

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 subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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.

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

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Senior’s Health Care Choice Act of 2001”.

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

Sec. 1. Short title; table of contents.

TITLE I—MEDICARE COVERAGE OF PREVENTIVE SERVICES

- Sec. 101. Counseling for cessation of tobacco use.
- Sec. 102. Screening for hypertension.
- Sec. 103. Counseling for hormone replacement therapy.
- Sec. 104. Screening for diminished visual acuity.
- Sec. 105. Screening for hearing impairment.
- Sec. 106. Screening and counseling for osteoporosis.
- Sec. 107. Screening for cholesterol.
- Sec. 108. Expansion of coverage of medical nutrition therapy services.
- Sec. 109. Expansion of coverage of glaucoma screening.
- Sec. 110. Routine annual physical checkups.
- Sec. 111. Routine annual dental examinations and cleaning.
- Sec. 112. Routine annual eye examinations.

TITLE II—MEDICARE PRESCRIPTION DRUG AND SUPPLEMENTAL BENEFIT PROGRAM

Sec. 201. Establishment of program.

“TITLE XXII—MEDICARE PRESCRIPTION DRUG BENEFIT PROGRAM

- “Sec. 2201. Establishment of prescription drug and supplemental benefit program.
- “Sec. 2202. Enrollment under program.
- “Sec. 2203. Election of a medicare prescription plus plan.
- “Sec. 2204. Beneficiary information.
- “Sec. 2205. Outpatient prescription drug and other supplemental benefits.
- “Sec. 2206. Beneficiary protections.
- “Sec. 2207. Requirements for entities offering medicare prescription plus plans.
- “Sec. 2208. Submission of medicare prescription plus plans.
- “Sec. 2209. Approval of medicare prescription plus plans.
- “Sec. 2210. Payments to medicare prescription plus plans for benefits.
- “Sec. 2211. Computation and collection of beneficiary share of premium.
- “Sec. 2212. Additional prescription drug subsidies through reinsurance.
- “Sec. 2213. Plan fees for administrative costs.
- “Sec. 2214. Medicare prescription drug account.
- “Sec. 2215. Secondary payer provisions.
- “Sec. 2216. Definitions; treatment of references to provisions in medicare+choice program.
- Sec. 202. Amendments to Federal Supplementary Medical Insurance Trust Fund.
- Sec. 203. Prescription drug coverage under the Medicare+Choice program.
- Sec. 205. Medigap provisions.

1 **TITLE I—MEDICARE COVERAGE**
2 **OF PREVENTIVE SERVICES**

3 **SEC. 101. COUNSELING FOR CESSATION OF TOBACCO USE.**

4 (a) **COVERAGE.**—Section 1861(s)(2) of the Social Se-
5 curity Act (42 U.S.C. 1395x(s)(2)), as amended by 102(a)
6 and 105(a) of the Medicare, Medicaid, and SCHIP Bene-
7 fits Improvement and Protection Act of 2000 (as enacted
8 into law by section 1(a)(6) of Public Law 106–554), is
9 amended—

10 (1) in subparagraph (U), by striking “and” at
11 the end;

12 (2) in subparagraph (V), by inserting “and” at
13 the end; and

14 (3) by adding at the end the following new sub-
15 paragraph:

16 “(W) counseling for cessation of tobacco use (as
17 defined in subsection (vv)) for individuals who have
18 a history of tobacco use;”.

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

1 “Counseling for Cessation of Tobacco Use

2 “(vv)(1) Except as provided in paragraph (2), the
3 term ‘counseling for cessation of tobacco use’ means diag-
4 nostic, therapy, and counseling services for cessation of
5 tobacco use which are furnished—

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

7 or

8 “(B) by any other health care professional who
9 is legally authorized to furnish such services under
10 State law (or the State regulatory mechanism pro-
11 vided by State law) of the State in which the serv-
12 ices are furnished, as would otherwise be covered if
13 furnished by a physician or as an incident to a phy-
14 sician’s professional service.

15 “(2) The term ‘counseling for cessation of tobacco
16 use’ does not include coverage for drugs or biologicals that
17 are not otherwise covered under this title.”.

