I

107TH CONGRESS
1ST SESSION

H. R. 828

To amend title XVIII of the Social Security Act to expand coverage of preventive services under the Medicare Program and to provide coverage of outpatient prescription drugs under that program.

IN THE HOUSE OF REPRESENTATIVES

MARCH 1, 2001

Mr. GRUCCI 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 subseqently 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 expand coverage of preventive services under the Medicare Program and to provide coverage of outpatient prescription drugs under that program.

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 ''Senior's Health Care Choice Act of 2001''.

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

TITLE I—MEDICARE COVERAGE OF PREVENTIVE SERVICES

SEC. 101. COUNSELING FOR CESSATION OF TOBACCO USE.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by 102(a) and 105(a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554), is amended—

(1) in subparagraph (U), by striking ''and'' at the end;

(2) in subparagraph (V), by inserting ''and'' at the end; and

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

''(W) counseling for cessation of tobacco use (as defined in subsection (vv)) for individuals who have a history of tobacco use;''.

(b) SERVICES DESCRIBED.—Section 1861 of such Act (42 U.S.C. 1395x), as amended by section 102(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554), is amended by adding at the end the following new subsection:

''Counseling for Cessation of Tobacco Use

''(vv)(1) Except as provided in paragraph (2), the term 'counseling for cessation of tobacco use' means diagnostic, therapy, and counseling services for cessation of tobacco use which are furnished—

''(A) by or under the supervision of a physician; or

''(B) by any other health care professional who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.

''(2) The term 'counseling for cessation of tobacco use' does not include coverage for drugs or biologicals that are not otherwise covered under this title.''.

(c) ELIMINATION OF COST-SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)), as amended by section 105(c) and 223(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554), is amended—

(A) by striking ''and'' before ''(U)''; and

(B) by inserting before the semicolon at the end the following: '', and (V) with respect to counseling for cessation of tobacco use (as defined in section 1861(vv)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph''.

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of such Act (42 U.S.C. 1395l(b)) is amended—

(A) by striking ''and'' before ''(6)''; and

(B) by inserting before the period the following: '', and (7) such deductible shall not apply with respect to counseling for cessation of tobacco use (as defined in section 1861(vv))''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2002.

SEC. 102. SCREENING FOR HYPERTENSION.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) (as amended by section 101(a)) is amended—

(1) in subparagraph (V), by striking ''and'' at the end;

(2) in subparagraph (W), by inserting ''and'' at the end; and

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

''(X) screening for hypertension (as defined in subsection (ww)) not more frequently than once every 2 years for individuals with normotensive blood pressure measurements and annually for individuals with blood pressure measurements that are not normotensive;''.

(b) SERVICES DESCRIBED.—Section 1861 of such Act (42 U.S.C. 1395x) (as amended by section 101(b)) is amended by adding at the end the following new subsection:

''Screening for Hypertension

''(ww) The term 'screening for hypertension' means diagnostic services for hypertension which are furnished—

''(1) by or under the supervision of a physician; or

''(2) by any other health care professional who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the serv-

ices are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.''.

(c) ELIMINATION OF COST-SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as amended by section 101(c)(1)) is amended—

(A) by striking ''and'' before ''(V)''; and

(B) by inserting before the semicolon at the end the following: '', and (W) with respect to screening for hypertension (as defined in section 1861(ww)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;''.

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of such Act (42 U.S.C. 1395l(b)) (as amended by section 101(c)(2)) is amended—

(A) by striking ''and'' before ''(7)''; and

(B) by inserting before the period the following: '', and (8) such deductible shall not apply with respect to screening for hypertension (as defined in section 1861(ww))''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2002.

SEC. 103. COUNSELING FOR HORMONE REPLACEMENT THERAPY.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) (as amended by section 102(a)) is amended—

(1) in subparagraph (W), by striking ''and'' at the end;

(2) in subparagraph (X), by inserting ''and'' at the end; and

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

''(Y) counseling for hormone replacement therapy (as defined in subsection (xx));''.

(b) SERVICES DESCRIBED.—Section 1861 of such Act (42 U.S.C. 1395x) (as amended by section 102(b)) is amended by adding at the end the following new subsection:

''Counseling for Hormone Replacement Therapy

''(xx)(1) Except as provided in paragraph (2), the term 'counseling for hormone replacement therapy' means diagnostic, therapy, and counseling services for hormone replacement which are furnished—

''(A) by or under the supervision of a physician; or

''(B) by any other health care professional who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.

''(2) The term 'counseling for hormone replacement therapy' does not include coverage for drugs or biologicals that are not otherwise covered under this title.''.

(c) ELIMINATION OF COST-SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as amended by section 102(c)(1)) is amended—

(A) by striking ''and'' before ''(W)''; and

(B) by inserting before the semicolon at the end the following: '', and (X) with respect to counseling for hormone replacement therapy (as defined in section 1861(xx)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the

Secretary for the purposes of this subparagraph;''.

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of such Act (42 U.S.C. 1395l(b)) (as amended by section 102(c)(2)) is amended—

(A) by striking ''and'' before ''(8)''; and

(B) by inserting before the period the following: '', and (9) such deductible shall not apply with respect to counseling for hormone replacement therapy (as defined in section 1861(xx))''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2002.

SEC. 104. SCREENING FOR DIMINISHED VISUAL ACUITY.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) (as amended by section 103(a)) is amended—

(1) in subparagraph (X), by striking ''and'' at the end;

(2) in subparagraph (Y), by inserting ''and'' at the end; and

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

''(Z) screening for diminished visual acuity (as defined in subsection (yy));''.

(b) SERVICES DESCRIBED.—Section 1861 of such Act (42 U.S.C. 1395x) (as amended by section 103(b)) is amended by adding at the end the following new subsection:

''Screening for Diminished Visual Acuity

''(yy) The term 'screening for diminished visual acuity' means diagnostic services for screening for diminished visual acuity which are furnished by or under the supervision of an optometrist or ophthalmologist who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.''.

(c) ELIMINATION OF COST-SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as amended by section 103(c)(1)) is amended—

(A) by striking ''and'' before ''(X)''; and

(B) by inserting before the semicolon at the end the following: '', and (Y) with respect to screening for diminished visual acuity (as defined in section 1861(yy)), the amount paid

shall be 100 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;''.

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of such Act (42 U.S.C. 1395l(b)) (as amended by section 103(c)(2)) is amended—

(A) by striking ''and'' before ''(9)''; and

(B) by inserting before the period the following: '', and (10) such deductible shall not apply with respect to screening for diminished visual acuity (as defined in section 1861(yy))''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2002.

SEC. 105. SCREENING FOR HEARING IMPAIRMENT.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) (as amended by section 104(a)) is amended—

(1) in subparagraph (Y), by striking ''and'' at the end;

(2) in subparagraph (Z), by inserting ''and'' at the end; and

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

''(AA) screening for hearing impairment (as defined in subsection (zz));''.

(b) SERVICES DESCRIBED.—Section 1861 of such Act (42 U.S.C. 1395x) (as amended by section 104(b)) is amended by adding at the end the following new subsection:

''Screening for Hearing Impairment

''(zz) The term 'screening for hearing impairment' means diagnostic services for hearing impairment by use of periodic questions, otoscopic examination and audio metric testing if such questions indicate potential hearing impairment, and counseling about hearing aid devices which are furnished—

''(1) by or under the supervision of a physician; or

''(2) by any other health care professional who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.''.

(c) ELIMINATION OF COST-SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as amended by section 104(c)(1)) is amended—

(A) by striking ''and'' before ''(Y)''; and

(B) by inserting before the semicolon at the end the following: '', and (Z) with respect to screening for hearing impairment (as defined in section 1861(zz)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;''.

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of such Act (42 U.S.C. 1395l(b)) (as amended by section 104(c)(2)) is amended—

(A) by striking ''and'' before ''(10)''; and

(B) by inserting before the period the following: '', and (11) such deductible shall not apply with respect to screening for hearing impairment (as defined in section 1861(zz))''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2002.

SEC. 106. SCREENING AND COUNSELING FOR OSTEOPOROSIS.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) (as amended by section 105(a)) is amended—

(1) in subparagraph (Z), by striking ''and'' at the end;

(2) in subparagraph (AA), by inserting ''and'' at the end; and

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

''(BB) screening and counseling for osteoporosis (as defined in subsection (aaa)) for—

''(i) women; and

''(ii) men with fractures;''.

