term 'poverty line' means the income 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.

''SUBPART 1—ESTABLISHMENT OF VOLUNTARY MEDICARE OUTPATIENT PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM

''ESTABLISHMENT OF PROGRAM

''SEC. 1860A. (a) PROVISION OF BENEFIT.—The Commissioner shall establish a Medicare Outpatient Prescription Drug Discount and Security Program under which an eligible beneficiary may voluntarily enroll and receive benefits under this part through enrollment with an eligible entity with a contract under this part.

''(b) PROGRAM TO BEGIN IN 2003.—The Commissioner shall establish the program under this part in a manner so that benefits are first provided for months beginning with January 2003.

''(c) VOLUNTARY NATURE OF PROGRAM.—Nothing in this part shall be construed as requiring an eligible beneficiary to enroll in the program under this part.

''(d) FINANCING.—The costs of providing benefits under this part shall be payable from the Federal Supplementary Medical Insurance Trust Fund established under section 1841.

''ENROLLMENT

''SEC. 1860B. (a) ENROLLMENT UNDER PART D.—

''(1) ESTABLISHMENT OF PROCESS.—

''(A) IN GENERAL.—The Commissioner shall establish a process through which an eligible beneficiary (including an eligible beneficiary enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization) may make an election to enroll under this part. Except as otherwise provided in this subsection, such process shall be similar to the process for enrollment under part B under section 1837.

''(B) REQUIREMENT OF ENROLLMENT.—An eligible beneficiary must enroll under this

part in order to be eligible to receive the benefits under this part.

''(2) ENROLLMENT PERIODS.—

''(A) IN GENERAL.—Except as provided under subparagraph (B) or (C), an eligible beneficiary may not enroll in the program under this part during any period after the beneficiary's initial enrollment period under part B (as determined under section 1837).

''(B) SPECIAL ENROLLMENT PERIOD.—In the case of eligible beneficiaries that have recently lost eligibility for prescription drug coverage under a medicaid plan under title XIX, the Commissioner shall establish a special enrollment period in which such beneficiaries may enroll under this part.

''(C) OPEN ENROLLMENT PERIOD IN 2003 FOR CURRENT BENEFICIARIES.—The Commissioner shall establish a period, which shall begin on the date on which the Commissioner first begins to accept elections for enrollment under this part and shall end on December 31, 2003, during which any eligible beneficiary may—

''(i) enroll under this part; or

"(ii) enroll or re-enroll under this part after having previously declined or terminated such enrollment.

"(3) PERIOD OF COVERAGE.—

"(A) IN GENERAL.—Except as provided in subparagraph (B) and subject to subparagraph (C), an eligible beneficiary's coverage under the program under this part shall be effective for the period provided under section 1838, as if that section applied to the program under this part.

"(B) ENROLLMENT DURING OPEN AND SPECIAL ENROLLMENT.—Subject to subparagraph (C), an eligible beneficiary who enrolls under the program under this part under subparagraph (B) or (C) of paragraph (2) shall be entitled to the benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

"(C) LIMITATION.—Coverage under this part shall not begin prior to January 1, 2003.

"(4) PART D COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PARTS A AND B OR ELIGIBILITY FOR MEDICAL ASSISTANCE.—

''(A) IN GENERAL.—In addition to the causes of termination specified in section 1838, the Commissioner shall terminate an individual's coverage under this part if the individual is—

''(i) no longer enrolled in part A or B; or

''(ii) eligible for prescription drug coverage under a medicaid plan under title XIX.

''(B) EFFECTIVE DATE.—The termination described in subparagraph (A) shall be effective on the effective date of—

''(i) the termination of coverage under part A or (if later) under part B; or

''(ii) the coverage under title XIX.

''(b) ENROLLMENT WITH ELIGIBLE ENTITY.—

''(1) PROCESS.—

''(A) IN GENERAL.—The Commissioner shall establish a process through which an eligible beneficiary who is enrolled under this part shall make an annual election to enroll with any eligible entity that has been awarded a contract under this part and serves the geographic area in which the beneficiary resides.

''(B) RULES.—In establishing the process under subparagraph (A), the Commissioner shall use rules similar to the rules for enrollment and disenrollment with a Medicare+Choice plan under section 1851 (including the special election periods under subsection (e)(4) of such section).

''(2) MEDICARE+CHOICE ENROLLEES.—An eligible beneficiary who is enrolled under this part and enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization must enroll with an eligible entity in order to receive benefits under this part. The beneficiary may elect to receive such benefits from the Medicare+Choice organization in which the beneficiary is enrolled if the organization has been awarded a contract under this part.

''(3) COMPETITION.—Eligible entities with a contract under this part shall compete for beneficiaries on the basis of discounts, formularies, pharmacy networks, and other services provided for under the contract.

''(c) ENROLLMENT PERIOD FOR BENEFITS IN 2003.—The processes developed under subsections (a) and (b) shall ensure that eligible beneficiaries are permitted to enroll under this part and with an eligible entity prior

to January 1, 2003, in order to ensure that coverage under this part is effective as of such date.