(b) SERVICES DESCRIBED.—Section 1861 of such Act (42 U.S.C. 1395x) (as amended by section 105(b)) is amended by adding at the end the following new subsection:

''Screening and Counseling for Osteoporosis

''(aaa) The term 'screening and counseling for osteoporosis' means diagnostic and counseling services for osteoporosis in addition to a bone mass measurement (as defined in subsection (rr)) which are furnished in accordance with methods approved by the Food and Drug Administration—

''(1) by or under the supervision of a physician; or

''(2) by any other health care professional who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.''.

(c) ELIMINATION OF COST-SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as amended by section 105(c)(1)) is amended—

(A) by striking ''and'' before ''(Z)''; and

(B) by inserting before the semicolon at the end and inserting the following: '', and (AA) with respect to screening and counseling for osteoporosis (as defined in section 1861(aaa)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;''.

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of such Act (42 U.S.C.

1395l(b)) (as amended by section 105(c)(2)) is amended—

(A) by striking ''and'' before ''(11)''; and

(B) by inserting before the period the following: '', and (12) such deductible shall not apply with respect to screening and counseling for osteoporosis (as defined in section 1861(aaa))''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2002.

SEC. 107. SCREENING FOR CHOLESTEROL.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) (as amended by section 106(a)) is amended—

(1) in subparagraph (AA), by striking ''and'' at the end;

(2) in subparagraph (BB), by inserting ''and'' at the end; and

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

''(CC) screening for cholesterol (as defined in subsection (bbb)) for individuals between the ages of 65 and 75 that exhibit major risk factors for coro-

nary heart disease, including smoking, hypertension, and diabetes;''.

(b) SERVICES DESCRIBED.—Section 1861 of such Act (42 U.S.C. 1395x) (as amended by section 106(b)) is amended by adding at the end the following new subsection:

''Screening for Cholesterol

''(bbb) The term 'screening for cholesterol' means diagnostic services for cholesterol that are furnished—

''(1) by or under the supervision of a physician; or

''(2) by any other health care professional who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.''.

(c) ELIMINATION OF COST-SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as amended by section 106(c)(1)) is amended—

(A) by striking ''and'' before ''(AA)''; and

(B) by inserting before the semicolon at the end the following: '', and (BB) with respect

to screening for cholesterol (as defined in section 1861(bbb)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;''.

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of such Act (42 U.S.C. 1395l(b)) (as amended by section 106(c)(2)) is amended—

(A) by striking ''and'' before ''(12)''; and

(B) by inserting before the period the following: '', and (13) such deductible shall not apply with respect to screening and counseling for osteoporosis (as defined in section 1861(bbb))''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2002.

SEC. 108. EXPANSION OF COVERAGE OF MEDICAL NUTRITION THERAPY SERVICES.

(a) EXPANSION OF MEDICAL NUTRITION THERAPY SERVICES TO BENEFICIARIES WITH A CARDIOVASCULAR DISEASE.—Section 1861(s)(2)(V) of the Social Security Act, as added by section 105(a) of the Medicare, Medicaid,

and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554), is amended by inserting ", a cardiovascular disease (including congestive heart failure, arteriosclerosis, hyperlipidemia, hypertension, and hypercholesterolemia),'' after ''diabetes''.

(b) ELIMINATION OF COST-SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as amended by section 107(c)(1)) is amended—

(A) by striking ''and'' before ''(BB)''; and

(B) by inserting before the semicolon at the end the following: ", and (CC) with respect to medical nutrition therapy services (as defined in section 1861(vv)(1)), the amount paid shall be 85 percent of the lesser of the actual charge for the services or the amount determined under the fee schedule established under section 1848(b) for the same services if furnished by a physician''.

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of such Act (42 U.S.C. 1395l(b)) (as amended by section 107(c)(2)) is amended—

(A) by striking ''and'' before ''(13)''; and

(B) by inserting before the period the following: ", and (14) such deductible shall not apply with respect to nutrition therapy services (as defined in section 1861(vv)(1))".

(c) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after January 1, 2002.

SEC. 109. EXPANSION OF COVERAGE OF GLAUCOMA SCREENING.

(a) EXPANSION OF GLAUCOMA SCREENING TO COVER INDIVIDUALS WITH MYOPIA.—Section 1861(s)(2)(U) of the Social Security Act, as added by section 101(a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554), is amended by inserting ''or myopia'' after ''diabetes''.

(b) ELIMINATION OF COST-SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as amended by section 108(b)(1) is amended—

(A) by striking ''and'' before ''(BB)''; and

(B) by inserting before the semicolon at the end the following: ", and (CC) with respect to screening for glaucoma (as defined in section 1861(uu)), the amount paid shall be 100 per-

cent of the lesser of the actual charge for the services or amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;''.

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of such Act (42 U.S.C. 1395l(b)) (as amended by section 108(b)(2)) is amended—

(A) by striking ''and'' before ''(14)''; and

(B) by inserting before the period the following: '', and (15) such deductible shall not apply with respect to screening for glaucoma (as defined in section 1861(uu))''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after January 1, 2002.

SEC. 110. ROUTINE ANNUAL PHYSICAL CHECKUPS.

(a) IN GENERAL.—Section 1862 of the Social Security Act (42 U.S.C. 1395y) is amended—

(1) in subsection (a)(7), by inserting ''subject to subsection (h),'' after ''(7)''; and

(2) by inserting after subsection (g) the following new subsection:

''(h)(1) The exclusion under subsection (a)(7) shall not include coverage of a routine annual physical checkup, including coverage of related laboratory tests.''.

(b) ELIMINATION OF COST-SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as amended by section 109(b)(1)) is amended—

(A) by striking ''and'' before ''(CC)''; and

(B) by inserting before the semicolon at the end the following: '', and (DD) with respect to routine annual physical checkups described in section 1862(h)(1), the amount paid shall be 100 percent of the lesser of the actual charge for the services or amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;''.

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of such Act (42 U.S.C. 1395l(b)) (as amended by section 109(b)(2)) is amended—

(A) by striking ''and'' before ''(15)''; and

(B) by inserting before the period the following: '', and (16) such deductible shall not apply with respect to routine annual physical checkups described in section 1862(h)(1)''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after January 1, 2002.

SEC. 111. ROUTINE ANNUAL DENTAL EXAMINATIONS AND CLEANING.

(a) IN GENERAL.—Section 1862 of the Social Security Act (42 U.S.C. 1395y), as amended by section 110(a), is amended—

(1) in subsection (a)(2), by inserting ''subject to subsection (h),'' after ''(7)''; and

(2) by adding at the end of subsection (h) the following new paragraph:

''(2) The exclusion subsection (a)(12) shall not include coverage of a routine annual dental examination and cleaning, including coverage of oral gum disease screening.''.

(b) ELIMINATION OF COST-SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as amended by section 110(b)(1)) is amended—

(A) by striking ''and'' before ''(DD)''; and

(B) by inserting before the semicolon at the end the following: '', and (EE) with respect to routine annual dental examination and cleaning described in section 1862(h)(2), the amount

paid shall be 100 percent of the lesser of the actual charge for the services or amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;''.

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of such Act (42 U.S.C. 1395l(b)) (as amended by section 110(b)(2)) is amended—

(A) by striking ''and'' before ''(16)''; and

(B) by inserting before the period the following: '', and (17) such deductible shall not apply with respect to routine annual dental examination and cleaning described in section 1862(h)(2)''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after January 1, 2002.

SEC. 112. ROUTINE ANNUAL EYE EXAMINATIONS.

(a) IN GENERAL.—Section 1862(h) of the Social Security Act (42 U.S.C. 1395y(h)), as inserted by section 111(a), is amended by adding at the end the following new paragraph:

''(3) The exclusion under subsection (a)(7) shall not include coverage of a routine annual eye examination, including a refraction, and of coverage per year of 1 pair

of glasses (or coverage of contract or other correctible lenses, up to the financial equivalence of a pair of glasses).''.

(b) ELIMINATION OF COST-SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as amended by section 111(b)(1)) is amended—

(A) by striking ''and'' before ''(EE)''; and

(B) by inserting before the semicolon at the end the following: '', and (FF) with respect to routine annual eye examinations and coverage of eyeglasses (or other lense equivalents) described in section 1862(h)(3), the amount paid shall be 100 percent of the lesser of the actual charge for the services or amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;''.