''PROVIDING ENROLLMENT AND COVERAGE INFORMATION TO BENEFICIARIES

''SEC. 1860C. (a) ACTIVITIES.—The Commissioner shall provide for activities under this part to broadly disseminate information to eligible beneficiaries (and prospective eligible beneficiaries) regarding enrollment under this part and the prescription drug coverage made available by eligible entities with a contract under this part.

''(b) SPECIAL RULE FOR FIRST ENROLLMENT UNDER THE PROGRAM.—To the extent practicable, the activities described in subsection (a) shall ensure that eligible beneficiaries are provided with such information at least 60 days prior to the first enrollment period described in section 1860B(c).

''ENROLLEE PROTECTIONS

''SEC. 1860D. (a) GUARANTEED ISSUE AND NONDISCRIMINATION.—

''(1) GUARANTEED ISSUE.—

''(A) IN GENERAL.—An eligible beneficiary who is eligible to enroll with an eligible entity under section 1860B(b) for prescription drug coverage under this part at a time during which elections are accepted under this part with respect to the coverage shall not be denied enroll-

ment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

''(B) MEDICARE+CHOICE LIMITATIONS PERMITTED.—The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i), relating to default enrollment) of section 1851(g) (relating to priority and limitation on termination of election) shall apply to eligible entities under this subsection.

''(2) NONDISCRIMINATION.—An eligible entity offering prescription drug coverage under this part shall not establish a service area in a manner that would discriminate based on health or economic status of potential enrollees.

''(b) DISSEMINATION OF INFORMATION.—

''(1) GENERAL INFORMATION.—An eligible entity with a contract under this part shall disclose, in a clear, accurate, and standardized form to each eligible beneficiary enrolled for prescription drug coverage with such entity under this part at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such prescription drug coverage. Such information includes the following:

''(A) Access to covered outpatient drugs, including access through pharmacy networks.

''(B) How any formulary used by the eligible entity functions.

''(C) Grievance and appeals procedures.

''(2) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an eligible beneficiary, the eligible entity shall provide the information described in section 1852(c)(2) (other than subparagraph (D)) to such beneficiary.

''(3) RESPONSE TO BENEFICIARY QUESTIONS.—Each eligible entity offering prescription drug coverage under this part shall have a mechanism for providing specific information to enrollees upon request. The entity shall make available, through an Internet website and in writing upon request, information on specific changes in its formulary.

''(c) ACCESS TO COVERED BENEFITS.—

''(1) ENSURING PHARMACY ACCESS.—

''(A) IN GENERAL.—Each eligible entity with a contract under this part shall permit any pharmacy located in the area covered by such contract to participate in the pharmacy network of the eligible entity if the pharmacy agrees to

accept such operating terms as the eligible entity may specify, including any fee schedule, requirements relating to covered expenses, and quality standards relating to the provision of prescription drug coverage.

''(B) CONSTRUCTION.—Nothing in this paragraph shall be construed as requiring a pharmacy to participate in a pharmacy network of an eligible entity with a contract under this part to participate in any other coverage program of the eligible entity.

''(2) ACCESS TO NEGOTIATED PRICES FOR PRESCRIPTION DRUGS.—For requirements relating to the access of an eligible beneficiary to negotiated prices (including applicable discounts), see section 1860F(a).

''(3) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—Insofar as an eligible entity with a contract under this part uses a formulary, the following requirements must be met:

''(A) FORMULARY COMMITTEE.—The eligible entity must establish a pharmaceutical and therapeutic committee that develops the formulary. Such committee shall include at least 1 physician and at least 1 pharmacist.

''(B) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES.—The formulary must include drugs within all therapeutic categories and classes of covered outpatient drugs (although not necessarily for all drugs within such categories and classes).

''(C) APPEALS AND EXCEPTIONS TO APPLICATION.—The entity must have, as part of the appeals process under subsection (f)(2), a process for appeals for denials of coverage based on such application of the formulary.

''(d) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE; MEDICATION THERAPY MANAGEMENT PROGRAM.—

''(1) IN GENERAL.—For purposes of providing access to negotiated benefits under section 1860F(a) and the catastrophic benefit described in section 1860F(b), the eligible entity shall have in place—

''(A) an effective cost and drug utilization management program, including appropriate incentives to use generic drugs, when appropriate;

''(B) quality assurance measures and systems to reduce medical errors and adverse drug interactions, including a medication therapy

management program described in paragraph (2); and

"(C) a program to control fraud, abuse, and waste.

"(2) MEDICATION THERAPY MANAGEMENT PROGRAM.—

"(A) IN GENERAL.—A medication therapy management program described in this paragraph is a program of drug therapy management and medication administration provided by a community-based pharmacy that is designed to ensure that prescription drugs made available under this part are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

"(B) ELEMENTS.—Such program shall include—

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

"(ii) increased beneficiary adherence with prescription medication regimens

through medication refill reminders, special packaging, and other appropriate means.

''(C) DEVELOPMENT OF PROGRAM IN CO-OPERATION WITH LICENSED PHARMACISTS.—The program shall be developed in cooperation with licensed pharmacists and physicians.