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of such Act (42 U.S.C. 1395l(b)) (as amended by section 111(b)(2)) is amended—

(A) by striking ''and'' before ''(17)''; and

(B) by inserting before the period the following: '', and (18) such deductible shall not apply with respect to routine annual eye exami-

nations and coverage of eyeglasses and other lenses described in section 1862(h)(3)''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after January 1, 2002.

TITLE II—MEDICARE PRESCRIPTION DRUG AND SUPPLEMENTAL BENEFIT PROGRAM

SEC. 201. ESTABLISHMENT OF PROGRAM.

(a) IN GENERAL.—The Social Security Act is amended by adding at the end the following new title:

''TITLE XXII—MEDICARE PRESCRIPTION DRUG BENEFIT PROGRAM

''ESTABLISHMENT OF PRESCRIPTION DRUG AND SUPPLEMENTAL BENEFIT PROGRAM

''SEC. 2201. (a) PROVISION OF BENEFIT.—The Secretary shall establish a Prescription Drug and Supplemental Benefit Program under which an eligible beneficiary may voluntarily enroll and receive access to covered outpatient prescription drugs and other benefits through enrollment in a Medicare Prescription Plus plan offered by a private entity or a Medicare+Choice plan offered by a Medicare+Choice organization.

''(b) PROGRAM TO BEGIN IN 2003.—The Secretary 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 Medicare Prescription Drug Account.

''(e) NO EFFECT ON TITLE XVIII BENEFITS.—The program under this part shall have no effect on the entitlement to benefits under title XVIII.

''ENROLLMENT UNDER PROGRAM

''SEC. 2202. (a) ESTABLISHMENT OF PROCESS.—

''(1) IN GENERAL.—The Secretary 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 the program under this part. Except as otherwise provided in this section, such process shall be similar to the process for enrollment in part B under section 1837.

''(2) REQUIREMENT OF ENROLLMENT.—An eligible beneficiary must enroll under this part in order to be eligible to receive benefits under this part.

''(b) ENROLLMENT PERIOD.—

''(1) IN GENERAL.—Except as provided in paragraph (2) or (3), an eligible beneficiary may not enroll in the program under this part during any period after the beneficiary's initial enrollment period.

''(2) OPEN ENROLLMENT PERIOD FOR BENEFICIARIES CURRENTLY COVERED.—In the case of an individual who is entitled to part A of title XVIII and enrolled under part B of such title as of November 1, 2002, there shall be an open enrollment period of 6 months beginning on that date.

''(3) SPECIAL ENROLLMENT PERIOD FOR BENEFICIARIES THAT LOSE OTHER DRUG COVERAGE.—

''(A) IN GENERAL.—Subject to subparagraph (D), in the case of an applicable eligible beneficiary, the Secretary shall establish procedures for permitting such beneficiary to enroll under the program under this part.

''(B) APPLICABLE ELIGIBLE BENEFICIARY.—For purposes of this paragraph, the term 'applicable eligible beneficiary' means an eligible beneficiary who—

''(i) had applicable drug coverage; and

''(ii) involuntarily lost such coverage.

''(C) APPLICABLE DRUG COVERAGE DEFINED.—For purposes of subparagraph (B),

the term 'applicable drug coverage' means any of the following prescription drug coverage:

"(i) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care for the Elderly (PACE) under section 1934, through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997), or through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

"(ii) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any outpatient prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified

retiree prescription drug plan (as defined in section 2212(e)(1)).

''(iii) PRESCRIPTION DRUG COVERAGE UNDER CERTAIN MEDIGAP POLICIES.—Coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)), but only if the policy was in effect on January 1, 2003.

''(iv) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program.

''(v) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans under chapter 17 of title 38, United States Code.

''(D) REQUIREMENTS.—The procedures established under subparagraph (A) shall require that an applicable eligible beneficiary—

''(i) seek to enroll under the program not later than 63 days after the date that

the beneficiary lost applicable drug coverage; and

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

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

''(A) STUDY.—The Secretary shall conduct a study on the need for rules relating to permitting individuals who are enrolled under part B of title XVIII but are not entitled to benefits under part A to buy into the program under this part.

''(B) REPORT.—Not later than January 1, 2002, the Secretary shall submit a report to Congress on the study conducted under subparagraph (A), together with any recommendations for legislation that the Secretary determines to be appropriate as a result of such study.

''(c) PERIOD OF COVERAGE.—

''(1) IN GENERAL.—Except as provided in paragraph (2) and subject to paragraph (3), an eligible beneficiary's coverage under the program under this

part shall be effective for the period provided in section 1838, as if that section applied to the program under this part.

''(2) ENROLLMENT DURING OPEN AND SPECIAL ENROLLMENT.—Subject to paragraph (3), an eligible beneficiary who enrolls under the program under this part pursuant to paragraph (2) or (3) of subsection (b) 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.

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

''(d) PROGRAM COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PARTS A AND B OF TITLE XVIII.—

''(1) IN GENERAL.—In addition to the causes of termination specified in section 1838, the Secretary shall terminate an individual's coverage under the program under this part if the individual is no longer enrolled in both parts A and B of title XVIII.

''(2) EFFECTIVE DATE.—The termination described in paragraph (1) shall be effective on the effective date of termination of coverage under part A of title XVIII or (if earlier) under part B of such title.

''(e) FIRST ENROLLMENT PERIOD.—The Secretary shall ensure that eligible beneficiaries are permitted to enroll under this part prior to January 1, 2003, in order to ensure that coverage under this part is effective as of such date.

''ELECTION OF A MEDICARE PRESCRIPTION PLUS PLAN

''SEC. 2203. (a) IN GENERAL.—

''(1) PROCESS.—

''(A) IN GENERAL.—Subject to paragraph (2), the Secretary shall establish a process through which an eligible beneficiary who is enrolled under this part shall make an annual election to enroll in a Medicare Prescription Plus plan offered by an eligible entity that serves the geographic area in which the beneficiary resides.

''(B) RULES.—In establishing the process under subparagraph (A), the Secretary shall use rules that are consistent with the rules for enrollment and disenrollment with a Medicare+Choice plan under section 1851, including—

''(i) annual, coordinated election periods, which shall be coordinated with such periods under part C of title XVIII;

"(ii) special election periods under subsection (e)(4) of section 1851; and

"(iii) the guaranteed issue requirements under subsection (g) 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 shall receive coverage of benefits under this part through such plan if such plan provides qualified prescription drug coverage. If the Medicare+Choice plan in which the beneficiary is enrolled does not provide such coverage, the beneficiary shall receive such coverage through the election of a Medicare Prescription Plus plan offered by an eligible entity under this part.

"(b) ASSURING ACCESS TO PRESCRIPTION DRUG COVERAGE IN AREAS WITH NO MEDICARE PRESCRIPTION PLUS PLAN OR MEDICARE+CHOICE PLAN PROVIDING DRUG COVERAGE AVAILABLE.—The Secretary shall develop procedures for the provision of the benefits required under section 2205(a) to each eligible beneficiary that resides in an area where there are no Medicare Prescription Plus plans or Medicare+Choice plans available that provide qualified prescription drug coverage.

''BENEFICIARY INFORMATION

''SEC. 2204. (a) IN GENERAL.—The Secretary shall conduct activities that are designed to broadly disseminate information to eligible beneficiaries (and prospective eligible beneficiaries) regarding the coverage provided under this part.

''(b) REQUIREMENTS.—The activities conducted under this subsection shall be—

''(1) similar to the activities performed by the Secretary under section 1851(d), including the dissemination of comparative information; and

''(2) coordinated with the activities performed by the Secretary under such section and under section 1804.

''OUTPATIENT PRESCRIPTION DRUG AND OTHER SUPPLEMENTAL BENEFITS

''SEC. 2205. (a) REQUIREMENTS.—

''(1) IN GENERAL.—For purposes of this part and part C of title XVIII, the term 'qualified prescription drug coverage' means either of the following:

''(A) STANDARD COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Standard coverage (as defined in subsection (d)) and access to negotiated prices under subsection (f).

"(B) ACTUARIALLY EQUIVALENT COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Coverage of covered outpatient drugs which meets the alternative coverage requirements of subsection (e) and access to negotiated prices under subsection (f).

"(2) PERMITTING ADDITIONAL OUTPATIENT PRESCRIPTION DRUG COVERAGE.—

"(A) IN GENERAL.—Subject to subparagraph (B) and section 2209(c)(2), nothing in this part shall be construed as preventing qualified prescription drug coverage from including coverage of covered outpatient drugs that exceeds the coverage required under paragraph (1).

"(B) REQUIREMENT.—An eligible entity may not offer a Medicare Prescription Plus plan that provides additional benefits pursuant to subparagraph (A) in an area unless the eligible entity offering such plan also offers a Medicare Prescription Plus plan in the area that only provides the coverage of prescription drugs that is required under subsection (a)(1).

"(3) COST CONTROL MECHANISMS.—In providing qualified prescription drug coverage, the enti-

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

''(b) PERMITTING BENEFITS IN ADDITION TO OUTPATIENT PRESCRIPTION DRUG COVERAGE.—

''(1) IN GENERAL.—Subject to paragraph (2) and section 2209(c)(2), nothing in this part shall be construed as preventing a Medicare Prescription Plus plan from including coverage of benefits that are in addition to the benefits available under title XVIII, including coverage of beneficiary cost-sharing for benefits under such title.

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

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

scription drugs that is required under subsection (a)(1); and

''(B) if the additional benefits include any of the core group of basic benefits described in section 1882(p)(2)(B), the Medicare Prescription Plus plan provides all of such core group of basic benefits.

''(c) APPLICATION OF SECONDARY PAYOR PROVISIONS.—The provisions of section 1852(a)(4) shall apply under this part in the same manner as they apply under part C of title XVIII.

''(d) STANDARD COVERAGE.—For purposes of this part and part C of title XVIII, the 'standard coverage' is coverage of covered outpatient drugs that meets the following requirements:

''(1) DEDUCTIBLE.—The coverage has an annual deductible—

''(A) for 2003, that is equal to $250; or

''(B) for a subsequent year, that is equal to the amount specified under this paragraph for the previous year increased by the percentage specified in paragraph (5) for the year involved.

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

''(2) LIMITS ON COST-SHARING.—The coverage has cost-sharing (for costs above the annual deductible specified in paragraph (1) and up to the initial coverage limit under paragraph (3)) that is equal to 50 percent or that is actuarially consistent (using processes established under subsection (g)) with an average expected payment of 50 percent of such costs.

''(3) INITIAL COVERAGE LIMIT.—Subject to paragraph (4), the coverage has an initial coverage limit on the maximum costs that may be recognized for payment purposes (above the annual deductible)—

''(A) for 2003, that is equal to $2,100; or

''(B) for a subsequent year, that is equal to the amount specified in this paragraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

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

''(4) LIMITATION ON OUT-OF-POCKET EXPENDITURES BY BENEFICIARY.—

''(A) IN GENERAL.—Notwithstanding paragraph (3), the coverage provides benefits without any cost-sharing after the individual has incurred costs (as described in subparagraph (C)) for covered outpatient drugs in a year equal to the annual out-of-pocket limit specified in subparagraph (B).

''(B) ANNUAL OUT-OF-POCKET LIMIT.—For purposes of this part, the 'annual out-of-pocket limit' specified in this subparagraph—

''(i) for 2003, is equal to $6,000; or

''(ii) for a subsequent year, is equal to the amount specified in the subparagraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

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

''(C) APPLICATION.—In applying subparagraph (A)—

''(i) incurred costs shall only include costs incurred for the annual deductible

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

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

''(5) ANNUAL PERCENTAGE INCREASE.—For purposes of this part, the annual percentage increase specified in this paragraph for a year is equal to the annual percentage increase in average per capita aggregate expenditures for covered outpatient 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.

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

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

"(1) ASSURING AT LEAST ACTUARIALLY EQUIVALENT COVERAGE.—

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

"(B) ASSURING EQUIVALENT UNSUBSIDIZED VALUE OF COVERAGE.—The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard coverage. For purposes of this subparagraph, the unsubsidized value of coverage is the amount by which the actuarial value of the coverage (as determined under subsection (g)) exceeds the actuarial value of the reinsurance subsidy payments under section 2212 with respect to such coverage.

"(C) ASSURING STANDARD PAYMENT FOR COSTS AT INITIAL COVERAGE LIMIT.—The coverage is designed, based upon an actuarially representative pattern of utilization (as determined under subsection (g)), to provide for the

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

Benefits other than qualified prescription drug coverage shall not be taken into account for purposes of this paragraph.

''(2) LIMITATION ON OUT-OF-POCKET EXPENDITURES BY BENEFICIARIES.—The coverage provides the limitation on out-of-pocket expenditures by beneficiaries described in subsection (d)(4).

''(f) ACCESS TO NEGOTIATED PRICES.—Under qualified prescription drug coverage offered by an eligible entity or a Medicare+Choice organization, the entity or organization shall provide beneficiaries with access to negotiated prices (including applicable discounts) used for payment for covered outpatient drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of cost-sharing or an initial coverage limit (described in subsection (d)(3)). In providing such access, the eligible entity or Medicare+Choice organization shall issue a card pursuant to section 2206(b)(1).

''(g) ACTUARIAL VALUATION; DETERMINATION OF ANNUAL PERCENTAGE INCREASES.—

''(1) PROCESSES.—For purposes of this section, the Secretary shall establish processes and methods—

''(A) for determining the actuarial valuation of prescription drug coverage, including—

''(i) an actuarial valuation of standard coverage and of the reinsurance subsidy payments under section 2212;

''(ii) the use of generally accepted actuarial principles and methodologies; and

''(iii) applying the same methodology for determinations of alternative coverage under subsection (e) as is used with respect to determinations of standard coverage under subsection (d); and

''(B) for determining annual percentage increases described in subsection (d)(5).

''(2) USE OF OUTSIDE ACTUARIES.—Under the processes under paragraph (1)(A), eligible entities and Medicare+Choice organizations may use actuarial opinions certified by independent, qualified actuaries to establish actuarial values.

''BENEFICIARY PROTECTIONS

''SEC. 2206. (a) DISSEMINATION OF INFORMATION.—

''(1) GENERAL INFORMATION.—An eligible entity offering a Medicare Prescription Plus plan shall disclose, in a clear, accurate, and standardized form to each enrollee at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such plan. Such information includes the following:

''(A) Access to covered outpatient drugs.

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

''(C) Co-payments, coinsurance, and deductible requirements.

''(D) Grievance and appeals procedures.

''(2) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an individual eligible to enroll in a Medicare Prescription Plus plan, the eligible entity offering such plan shall provide the information described in section 1852(c)(2) to such individual.

''(3) RESPONSE TO BENEFICIARY QUESTIONS.—An eligible entity offering a Medicare Prescription

Plus plan shall have a mechanism for providing specific information to enrollees upon request, including information on specific changes in its formulary.

''(4) CLAIMS INFORMATION.—An eligible entity offering a Medicare Prescription Plus plan must furnish to enrolled individuals in a form easily understandable to such individuals an explanation of benefits (in accordance with section 1806(a) or in a comparable manner) and a notice of the benefits in relation to initial coverage limit and annual out-of-pocket limit for the current year, whenever prescription drug benefits are provided under this part (except that such notice need not be provided more often than monthly).

''(b) ACCESS TO COVERED OUTPATIENT DRUGS.—

''(1) ACCESS TO NEGOTIATED PRICES FOR PRESCRIPTION DRUGS.—An eligible entity offering a Medicare Prescription Plus plan shall issue such a card that may be used by an enrolled beneficiary to assure access to negotiated prices under section 2205(f) for the purchase of prescription drugs for which coverage is not otherwise provided under the Medicare Prescription Plus plan.

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

gible entity offering a Medicare Prescription Plus plan uses a formulary with respect to qualified prescription drug coverage, the following requirements must be met:

''(A) 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).

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

''(c) COST AND UTILIZATION MANAGEMENT.—

''(1) IN GENERAL.—An 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 to reduce medical errors and adverse drug interactions,

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

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

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

''(d) GRIEVANCE MECHANISM.—An eligible entity shall provide meaningful procedures for hearing and resolving grievances between the eligible entity (including any entity or individual through which the eligible entity provides covered benefits) and enrollees in a Medicare Prescription Plus plan offered by the eligible entity in accordance with section 1852(f).

''(e) 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 Medicare Prescription Plus plan 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 of title XVIII.

''(2) APPEALS OF FORMULARY DETERMINATIONS.—Consistent with the requirements of section 1852(g), an eligible entity shall establish a process for appeals of formulary determinations.