''(D) CONSIDERATIONS IN PHARMACY FEES.—An eligible entity with a contract under this part shall establish fees for pharmacists, pharmacies, and others providing services under the medication therapy management program that take into account the resources and time used in implementing the program.

''(3) TREATMENT OF ACCREDITATION.—Section 1852(e)(4) (relating to treatment of accreditation) shall apply to prescription drug coverage provided under this part with respect to the following requirements, in the same manner as they apply to Medicare+Choice plans under part C with respect to the requirements described in a clause of section 1852(e)(4)(B):

''(A) Subsection (c)(1) (relating to access to covered benefits).

''(B) Subsection (g) (relating to confidentiality and accuracy of enrollee records).

''(e) GRIEVANCE MECHANISM.—Each eligible entity shall provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the eligible entity provides covered benefits) and eligible beneficiaries enrolled with the entity under this part in accordance with section 1852(f).

''(f) COVERAGE DETERMINATIONS, RECONSIDERATIONS, AND APPEALS.—

''(1) IN GENERAL.—An eligible entity shall meet the requirements of section 1852(g) with respect to covered benefits under the prescription drug coverage it offers under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

''(2) APPEALS OF FORMULARY DETERMINATIONS.—Under the appeals process under paragraph (1) an individual who is enrolled with an eligible entity with a contract under this part for prescription drug coverage may appeal any denial of coverage of a prescription drug to obtain coverage for a medically necessary covered outpatient drug that is not on the formulary of the eligible entity (established

under subsection (c)) if the prescribing physician determines that the therapeutically similar drug that is on the formulary is not effective for the enrollee or has significant adverse effects for the enrollee.

''(g) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—An eligible entity shall meet the requirements of section 1852(h) with respect to enrollees under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to enrollees under part C.

''ANNUAL ENROLLMENT FEE

''SEC. 1860E. (a) AMOUNT.—

''(1) IN GENERAL.—Except as provided in subsection (c), enrollment under the program under this part is conditioned upon payment of an annual enrollment fee of $25.

''(2) ANNUAL PERCENTAGE INCREASE.—

''(A) IN GENERAL.—In the case of any calendar year beginning after 2003, the dollar amount in paragraph (1) shall be increased by an amount equal to—

''(i) such dollar amount; multiplied by

''(ii) the inflation adjustment.

''(B) INFLATION ADJUSTMENT.—For purposes of subparagraph (A)(ii), the inflation ad-

justment for any calendar year is the percentage (if any) by which—

"(i) the average per capita aggregate expenditures for covered outpatient drugs in the United States for medicare beneficiaries, as determined by the Commissioner for the 12-month period ending in July of the previous year; exceeds

"(ii) such aggregate expenditures for the 12-month period ending with July 2003.

"(C) ROUNDING.—If any increase determined under clause (ii) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

"(b) COLLECTION OF ANNUAL ENROLLMENT FEE.—

"(1) IN GENERAL.—Unless the eligible beneficiary makes an election under paragraph (2), the annual enrollment fee described in subsection (a) shall be collected and credited to the Federal Supplementary Medical Insurance Trust Fund in the same manner as the monthly premium determined under section 1839 is collected and credited to such Trust Fund under section 1840.

''(2) DIRECT PAYMENT.—An eligible beneficiary may elect to pay the annual enrollment fee directly or in any other manner approved by the Commissioner. The Commissioner shall establish procedures for making such an election.

''(c) WAIVER.—The Commissioner shall waive the enrollment fee described in subsection (a) in the case of an eligible beneficiary whose income is below 200 percent of the poverty line.

''BENEFITS UNDER THE PROGRAM

''SEC. 1860F. (a) ACCESS TO NEGOTIATED PRICES.—

''(1) NEGOTIATED PRICES.—

''(A) IN GENERAL.—Subject to subparagraph (B), each eligible entity with a contract under this part shall provide each eligible beneficiary enrolled with the entity with access to negotiated prices (including applicable discounts) for such prescription drugs as the eligible entity determines appropriate. If such a beneficiary becomes eligible for the catastrophic benefit under subsection (b), the negotiated prices (including applicable discounts) shall continue to be available to the beneficiary for those prescription drugs for which payment may not be made under section 1860H(b). For purposes

of this subparagraph, the term 'prescription drugs' is not limited to covered outpatient drugs, but does not include any over-the-counter drug that is not a covered outpatient drug.

"(B) LIMITATIONS.—

"(i) FORMULARY RESTRICTIONS.—Insofar as an eligible entity with a contract under this part uses a formulary, the negotiated prices (including applicable discounts) for prescription drugs shall only be available for drugs included in such formulary.

"(ii) AVOIDANCE OF DUPLICATE COVERAGE.—The negotiated prices (including applicable discounts) for prescription drugs shall not be available for any drug prescribed for an eligible beneficiary if payment for the drug is available under part A or B (but such negotiated prices shall be available if payment under part A or B is not available because the beneficiary has not met the deductible or has exhausted benefits under part A or B).

''(2) DISCOUNT CARD.—The Commissioner shall develop a uniform standard card format to be issued by each eligible entity that may be used by an enrolled beneficiary to ensure the access of such beneficiary to negotiated prices under paragraph (1).

''(3) ENSURING DISCOUNTS IN ALL AREAS.—The Commissioner shall develop procedures that ensure that each eligible beneficiary that resides in an area where no eligible entity has been awarded a contract under this part is provided with access to negotiated prices for prescription drugs (including applicable discounts).

''(b) CATASTROPHIC BENEFIT.—

''(1) IN GENERAL.—Subject to paragraph (4) (relating to eligibility for the catastrophic benefit) and any formulary used by the eligible entity with which the eligible beneficiary is enrolled, the catastrophic benefit shall be administered as follows:

''(A) BENEFICIARIES WITH ANNUAL INCOMES BELOW 200 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose modified adjusted gross income (as defined in paragraph (4)(E)) is below 200 percent of the poverty line, the beneficiary shall not be responsible for making a payment for a covered

outpatient drug provided to the beneficiary in a year to the extent that the out-of-pocket expenses of the beneficiary for such drug, when added to the out-of-pocket expenses of the beneficiary for covered outpatient drugs previously provided in the year, exceed $1,200.

''(B) BENEFICIARIES WITH ANNUAL INCOMES BETWEEN 200 AND 400 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose modified adjusted gross income (as so defined) exceeds 200 percent, but does not exceed 400 percent, of the poverty line, the beneficiary shall not be responsible for making a payment for a covered outpatient drug provided to the beneficiary in a year to the extent that the out-of-pocket expenses of the beneficiary for such drug, when added to the out-of-pocket expenses of the beneficiary for covered outpatient drugs previously provided in the year, exceed $2,500.

''(C) BENEFICIARIES WITH ANNUAL INCOMES ABOVE 400 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose modified adjusted gross income (as so defined) exceeds 400 percent of the poverty

line, the beneficiary shall not be responsible for making a payment for a covered outpatient drug provided to the beneficiary in a year to the extent that the out-of-pocket expenses of the beneficiary for such drug, when added to the out-of-pocket expenses of the beneficiary for covered outpatient drugs previously provided in the year, exceed $5,000.

''(2) ANNUAL PERCENTAGE INCREASE.—

''(A) IN GENERAL.—In the case of any calendar year after 2003, the dollar amounts in paragraph (1) shall be increased by an amount equal to—

''(i) such dollar amount; multiplied by

''(ii) the inflation adjustment determined under section 1860E(a)(2)(B) for such calendar year.

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

''(3) ELIGIBLE ENTITY NOT AT RISK FOR CATASTROPHIC BENEFIT.—

''(A) IN GENERAL.—The Commissioner, and not the eligible entity, shall be at risk for

the provision of the catastrophic benefit under this subsection.

"(B) PROVISIONS RELATING TO PAYMENTS TO ELIGIBLE ENTITIES.—For provisions relating to payments to eligible entities for administering the catastrophic benefit under this subsection, see section 1860H.

"(4) CATASTROPHIC BENEFIT NOT AVAILABLE TO CERTAIN HIGH INCOME INDIVIDUALS.—

"(A) IN GENERAL.—An eligible beneficiary enrolled under this part whose modified adjusted gross income for a taxable year exceeds 600 percent of the poverty line shall not be eligible for the catastrophic benefit under this subsection.

"(B) BENEFICIARY STILL ELIGIBLE FOR DISCOUNT BENEFIT.—Nothing in subparagraph (A) shall be construed as affecting the eligibility of a beneficiary described in such subparagraph for the benefits under subsection (a).

"(C) PROCEDURES FOR DETERMINING MODIFIED ADJUSTED GROSS INCOME.—

"(i) IN GENERAL.—The Commissioner shall establish procedures for determining

the modified adjusted gross income of eligible beneficiaries enrolled under this part.

"(ii) CONSULTATION.—The Commissioner shall consult with the Secretary of the Treasury in making the determinations described in clause (i).

"(iii) DISCLOSURE OF INFORMATION.—Notwithstanding section 6103(a) of the Internal Revenue Code of 1986, the Secretary of the Treasury may, upon written request from the Commissioner, disclose to officers and employees of the Medicare Prescription Drug Agency such return information as is necessary to make the determinations described in clause (i). Return information disclosed under the preceding sentence may be used by officers and employees of the Medicare Prescription Drug Agency only for the purposes of, and to the extent necessary in, making such determinations.

"(D) DEFINITION OF MODIFIED ADJUSTED GROSS INCOME.—In this paragraph, the term 'modified adjusted gross income' means ad-

justed gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

"(i) determined without regard to sections 135, 911, 931, and 933 of such Code; and

"(ii) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax under such Code.

"(5) ENSURING CATASTROPHIC BENEFIT IN ALL AREAS.—The Commissioner shall develop procedures for the provision of the catastrophic benefit under this subsection to each eligible beneficiary that resides in an area where there are no eligible entities that have been awarded a contract under this part.

"SELECTION OF ENTITIES TO PROVIDE PRESCRIPTION DRUG COVERAGE

"SEC. 1860G. (a) ESTABLISHMENT OF BIDDING PROCESS.—The Commissioner shall establish a process under which the Commissioner accepts bids from eligible entities and awards contracts to the entities to provide the benefits under this part to eligible beneficiaries in an area.