''(f) 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 of title XVIII.

''(g) UNIFORM PREMIUM.—An eligible entity shall ensure that the premium for a Medicare Prescription Plus plan charged under this section is the same for all individuals enrolled in the plan in the same service area.

''REQUIREMENTS FOR ENTITIES OFFERING MEDICARE PRESCRIPTION PLUS PLANS

''SEC. 2207. (a) GENERAL REQUIREMENTS.—An eligible entity offering a Medicare Prescription Plus plan shall meet the following requirements:

''(1) LICENSURE.—Subject to subsection (c), the entity is organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a Medicare Prescription Plus plan.

''(2) ASSUMPTION OF FULL FINANCIAL RISK.—

''(A) IN GENERAL.—Subject to subparagraph (B), the entity assumes full financial risk on a prospective basis for the benefits that it offers under a Medicare Prescription Plus plan and that is not covered under reinsurance under section 2212.

''(B) REINSURANCE PERMITTED.—The entity may obtain insurance or make other arrangements for the cost of coverage provided to any enrolled member under this part.

''(3) SOLVENCY FOR UNLICENSED ENTITIES.—In the case of an eligible entity that is not described in paragraph (1), the entity shall meet solvency standards established by the Secretary under subsection (d).

''(b) CONTRACT REQUIREMENTS.—The Secretary shall not permit an eligible beneficiary to elect a Medicare Prescription Plus plan offered by an eligible entity under this part, and the entity shall not be eligible for payments under section 2210, 2211(e), or 2212, unless the Secretary has entered into a contract under this subsection with the entity with respect to the offering of such plan. Such a contract with an entity may cover more than 1 Medicare Prescription Plus plan. Such contract shall provide that the entity agrees to comply with the applicable

requirements and standards of this part and the terms and conditions of payment as provided for in this part.

''(c) WAIVER OF CERTAIN REQUIREMENTS TO EXPAND CHOICE.—

''(1) IN GENERAL.—In the case of an eligible entity that seeks to offer a Medicare Prescription Plus plan in a State, the Secretary shall waive the requirement of subsection (a)(1) that the entity be licensed in that State if the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for approval of the application described in paragraph (2) have been met.

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

''(3) APPLICATION OF MEDICARE+CHOICE PSO WAIVER PROCEDURES.—With respect to an application for a waiver (or a waiver granted) under this subsection, the provisions of subparagraphs (E), (F), and (G) of section 1855(a)(2) shall apply.

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

''(5) REFERENCES TO CERTAIN PROVISIONS.—For purposes of this subsection, in applying the provisions of section 1855(a)(2) under this subsection to Medicare Prescription Plus plans and eligible entities—

''(A) any reference to a waiver application under section 1855 shall be treated as a reference to a waiver application under paragraph (1); and

''(B) any reference to solvency standards were treated as a reference to solvency standards established under subsection (d).

''(d) SOLVENCY STANDARDS FOR NON-LICENSED ENTITIES.—

''(1) ESTABLISHMENT.—The Secretary shall establish, by not later than October 1, 2001, financial solvency and capital adequacy standards that an entity that does not meet the requirements of sub-

section (a)(1) must meet to qualify as an eligible entity under this part.

''(2) COMPLIANCE WITH STANDARDS.—An eligible entity that is not licensed by a State under subsection (a)(1) and for which a waiver application has been approved under subsection (c) shall meet solvency and capital adequacy standards established under paragraph (1). The Secretary shall establish certification procedures for such eligible entities with respect to such solvency standards in the manner described in section 1855(c)(2).

''(e) OTHER STANDARDS.—The Secretary shall establish by regulation other standards (not described in subsection (d)) for eligible entities and Medicare Prescription Plus plans consistent with, and to carry out, this part. The Secretary shall publish such regulations by October 1, 2001.

''(f) RELATION TO STATE LAWS.—

''(1) IN GENERAL.—The standards established under this section shall supersede any State law or regulation (including standards described in paragraph (2)) with respect to Medicare Prescription Plus plans which are offered by eligible entities under this part to the extent such law or regulation is inconsistent with such standards, in the same

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

''(2) STANDARDS SPECIFICALLY SUPERSEDED.—State standards relating to the following are superseded under this section:

''(A) Benefit requirements.

''(B) Requirements relating to inclusion or treatment of providers.

''(C) Coverage determinations (including related appeals and grievance processes).

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

''SUBMISSION OF MEDICARE PRESCRIPTION PLUS PLANS

''SEC. 2208. (a) IN GENERAL.—Each eligible entity that intends to offer a Medicare Prescription Plus plan in a year (beginning with 2003) shall submit to the Secretary, at such time and in such manner as the Secretary may specify, such information as the Secretary may require, including the information described in subsection (b).

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

''(1) A description of the benefits under the plan, including any supplemental benefits pursuant to section 2205(b).

''(2) Information on the actuarial value of the qualified prescription drug coverage.

''(3) Information on the monthly premium to be charged for all benefits, including an actuarial certification of—

''(A) the actuarial basis for such premium;

''(B) the portion of such premium attributable to benefits in excess of standard coverage; and

''(C) the reduction in such premium resulting from the reinsurance subsidy payments provided under section 2212.

''(4) The service area for the plan.

''(5) Such other information as the Secretary may require to carry out this part.

''APPROVAL OF MEDICARE PRESCRIPTION PLUS PLANS

''SEC. 2209. (a) IN GENERAL.—The Secretary shall review the information filed under section 2208 and shall approve or disapprove the Medicare Prescription Plus plan.

''(b) NEGOTIATION.—In exercising such authority, the Secretary shall have the same authority to negotiate the terms and conditions of the premiums submitted and other terms and conditions of plans as the Director of the Office of Personnel Management has with respect to health benefits plans under chapter 89 of title 5, United States Code.

''(c) SPECIAL RULES FOR APPROVAL.—

''(1) SERVICE AREA.—The Secretary may approve a service area submitted under section 2208(b)(4) only if the Secretary finds that—

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

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

''(2) AVOIDANCE OF FAVORABLE SELECTION.—The Secretary may approve a Medicare Prescription Plus plan submitted under section 2208 only if the benefits under such plan—

''(A) include the required benefits under section 2205(a)(1); and

''(B) are not designed in such a manner that the Secretary finds is likely to result in favorable selection of eligible beneficiaries.

''PAYMENTS TO MEDICARE PRESCRIPTION PLUS PLANS FOR BENEFITS

''SEC. 2210. (a) IN GENERAL.—Subject to subsection (b), for each year (beginning with 2003), the Secretary shall pay to each eligible entity offering a Medicare Prescription Plus plan in which an eligible beneficiary is enrolled an amount equal to—

''(1) the full amount of the premium approved under section 2209 on behalf of each eligible beneficiary enrolled in such plan for the year; minus

''(2) the amount of any fees imposed on the entity pursuant to section 2213).

''(b) PAYMENT TERMS.—Payment under this section to an eligible entity offering a Medicare Prescription Plus plan shall be made in a manner determined by the Secretary and based upon the manner in which payments are made under section 1853(a) (relating to payments to Medicare+Choice organizations).

''COMPUTATION AND COLLECTION OF BENEFICIARY SHARE OF PREMIUM

''SEC. 2211. (a) COMPUTATION.—

''(1) AMOUNT.—The annual beneficiary premium for enrollment in a Medicare Prescription Plus

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

"(A) an amount equal to the full amount of the premium approved under section 2209 for the plan in which the beneficiary is enrolled; minus

"(B) the amount of the discount determined under subsection (b).

"(2) COLLECTION OF PREMIUM AMOUNT IN SAME MANNER AS PART B PREMIUM.—

"(A) IN GENERAL.—The amount of the annual beneficiary premium determined under paragraph (1) shall be collected and credited to the Medicare Prescription Drug Account in the same manner as the monthly premium determined under section 1839 is collected and credited to the Federal Supplementary Medical Insurance Trust Fund under section 1840.

"(B) INFORMATION NECESSARY FOR COLLECTION.—In order to carry out subparagraph (A), the Secretary shall transmit to the Secretary of Social Security—

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

individual enrolled in a Medicare Prescription Plus plan for each month during the year; and

''(ii) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.

''(b) DISCOUNTS FOR REQUIRED DRUG PORTION OF PREMIUM.—

''(1) FULL PREMIUM DISCOUNT AND REDUCTION OF COST-SHARING FOR INDIVIDUALS WITH INCOME BELOW 135 PERCENT OF FEDERAL POVERTY LEVEL.—In the case of a low-income individual (as defined in paragraph (5)(A)) who is determined to have income that does not exceed 135 percent of the Federal poverty level, the individual is entitled under this section—

''(A) to a premium discount equal to 100 percent of the amount described in subsection (c); and

''(B) subject to subsection (d), to the substitution for the beneficiary cost-sharing described in paragraphs (1) and (2) of section 2205(d) (up to the initial coverage limit speci-

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

''(2) SLIDING SCALE PREMIUM DISCOUNT FOR INDIVIDUALS WITH INCOME ABOVE 135, BUT BELOW 150 PERCENT, OF FEDERAL POVERTY LEVEL.—In the case of a low-income individual who is determined to have income that exceeds 135 percent, but does not exceed 150 percent, of the Federal poverty level, the individual is entitled under this section to a premium discount determined on a linear sliding scale ranging from 100 percent of the amount described in subsection (c) for individuals with incomes at 135 percent of such level to 25 percent of such amount for individuals with incomes at 150 percent of such level.

''(3) PARTIAL PREMIUM DISCOUNT FOR INDIVIDUALS WITH INCOME ABOVE 150 PERCENT OF FEDERAL POVERTY LEVEL.—In the case of an eligible beneficiary who is not a low-income individual, the beneficiary is entitled under this section to a premium discount equal to 25 percent of the amount described in subsection (c).

''(4) TAX TREATMENT OF PREMIUM DISCOUNT.—

''(A) IN GENERAL.—For purposes of the Internal Revenue Code of 1986, the premium discount determined under this subsection for an eligible beneficiary for a year shall be included in the gross income of the beneficiary for the year.

''(B) STATEMENT OF TAXABLE AMOUNT.—Not later than January 31 of each year (beginning with 2004), the Secretary shall provide—

''(i) each eligible beneficiary enrolled under this part with a statement that describes the amount of the discount that is required to be included in the gross income of the beneficiary for the previous year pursuant to subparagraph (A); and

''(ii) the Secretary of the Treasury with the information described in clause (i).

''(5) DETERMINATION OF ELIGIBILITY.—

''(A) LOW-INCOME INDIVIDUAL DEFINED.—For purposes of this section, subject to subparagraph (D), the term 'low-income individual' means an individual who—

''(i) is eligible to enroll, and has enrolled, under this part;

"(ii) has income below 150 percent of the Federal poverty line; and

"(iii) meets the resources requirement described in section 1905(p)(1)(C).

"(B) DETERMINATIONS.—The determination of whether an individual residing in a State is a low-income individual and the amount of such individual's income shall be determined under the State medicaid plan for the State under section 1935(a). In the case of a State that does not operate such a medicaid plan (either under title XIX or under a statewide waiver granted under section 1115), such determination shall be made under arrangements made by the Secretary.

"(C) INCOME DETERMINATIONS.—For purposes of applying this section—

"(i) income shall be determined in 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.

''(D) 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 low-income individual but may be eligible for financial assistance with prescription drug expenses under section 1935(e).

''(c) PREMIUM DISCOUNT AMOUNT.—The premium discount amount described in this subsection for an eligible beneficiary residing in an area is an amount equal to—

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

''(2) in the case of an individual enrolled in a Medicare+Choice plan that provides qualified prescription drug coverage, the standard premium computed under section 1851(j)(5)(A)(iii).

''(d) RULES IN APPLYING COST-SHARING SUBSIDIES.—

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

"(A) the maximum amount of subsidy that may be provided with respect to an enrollee for a year may not exceed 95 percent of the maximum cost-sharing described in such subsection that may be incurred for standard coverage;

"(B) the Secretary shall determine what is 'nominal' taking into account the rules applied under section 1916(a)(3); and

"(C) nothing in this part shall be construed as preventing a plan or provider from waiving or reducing the amount of cost-sharing otherwise applicable.

"(2) LIMITATION ON CHARGES.—In the case of a low-income individual receiving cost-sharing subsidies under subsection (b)(1)(B), the eligible entity may not charge more than a nominal amount in cases in which the cost-sharing subsidy is provided under such subsection.

"(e) ADMINISTRATION OF COST-SHARING PROGRAM.—The Secretary shall provide a process whereby, in the case of a low-income individual who is eligible for reduced cost-sharing under subsection (b)(1)(B) and is enrolled in a Medicare Prescription Plus plan or a Medicare+Choice plan under which qualified prescription drug coverage is provided—

''(1) the Secretary provides for a notification of the eligible entity or Medicare+Choice organization involved that the individual is eligible for such reduced cost-sharing;

''(2) the entity or organization involved reduces the cost-sharing pursuant to this section and submits to the Secretary information on the amount of such reduction; and

''(3) the Secretary periodically and on a timely basis reimburses the entity or organization for the amount of such reductions.

The reimbursement under paragraph (3) may be computed on a capitated basis, taking into account the actuarial value of the reductions and with appropriate adjustments to reflect differences in the risks actually involved.

''(f) RELATION TO MEDICAID PROGRAM.—

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

''(2) MEDICAID PROVIDING WRAP AROUND BENEFITS.—The coverage provided under this part is primary payor to benefits for prescribed drugs provided under the medicaid program under title XIX.

''ADDITIONAL PRESCRIPTION DRUG SUBSIDIES THROUGH REINSURANCE

''SEC. 2212. (a) REINSURANCE SUBSIDY PAYMENT.—In order to reduce premium levels applicable to qualified prescription drug coverage for all medicare beneficiaries, to reduce adverse selection among Medicare Prescription Plus plans and Medicare+Choice plans that provide qualified prescription drug coverage, and to promote the participation of eligible entities under this part, the Secretary shall provide in accordance with this section for payment to a qualifying entity (as defined in subsection (b)) of the reinsurance payment amount (as defined in subsection (c)) for excess costs incurred in providing qualified prescription drug coverage—

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

''(2) for individuals enrolled with a Medicare+Choice plan that provides qualified prescription drug coverage under part C of title XVIII; and

''(3) for medicare secondary payer eligible individuals (described in subsection (e)(3)(D)) who are enrolled in a qualified retiree prescription drug plan.

This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Sec-

retary to provide for the payment of amounts provided under this section.

''(b) QUALIFYING ENTITY DEFINED.—For purposes of this section, the term 'qualifying entity' means any of the following that has entered into an agreement with the Secretary to provide the Secretary with such information as may be required to carry out this section:

''(1) An eligible entity offering a Medicare Prescription Plus plan under this part.

''(2) A Medicare+Choice organization that provides qualified prescription drug coverage under a Medicare+Choice plan under part C of title XVIII.

''(3) The sponsor of a qualified retiree prescription drug plan (as defined in subsection (e)).

''(c) REINSURANCE PAYMENT AMOUNT.—

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

''(2) ALLOWABLE COSTS.—For purposes of this section, the term 'allowable costs' means, with re-

spect to gross covered prescription drug costs under a plan described in subsection (b) offered by a qualifying entity, the part of such costs that are actually paid under the plan, but in no case more than the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were standard coverage.

''(3) GROSS COVERED PRESCRIPTION DRUG COSTS.—For purposes of this section, the term 'gross covered prescription drug costs' means, with respect to an enrollee with a qualifying entity under a plan described in subsection (b) during a coverage year, the costs incurred under the plan for covered prescription drugs dispensed during the year, including costs relating to the deductible, whether paid by the enrollee or under the plan, regardless of whether the coverage under the plan exceeds standard coverage and regardless of when the payment for such drugs is made.

''(4) INDEXING DOLLAR AMOUNT.—

''(A) AMOUNT FOR 2003.—The dollar amount applied under paragraph (1) for 2003 shall be the dollar amount specified in such paragraph.

"(B) FOR 2004.—The dollar amount applied under paragraph (1) for 2004 shall be the dollar amount specified in such paragraph increased by the annual percentage increase described in section 2205(d)(5) for 2004.

"(C) FOR SUBSEQUENT YEARS.—The dollar amount applied under paragraph (1) for a year after 2004 shall be the dollar amount (under this paragraph) applied under paragraph (1) for the preceding year increased by the annual percentage increase described in section 2205(d)(5) for the year involved.