"(b) SUBMISSION OF BIDS.—Each eligible entity desiring to enter into a contract under this part shall submit a bid to the Commissioner at such time, in such manner,

and accompanied by such information as the Commissioner may reasonably require.

''(c) AWARDING OF CONTRACTS.—

''(1) IN GENERAL.—The Commissioner shall, consistent with the requirements of this part and the goal of containing medicare program costs, award at least 2 contracts in each area, unless only 1 bidding entity meets the terms and conditions specified by the Commissioner under paragraph (2).

''(2) TERMS AND CONDITIONS.—The Commissioner shall not award a contract to an eligible entity under this section unless the Commissioner finds that the eligible entity is in compliance with such terms and conditions as the Commissioner shall specify.

''(3) COMPARATIVE MERITS.—In determining which of the eligible entities that submitted bids that meet the terms and conditions specified by the Commissioner under paragraph (2) to award a contract, the Commissioner shall consider the comparative merits of each of the bids.

''PAYMENTS TO ELIGIBLE ENTITIES FOR ADMINISTERING THE CATASTROPHIC BENEFIT

''SEC. 1860H. (a) IN GENERAL.—The Commissioner shall establish procedures for making payments to an eligi-

ble entity under a contract entered into under this part for—

"(1) providing covered outpatient prescription drugs to beneficiaries eligible for the catastrophic benefit in accordance with subsection (b); and

"(2) costs incurred by the entity in administering the catastrophic benefit in accordance with subsection (c).

"(b) PAYMENT FOR COVERED OUTPATIENT PRESCRIPTION DRUGS.—

"(1) IN GENERAL.—Except as provided in subsection (c) and subject to paragraph (2), the Commissioner may only pay an eligible entity for covered outpatient drugs furnished by the eligible entity to an eligible beneficiary enrolled with such entity under this part that is eligible for the catastrophic benefit under section 1860F(b).

"(2) LIMITATIONS.—

"(A) FORMULARY RESTRICTIONS.—Insofar as an eligible entity with a contract under this part uses a formulary, the Commissioner may not make any payment for a covered outpatient drug that is not included in such formulary.

"(B) NEGOTIATED PRICES.—The Commissioner may not pay an amount for a covered

outpatient drug furnished to an eligible beneficiary that exceeds the negotiated price (including applicable discounts) that the beneficiary would have been responsible for under section 1860F(a).

''(c) PAYMENT FOR ADMINISTRATIVE COSTS.—

''(1) PROCEDURES.—The procedures established under subsection (a)(1) shall provide for payment to the eligible entity of an administrative fee for each prescription filled by the entity for an eligible beneficiary—

''(A) who is enrolled with the entity; and

''(B) to whom subparagraph (A), (B), or (C) of section 1860F(b)(1) applies with respect to a covered outpatient drug.

''(2) AMOUNT.—The fee described in paragraph (1) shall be—

''(A) negotiated by the Commissioner; and

''(B) consistent with such fees paid under private sector pharmaceutical benefit contracts.

''(d) SECONDARY PAYER PROVISIONS.—The provisions of section 1862(b) shall apply to the benefits provided under this part.

''DETERMINATION OF INCOME LEVELS

''SEC. 1860I. (a) PROCEDURES.—The Commissioner shall establish procedures for determining the income lev-

els of eligible beneficiaries for purposes of sections 1860E(c) and 1860F(b).

''(b) PERIODIC REDETERMINATIONS.—Such income determinations shall be valid for a period (of not less than 1 year) specified by the Commissioner.

''APPROPRIATIONS

''SEC. 1860J. There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund established under section 1841, an amount equal to the amount by which the benefits and administrative costs of providing the benefits under this part exceed the enrollment fees collected under section 1860E.

''SUBPART 2—ESTABLISHMENT OF THE MEDICARE PRESCRIPTION DRUG AGENCY

''MEDICARE PRESCRIPTION DRUG AGENCY

''SEC. 1860S. (a) ESTABLISHMENT.—There is established, as an independent agency in the executive branch of the Government, a Medicare Prescription Drug Agency (in this part referred to as the 'Agency').

''(b) DUTY.—It shall be the duty of the Agency to administer the Medicare Outpatient Prescription Drug Discount and Security Program under subpart 1.

''COMMISSIONER; DEPUTY COMMISSIONER; OTHER OFFICERS

''SEC. 1860T. (a) COMMISSIONER OF MEDICARE PRESCRIPTION DRUGS.—

''(1) APPOINTMENT.—There shall be in the Agency a Commissioner of Medicare Prescription Drugs (in this subpart referred to as the 'Commissioner') who shall be appointed by the President, by and with the advice and consent of the Senate.

''(2) COMPENSATION.—The Commissioner shall be compensated at the rate provided for level I of the Executive Schedule.

''(3) TERM.—

''(A) IN GENERAL.—The Commissioner shall be appointed for a term of 6 years.

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

''(C) DELAYED APPOINTMENTS.—A Commissioner appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(D) REMOVAL.—An individual serving in the office of Commissioner may be removed from office only under a finding by the President of neglect of duty or malfeasance in office.

''(4) RESPONSIBILITIES.—The Commissioner shall be responsible for the exercise of all powers and the discharge of all duties of the Agency, and shall have authority and control over all personnel and activities thereof.

''(5) PROMULGATION OF RULES AND REGULATIONS.—

''(A) IN GENERAL.—The Commissioner may prescribe such rules and regulations as the Commissioner determines necessary or appropriate to carry out the functions of the Agency.

''(B) RULEMAKING.—The regulations prescribed by the Commissioner shall be subject to the rulemaking procedures established under section 553 of title 5, United States Code.

''(6) DELEGATION OF AUTHORITY.—

''(A) IN GENERAL.—The Commissioner may assign duties, and delegate, or authorize successive redelegations of, authority to act and to render decisions, to such officers and employ-

ees of the Agency as the Commissioner may find necessary.

''(B) EFFECT OF DELEGATION.—Within the limitations of such delegations, redelegations, or assignments, all official acts and decisions of such officers and employees shall have the same force and effect as though performed or rendered by the Commissioner.

''(7) CONSULTATION WITH SECRETARY OF HEALTH AND HUMAN SERVICES.—The Commissioner and the Secretary shall consult, on an ongoing basis, to ensure the coordination of the programs administered by the Commissioner with the programs administered by the Secretary under this title and under title XIX.

''(b) DEPUTY COMMISSIONER OF MEDICARE PRESCRIPTION DRUGS.—

''(1) APPOINTMENT.—There shall be in the Agency a Deputy Commissioner of Medicare Prescription Drugs (in this subpart referred to as the 'Deputy Commissioner') who shall be appointed by the President, by and with the advice and consent of the Senate.

''(2) TERM.—

''(A) IN GENERAL.—The Deputy Commissioner shall be appointed for a term of 6 years.

''(B) CONTINUANCE IN OFFICE.—In any case in which a successor does not take office at the end of a Deputy Commissioner's term of office, such Deputy Commissioner may continue in office until the entry upon office of such a successor.

''(C) DELAYED APPOINTMENT.—A Deputy Commissioner appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(3) COMPENSATION.—The Deputy Commissioner shall be compensated at the rate provided for level II of the Executive Schedule.

''(4) DUTIES.—

''(A) IN GENERAL.—The Deputy Commissioner shall perform such duties and exercise such powers as the Commissioner shall from time to time assign or delegate.

''(B) ACTING COMMISSIONER.—The Deputy Commissioner shall be Acting Commissioner of the Agency during the absence or disability of the Commissioner, unless the President des-

ignates another officer of the Government as Acting Commissioner, in the event of a vacancy in the office of the Commissioner.

''(c) CHIEF ACTUARY.—

''(1) APPOINTMENT.—

''(A) IN GENERAL.—There shall be in the Agency a Chief Actuary, who shall be appointed by, and in direct line of authority to, the Commissioner.

''(B) QUALIFICATIONS.—The Chief Actuary shall be appointed from individuals who have demonstrated, by their education and experience, superior expertise in the actuarial sciences.

''(C) DUTIES.—The Chief Actuary shall serve as the chief actuarial officer of the Agency, and shall exercise such duties as are appropriate for the office of the Chief Actuary and in accordance with professional standards of actuarial independence.

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

''ADMINISTRATIVE DUTIES OF THE COMMISSIONER

''SEC. 1860U. (a) PERSONNEL.—

''(1) IN GENERAL.—The Commissioner may employ, without regard to chapter 31 of title 5, United States Code, such officers and employees as are necessary to administer the activities to be carried out through the Medicare Prescription Drug Agency.

''(2) FLEXIBILITY WITH RESPECT TO CIVIL SERVICE LAWS.—

''(A) IN GENERAL.—The staff of the Medicare Prescription Drug Agency shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and, subject to subparagraph (B), shall be paid without regard to the provisions of chapters 51 and 53 of such title (relating to classification and schedule pay rates).

''(B) MAXIMUM RATE.—In no case may the rate of compensation determined under subparagraph (A) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(b) BUDGETARY MATTERS.—

''(1) SUBMISSION OF ANNUAL BUDGET.—The Commissioner shall prepare an annual budget for the Agency, which shall be submitted by the President to Congress without revision, together with the President's annual budget for the Agency.

''(2) APPROPRIATIONS REQUESTS.—

''(A) STAFFING AND PERSONNEL.—Appropriations requests for staffing and personnel of the Agency shall be based upon a comprehensive workforce plan, which shall be established and revised from time to time by the Commissioner.

''(B) ADMINISTRATIVE EXPENSES.—Appropriations for administrative expenses of the Agency are authorized to be provided on a biennial basis.

''(c) SEAL OF OFFICE.—

''(1) IN GENERAL.—The Commissioner shall cause a Seal of Office to be made for the Agency of such design as the Commissioner shall approve.