"(D) ROUNDING.—Any amount, determined under the preceding provisions of this paragraph for a year, which is not a multiple of $5 shall be rounded to the nearest multiple of $5.

"(d) PAYMENT METHODS.—

"(1) IN GENERAL.—Payments under this section shall be based on such a method as the Secretary determines. The Secretary may establish a payment method by which interim payments of amounts under this section are made during a year based on the Secretary's best estimate of amounts

that will be payable after obtaining all of the information.

''(2) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Medicare Prescription Drug Account.

''(e) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN DEFINED.—

''(1) IN GENERAL.—For purposes of this section, the term 'qualified retiree prescription drug plan' means employment-based retiree health coverage (as defined in paragraph (3)(A)) if, with respect to an individual enrolled (or eligible to be enrolled) under this part who is covered under the plan, the following requirements are met:

''(A) ASSURANCE.—The sponsor of the plan shall annually attest, and provide such assurances as the Secretary may require, that the coverage meets the requirements for qualified prescription drug coverage.

''(B) AUDITS.—The sponsor (and the plan) shall maintain, and afford the Secretary access to, such records as the Secretary may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage, the accuracy of pay-

ments made, and such other matters as may be appropriate.

''(C) OTHER REQUIREMENTS.—The sponsor of the plan shall comply with such other requirements as the Secretary finds necessary to administer the program under this section.

''(2) LIMITATION ON BENEFIT ELIGIBILITY.—No payment shall be provided under this section with respect to an individual who is enrolled under a qualified retiree prescription drug plan unless the individual is a medicare secondary payer eligible individual who—

''(A) is covered under the plan; and

''(B) is eligible to obtain qualified prescription drug coverage under this part but did not elect such coverage (either through a Medicare Prescription Plus plan or through a Medicare+Choice plan).

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

''(A) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage of health care costs for medicare secondary payer eligible individuals (or for such individuals and their spouses

and dependents) based on their status as former employees or labor union members.

"(B) EMPLOYER.—The term 'employer' has the meaning given such term by section 3(5) of the Employee Retirement Income Security Act of 1974 (except that such term shall include only employers of 2 or more employees).

"(C) SPONSOR.—The term 'sponsor' means a plan sponsor, as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

"(D) MEDICARE SECONDARY PAYER INDIVIDUAL.—The term 'medicare secondary payer eligible individual' means, with respect to a plan, an individual who is covered under the plan and with respect to whom the plan is not a primary plan (as defined in section 1862(b)(2)(A)).

"(f) GENERAL DEFINITIONS.—For purposes of this section:

"(1) QUALIFIED BENEFICIARY.—The term 'qualified beneficiary' means an individual who—

"(A) is enrolled with a Medicare Prescription Plus plan under this part;

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

''(C) is covered as a medicare secondary payer eligible individual under a qualified retiree prescription drug plan.

''(2) COVERAGE YEAR.—The term 'coverage year' means a calendar year in which covered outpatient drugs are dispensed if a claim for payment is made under the plan for such drugs, regardless of when the claim is paid.

''PLAN FEES FOR ADMINISTRATIVE COSTS

''SEC. 2213. (a) IN GENERAL.—The Secretary may levy on Medicare Prescription Plus plans and Medicare+Choice plans that provide drug coverage pursuant to this part an assessment sufficient to pay the estimated expenses of the Secretary for administering the program under this part.

''(b) DEPOSITS AND USE.—The assessments described in subsection (a) shall be—

''(1) deposited into the Medicare Prescription Drug Account; and

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

''MEDICARE PRESCRIPTION DRUG ACCOUNT

''SEC. 2214. (a) ESTABLISHMENT.—There is created within the Federal Supplementary Medical Insurance Trust Fund established under section 1841 an account to be known as the 'Medicare Prescription Drug Account'.

''(b) AMOUNTS IN ACCOUNT.—

''(1) IN GENERAL.—The Medicare Prescription Drug Account shall consist of—

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

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

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

''(c) PAYMENTS FROM ACCOUNT.—

''(1) IN GENERAL.—The Managing Trustee shall pay from time to time from the Medicare Prescription Drug Account such amounts as the Secretary certifies are necessary to make the payments provided for by this part, and the payments with re-

spect to administrative expenses in accordance with section 201(g).

''(2) TRANSFERS TO MEDICAID ACCOUNT FOR INCREASED ADMINISTRATIVE COSTS.—The Managing Trustee shall transfer from time to time from the Account to the Grants to States for Medicaid account amounts the Secretary certifies are attributable to increases in payment resulting from the application of a higher Federal matching percentage under section 1935(b).

''(d) DEPOSITS INTO ACCOUNT.—

''(1) MEDICAID TRANSFER.—There is hereby transferred to the Account, from amounts appropriated for Grants to States for Medicaid, amounts equivalent to the aggregate amount of the reductions in payments under section 1903(a)(1) attributable to the application of section 1935(c).

''(2) APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Account, an amount equivalent to the amount of payments made from the Account, reduced by—

''(1) the amount transferred to the Account under paragraph (1);

''(2) the beneficiary premiums collected and credited to the account under section 2211(b)(2); and

''(3) fees collected and credited to the account under section 2213.

''SECONDARY PAYER PROVISIONS

''SEC. 2215. The provisions of section 1862(b) shall apply to the benefits provided under this part.

''DEFINITIONS; TREATMENT OF REFERENCES TO PROVISIONS IN MEDICARE+CHOICE PROGRAM

''SEC. 2216. (a) DEFINITIONS.—In this part:

''(1) COVERED OUTPATIENT DRUG.—

''(A) IN GENERAL.—Except as provided in this 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 section 1927(k)(2)(A); 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 subparagraph (E) thereof (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 so considered if payment for such drug is available under part A or B of title XVIII (but shall be so considered if such payment is not available because benefits under part A or B of title XVIII have been exhausted), without regard to whether the individual is entitled to benefits under such part A or enrolled under such part B.

''(3) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual that is entitled to benefits under part A of title XVIII and enrolled under part B of such title.

''(4) ELIGIBLE ENTITY.—The term 'eligible entity' means any risk-bearing entity that the Secretary determines to be appropriate to provide eligi-

ble beneficiaries with the benefits under a Medicare Prescription Plus plan, including—

"(A) a pharmaceutical benefit management company;

"(B) a wholesale or retail pharmacist delivery system;

"(C) an insurer (including an insurer that offers medicare supplemental policies under section 1882);

"(D) another entity; or

"(E) any combination of the entities described in subparagraphs (A) through (D).

"(5) INITIAL COVERAGE LIMIT.—The term 'initial coverage limit' means the limit as established under section 2205(d)(3), or, in the case of coverage that is not standard coverage, the comparable limit (if any) established under the coverage.

"(6) MEDICARE+CHOICE ORGANIZATION; MEDICARE+CHOICE PLAN.—The terms 'Medicare+Choice organization' and 'Medicare+Choice plan' have the meanings given such terms in subsections (a)(1) and (b)(1), respectively, of section 1859 (relating to definitions relating to Medicare+Choice organizations and plans).

''(7) MEDICARE PRESCRIPTION DRUG ACCOUNT.—The term 'Medicare Prescription Drug Account' means the Medicare Prescription Drug Account established under section 2214 and located within the Federal Supplementary Medical Insurance Trust Fund established under section 1841.

''(8) MEDICARE PRESCRIPTION PLUS PLAN.—The term 'Medicare Prescription Plus plan' means a health benefits plan that the Secretary has approved under section 2209.

''(9) STANDARD COVERAGE.—The term 'standard coverage' means the coverage described in section 2205(d).

''(b) APPLICATION OF MEDICARE+CHOICE PROVISIONS UNDER THIS PART.—For purposes of applying provisions of part C of title XVIII under this part with respect to a Medicare Prescription Plus plan and an eligible entity, unless otherwise provided in this part such provisions shall be applied as if—

''(1) any reference to a Medicare+Choice plan included a reference to a Medicare Prescription Plus plan;

''(2) any reference to a provider-sponsored organization included a reference to an eligible entity;

''(3) any reference to a contract under section 1857 included a reference to a contract under section 2207(b); and

''(4) any reference to part C of title XVIII included a reference to this part.''.

(b) SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of enactment of this Act, 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 Act.

SEC. 202. AMENDMENTS TO FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.