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

''(d) DATA EXCHANGES.—

''(1) DISCLOSURE OF RECORDS AND OTHER INFORMATION.—Notwithstanding any other provision

of law (including subsections (b), (o), (p), (q), (r), and (u) of section 552a of title 5, United States Code)—

"(A) the Secretary shall disclose to the Commissioner any record or information requested in writing by the Commissioner for the purpose of administering any program administered by the Commissioner, if records or information of such type were disclosed to the Administrator of the Health Care Financing Administration in the Department of Health and Human Services under applicable rules, regulations, and procedures in effect before the date of enactment of the Medicare Rx Drug Discount and Security Act of 2001; and

"(B) the Commissioner shall disclose to the Secretary or to any State any record or information requested in writing by the Secretary to be so disclosed for the purpose of administering any program administered by the Secretary, if records or information of such type were so disclosed under applicable rules, regulations, and procedures in effect before the date of enactment of the Medicare Rx Drug Discount and Security Act of 2001.

''(2) EXCHANGE OF OTHER DATA.—The Commissioner and the Secretary shall periodically review the need for exchanges of information not referred to in paragraph (1) and shall enter into such agreements as may be necessary and appropriate to provide information to each other or to States in order to meet the programmatic needs of the requesting agencies.

''(3) ROUTINE USE.—

''(A) IN GENERAL.—Any disclosure from a system of records (as defined in section 552a(a)(5) of title 5, United States Code) pursuant to this subsection shall be made as a routine use under subsection (b)(3) of section 552a of such title (unless otherwise authorized under such section 552a).

''(B) COMPUTERIZED COMPARISON.—Any computerized comparison of records, including matching programs, between the Commissioner and the Secretary shall be conducted in accordance with subsections (o), (p), (q), (r), and (u) of section 552a of title 5, United States Code.

''(4) TIMELY ACTION.—The Commissioner and the Secretary shall each ensure that timely action is taken to establish any necessary routine uses for dis-

closures required under paragraph (1) or agreed to under paragraph (2).

''MEDICARE COMPETITION AND PRESCRIPTION DRUG ADVISORY BOARD

''SEC. 1860V. (a) ESTABLISHMENT OF BOARD.—There is established a Medicare Prescription Drug Advisory Board (in this section referred to as the 'Board').

''(b) ADVICE ON POLICIES; REPORTS.—

''(1) ADVICE ON POLICIES.—On and after the date the Commissioner takes office, the Board shall advise the Commissioner on policies relating to the Medicare Outpatient Prescription Drug Discount and Security Program under subpart 1.

''(2) REPORTS.—

''(A) IN GENERAL.—With respect to matters of the administration of subpart 1, the Board shall submit to Congress and to the Commissioner of Medicare Prescription Drugs such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of such subpart. Each such report shall be published in the Federal Register.

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

''(c) STRUCTURE AND MEMBERSHIP OF THE BOARD.—

''(1) MEMBERSHIP.—The Board shall be composed of 7 members who shall be appointed as follows:

''(A) PRESIDENTIAL APPOINTMENTS.—

''(i) IN GENERAL.—Three members shall be appointed by the President, by and with the advice and consent of the Senate.

''(ii) LIMITATION.—Not more than 2 such members may be from the same political party.

''(B) SENATORIAL APPOINTMENTS.—Two members (each member from a different political party) 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.

''(C) CONGRESSIONAL APPOINTMENTS.—Two members (each member from a different political party) shall be appointed by the Speaker of the House of Representatives, with the advice of the Chairman and the Ranking Minority Member of the Committee on Ways and Means of the House of Representatives.

''(2) 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 education, experience, and attainments, exceptionally qualified to perform the duties of members of the Board.

''(d) TERMS OF APPOINTMENT.—

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

''(2) CONTINUANCE IN OFFICE AND STAGGERED TERMS.—

''(A) CONTINUANCE IN OFFICE.—A member appointed to a term of office after the commencement of such term may serve under such

appointment only for the remainder of such term.

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

''(i) PRESIDENTIAL APPOINTMENTS.—The terms of service of the members initially appointed by the President shall expire as designated by the President at the time of nomination, 1 each at the end of—

''(I) 2 years;

''(II) 4 years; and

''(III) 6 years.

''(ii) SENATORIAL APPOINTMENTS.—The terms of service of members initially appointed by the President pro tempore of the Senate shall expire as designated by the President pro tempore of the Senate at the time of nomination, 1 each at the end of—

''(I) 3 years; and

''(II) 6 years.

''(iii) CONGRESSIONAL APPOINTMENTS.—The terms of service of members

initially appointed by the Speaker of the House of Representatives shall expire as designated by the Speaker of the House of Representatives at the time of nomination, 1 each at the end of—

"(I) 4 years; and

"(II) 5 years.

"(C) REAPPOINTMENTS.—Any person appointed as a member of the Board may not serve for more than 8 years.

"(D) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Board shall be filled in the manner in which the original appointment was made.

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

"(f) EXPENSES AND PER DIEM.—Members of the Board shall serve without compensation, except that, while

serving on business of the Board away from their homes or regular places of business, members may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government employed intermittently.

''(g) MEETING.—

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

''(2) QUORUM.—Four members of the Board (not more than 3 of whom may be of the same political party) shall constitute a quorum for purposes of conducting business.

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

''(i) PERSONNEL.—

''(1) STAFF DIRECTOR.—The Board shall, without regard to the provisions of title 5, United States Code, relating to the competitive service, appoint a Staff Director who shall be paid at a rate equivalent

to a rate established for the Senior Executive Service under section 5382 of title 5, United States Code.

''(2) STAFF.—

''(A) IN GENERAL.—The Board may employ, without regard to chapter 31 of title 5, United States Code, such officers and employees as are necessary to administer the activities to be carried out by the Board.

''(B) FLEXIBILITY WITH RESPECT TO CIVIL SERVICE LAWS.—

''(i) IN GENERAL.—The staff of the Board shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and, subject to clause (ii), shall be paid without regard to the provisions of chapters 51 and 53 of such title (relating to classification and schedule pay rates).

''(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive

Schedule under section 5315 of title 5, United States Code.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, out of the Federal Supplemental Medical Insurance Trust Fund established under section 1841, and the general fund of the Treasury, such sums as are necessary to carry out the purposes of this section.''.

(b) CONFORMING REFERENCES TO PREVIOUS PART D.—

(1) IN GENERAL.—Any reference in law (in effect before the date of enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part E of such title (as in effect after such date).

(2) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of enactment of this section, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this section.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act.

(2) TIMING OF INITIAL APPOINTMENTS.—The Commissioner and Deputy Commissioner of Medicare Prescription Drugs may not be appointed before March 1, 2002.

SEC. 3. COMMISSIONER AS MEMBER OF THE BOARD OF TRUSTEES OF THE MEDICARE TRUST FUNDS.

(a) IN GENERAL.—Section 1841(b) of the Social Security Act (42 U.S.C. 1395t(b)) is amended by striking ''and the Secretary of Health and Human Services, all ex officio,'' and inserting '', the Secretary of Health and Human Services, and the Commissioner of Medicare Prescription Drugs, all ex officio,''.

(b) EFFECTIVE DATE.—The amendment made by this subsection shall take effect on March 1, 2002.

SEC. 4. EXCLUSION OF PART D COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.

Section 1839(g) of the Social Security Act (42 U.S.C. 1395r(g)) is amended—

(1) by striking ''attributable to the application of section'' and inserting ''attributable to—

''(1) the application of section'';

(2) by striking the period and inserting ''; and''; and

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

''(2) the Voluntary Medicare Outpatient Prescription Drug Discount and Security Program under part D.''.

SEC. 5. MEDIGAP REVISIONS.

Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

''(v) MODERNIZATION OF MEDICARE SUPPLEMENTAL POLICIES.—

''(1) PROMULGATION OF MODEL REGULATION.—

''(A) NAIC MODEL REGULATION.—If, within 9 months after the date of enactment of the Medicare Rx Drug Discount and Security Act of 2001, 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 revise the benefit package classified as 'J' under the standards established by subsection (p)(2) (including the benefit package classified

as 'J' with a high deductible feature, as described in subsection (p)(11)) so that—

"(i) the coverage for outpatient prescription drugs available under such benefit package is replaced with coverage for outpatient prescription drugs that complements but does not duplicate the benefits for outpatient prescription drugs that beneficiaries are otherwise entitled to under this title;

"(ii) a uniform format is used in the policy with respect to such revised benefits; and

"(iii) such revised standards meet any additional requirements imposed by the Medicare Rx Drug Discount and Security Act of 2001;

subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy holders on and after January 1, 2003, 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 '2003 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 January 1, 2003, 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 '2003 Federal Regulation').

''(C) CONSULTATION WITH WORKING GROUP.—In promulgating standards under this paragraph, the NAIC or Secretary shall consult with a working group similar to the working group described in subsection (p)(1)(D).

''(D) MODIFICATION OF STANDARDS IF MEDICARE BENEFITS CHANGE.—If benefits under part D of this title are changed and the

Secretary determines, in consultation with the NAIC, that changes in the 2003 NAIC Model Regulation or 2003 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) CONSTRUCTION OF BENEFITS IN OTHER MEDICARE SUPPLEMENTAL POLICIES.—Nothing in the benefit packages classified as 'A' through 'I' under the standards established by subsection (p)(2) (including the benefit package classified as 'F' with a high deductible feature, as described in subsection (p)(11)) shall be construed as providing coverage for benefits for which payment may be made under part D.

''(3) APPLICATION OF PROVISIONS AND CONFORMING REFERENCES.—

''(A) APPLICATION OF PROVISIONS.—The provisions of paragraphs (4) through (10) of subsection (p) shall apply under this section, except that—

''(i) any reference to the model regulation applicable under that subsection

shall be deemed to be a reference to the applicable 2003 NAIC Model Regulation or 2003 Federal Regulation; and

"(ii) any reference to a date under such paragraphs of subsection (p) shall be deemed to be a reference to the appropriate date under this subsection.

"(B) OTHER REFERENCES.—Any reference to a provision of subsection (p) or a date applicable under such subsection shall also be considered to be a reference to the appropriate provision or date under this subsection.".

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