Section 1841 of the Social Security Act (42 U.S.C. 1395t) is amended—

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

(A) by striking ''and'' after ''section 201(i)(1)''; and

(B) by inserting before the period the following: '', and such amounts as may be deposited in, or appropriated to, the Medicare Prescription Drug Account established by section 2214'';

(2) in subsection (g), by inserting after ''by this part,'' the following: ''the payments provided for under the Prescription Drug and Supplemental Benefit Program under title XXII (in which case the payments shall come from the Medicare Prescription Drug Account in the Supplementary Medical Insurance Trust Fund),'';

(3) in the first sentence of subsection (h), by inserting ''(or the Secretary by reason of section 2215 (in which case the payments shall come from the Medicare Prescription Drug Account within such Trust Fund))'' after ''Human Services''; and

(4) in the first sentence of subsection (i), by inserting ''(or the Secretary by reason of section 2215 (in which case the payments shall come from the Medicare Prescription Drug Account within such Trust Fund))'' after ''Human Services''.

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

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

''(j) AVAILABILITY OF PRESCRIPTION DRUG BENEFITS.—

''(1) IN GENERAL.—A Medicare+Choice organization may not offer prescription drug coverage (other than that required under parts A and B) to an enrollee under a Medicare+Choice plan unless such drug coverage is at least qualified prescription drug coverage and unless the requirements of this subsection with respect to such coverage are met.

''(2) COMPLIANCE WITH ADDITIONAL BENEFICIARY PROTECTIONS.—With respect to the offering of qualified prescription drug coverage by a Medicare+Choice organization under a Medicare+Choice plan, the organization and plan shall meet the requirements of section 2206, including requirements relating to information dissemination and grievance and appeals, in the same manner as they apply to an eligible entity and a Medicare Prescription Plus plan under title XXII. The Secretary shall waive such requirements to the extent the Administrator determines that such requirements duplicate requirements otherwise applicable to the organization or plan under this part.

''(3) TREATMENT OF COVERAGE.—Except as provided in this subsection, qualified prescription drug coverage offered under this subsection shall be treated under this part in the same manner as sup-

plemental health care benefits described in section 1852(a)(3)(A).

''(4) AVAILABILITY OF COST-SHARING SUBSIDIES FOR LOW-INCOME ENROLLEES AND REINSURANCE SUBSIDY PAYMENTS FOR ORGANIZATIONS.—For provisions—

''(A) providing cost-sharing subsidies to low-income individuals receiving qualified prescription drug coverage through a Medicare+Choice plan, see section 2211; and

''(B) providing a Medicare+Choice organization with reinsurance subsidy payments for providing qualified prescription drug coverage under this part, see section 2212.

''(5) SPECIFICATION OF SEPARATE AND STANDARD PREMIUM.—

''(A) IN GENERAL.—For purposes of applying section 1854 and determining the premium discount under section 2211(c) with respect to qualified prescription drug coverage offered under this subsection under a plan, the Medicare+Choice organization shall compute and publish the following:

''(i) SEPARATE PRESCRIPTION DRUG PREMIUM.—A premium for prescription

drug benefits that constitutes qualified prescription drug coverage that is separate from other coverage under the plan.

''(ii) PORTION OF COVERAGE ATTRIBUTABLE TO STANDARD BENEFITS.—The ratio of the actuarial value of standard coverage to the actuarial value of the qualified prescription drug coverage offered under the plan.

''(iii) PORTION OF PREMIUM ATTRIBUTABLE TO STANDARD BENEFITS.—A standard premium equal to the product of the premium described in clause (i) and the ratio under clause (ii).

The premium under clause (i) shall be computed without regard to any reduction in the premium permitted under subparagraph (B).

''(B) REDUCTION OF PREMIUMS ALLOWED.—Nothing in this subsection shall be construed as preventing a Medicare+Choice organization from reducing the amount of a premium charged for prescription drug coverage because of the application of subsections (f)(1)(A) and (i)(2)(A) of section 1854 to other coverage.

''(6) TRANSITION IN INITIAL ENROLLMENT PERIOD.—Notwithstanding any other provision of this part, the annual, coordinated election period under subsection (e)(3)(B) for 2003 shall be the 6-month period beginning with November 2002.

''(7) QUALIFIED PRESCRIPTION DRUG COVERAGE; STANDARD COVERAGE.—For purposes of this part, the terms 'qualified prescription drug coverage' and 'standard coverage' have the meanings given such terms in section 2205.''.

(b) CONFORMING AMENDMENTS.—Section 1851(a)(1) of such Act (42 U.S.C. 1395w–21(a)(1)) is amended—

(1) by inserting ''(other than qualified prescription drug benefits)'' after ''benefits'';

(2) by striking the period at the end of subparagraph (B) and inserting a comma; and

(3) by adding at the end the following flush language:

''and may elect qualified prescription drug coverage in accordance with title XXII.''.

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

SEC. 205. MEDIGAP PROVISIONS.

(a) IN GENERAL.—Notwithstanding any other provision of law, no new medicare supplemental policy that provides coverage of expenses for prescription drugs may be issued under section 1882 of the Social Security Act on or after January 1, 2003, to an individual unless it replaces a medicare supplemental policy that was issued to that individual and that provided some coverage of expenses for prescription drugs.

(b) ISSUANCE OF SUBSTITUTE POLICIES IF OBTAINING PRESCRIPTION DRUG COVERAGE THROUGH MEDICARE.—

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

(A) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as ''A'', ''B'', ''C'', ''D'', ''E'', ''F'', or ''G'' (under the standards established under subsection (p)(2) of section 1882 of the Social Security Act (42 U.S.C. 1395ss)) and that is offered and is available for issuance to new enrollees by such issuer;

(B) may not discriminate in the pricing of such policy, because of health status, claims ex-

perience, receipt of health care, or medical condition; and

(C) may not impose an exclusion of benefits based on a preexisting condition under such policy,

in the case of an individual described in paragraph (2) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such paragraph and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

(2) INDIVIDUAL COVERED.—An individual described in this paragraph is an individual who—

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

(B) at the time of such enrollment was enrolled and terminates enrollment in a medicare supplemental policy which has a benefit package classified as ''H'', ''I'', or ''J'' under the standards referred to in paragraph (1)(A) or terminates enrollment in a policy to which such standards do not apply but which provides benefits for prescription drugs.

(3) ENFORCEMENT.—The provisions of paragraph (1) shall be enforced as though such provisions were included in section 1882(s) of the Social Security Act (42 U.S.C. 1395ss(s)).

(4) DEFINITIONS.—For purposes of this subsection, the term ''medicare supplemental policy'' has the meaning given such term in section 1882(g) of the Social Security Act (42 U.S.C. 1395ss(g)).

(c) MEDIGAP PROTECTIONS FOR INDIVIDUALS WHO LOSE MEDICARE PRESCRIPTION PLUS PLAN COVERAGE.—Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended—

(1) in subsection (d)(3)—

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

''(ix) Nothing in this subparagraph shall be construed as preventing the sale of 1 medicare supplemental policy and 1 Medicare Prescription Plus plan to an individual, except that the sale of such a policy or plan may not duplicate any health benefits under any policy or plan owned by the individual.''; and

(B) in subparagraph (B)(iii)—

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

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

(iii) 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 medicare supplemental policy or 1 Medicare Prescription Plus plan, the sale of another policy or plan is not in violation of clause (i) if such other policy or plan does not duplicate health benefits under the policy or plan in which the individual is enrolled.'';

(2) in subsection (g)(1), by inserting '', Medicare Prescription Plus plan,'' after ''Medicare+Choice plan''; and

(3) in subsection (s)(3)—

(A) in subparagraph (B)—

(i) in clause (ii), by inserting ''is enrolled with an eligible entity under a Medicare Prescription Plus plan under title XXII or'' after ''section 1851(e)(4) or the individual'';

(ii) in clause (v)(II), by inserting ''with any eligible entity under a Medicare Prescription Plus plan under title XXII,'' after ''under part C,''; and

(iii) in clause (vi), by inserting ", in a Medicare Prescription Plus plan under title XXII," after "under part C"; and

(B) in subparagraph (E)—

(i) in clause (i), by inserting "(or, in the case of an individual enrolled under a Medicare Prescription Plus plan, the date on which the individual was notified by the eligible entity of the impending termination or discontinuance of the Medicare Prescription Plus plan) after "it offers in the area"; and

(ii) in clause (ii), by inserting "or Medicare Prescription Plus plan" after "Medicare+Choice plan".

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