18 (c) ELIMINATION OF COST-SHARING.—

19 (1) ELIMINATION OF COINSURANCE.—Section
20 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)), as
21 amended by section 105(c) and 223(c) of the Medi-
22 care, Medicaid, and SCHIP Benefits Improvement
23 and Protection Act of 2000 (as enacted into law by
24 section 1(a)(6) of Public Law 106–554), is
25 amended—

1 (A) by striking “and” before “(U)”;

2 (B) by inserting before the semicolon at
 3 the end the following: “, and (V) with respect
 4 to counseling for cessation of tobacco use (as
 5 defined in section 1861(vv)), the amount paid
 6 shall be 100 percent of the lesser of the actual
 7 charge for the services or the amount deter-
 8 mined by a fee schedule established by the Sec-
 9 retary for the purposes of this subparagraph”.

10 (2) ELIMINATION OF DEDUCTIBLE.—The first
 11 sentence of section 1833(b) of such Act (42 U.S.C.
 12 1395l(b)) is amended—

13 (A) by striking “and” before “(6)”;

14 (B) by inserting before the period the fol-
 15 lowing: “, and (7) such deductible shall not
 16 apply with respect to counseling for cessation of
 17 tobacco use (as defined in section 1861(vv))”.

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

21 **SEC. 102. SCREENING FOR HYPERTENSION.**

22 (a) COVERAGE.—Section 1861(s)(2) of the Social Se-
 23 curity Act (42 U.S.C. 1395x(s)(2)) (as amended by sec-
 24 tion 101(a)) is amended—

1 (1) in subparagraph (V), by striking “and” at
2 the end;

3 (2) in subparagraph (W), by inserting “and” at
4 the end; and

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

7 “(X) screening for hypertension (as defined in
8 subsection (ww)) not more frequently than once
9 every 2 years for individuals with normotensive
10 blood pressure measurements and annually for indi-
11 viduals with blood pressure measurements that are
12 not normotensive;”.

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

17 “Screening for Hypertension

18 “(ww) The term ‘screening for hypertension’ means
19 diagnostic services for hypertension which are furnished—

20 “(1) by or under the supervision of a physician;
21 or

22 “(2) by any other health care professional who
23 is legally authorized to furnish such services under
24 State law (or the State regulatory mechanism pro-
25 vided 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(w)), 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(w))”.

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

4 **SEC. 103. COUNSELING FOR HORMONE REPLACEMENT**
 5 **THERAPY.**

6 (a) COVERAGE.—Section 1861(s)(2) of the Social Se-
 7 curity Act (42 U.S.C. 1395x(s)(2)) (as amended by sec-
 8 tion 102(a)) is amended—

9 (1) in subparagraph (W), by striking “and” at
 10 the end;

11 (2) in subparagraph (X), by inserting “and” at
 12 the end; and

13 (3) by adding at the end the following new sub-
 14 paragraph:

15 “(Y) counseling for hormone replacement ther-
 16 apy (as defined in subsection (xx));”.

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

21 “Counseling for Hormone Replacement Therapy

22 “(xx)(1) Except as provided in paragraph (2), the
 23 term ‘counseling for hormone replacement therapy’ means
 24 diagnostic, therapy, and counseling services for hormone
 25 replacement which are furnished—

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

2 or

3 “(B) by any other health care professional who
4 is legally authorized to furnish such services under
5 State law (or the State regulatory mechanism pro-
6 vided by State law) of the State in which the serv-
7 ices are furnished, as would otherwise be covered if
8 furnished by a physician or as an incident to a phy-
9 sician’s professional service.

10 “(2) The term ‘counseling for hormone replacement
11 therapy’ does not include coverage for drugs or biologicals
12 that are not otherwise covered under this title.”.

13 (c) ELIMINATION OF COST-SHARING.—

14 (1) ELIMINATION OF COINSURANCE.—Section
15 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as
16 amended by section 102(c)(1)) is amended—

17 (A) by striking “and” before “(W)”; and

18 (B) by inserting before the semicolon at
19 the end the following: “, and (X) with respect
20 to counseling for hormone replacement therapy
21 (as defined in section 1861(xx)), the amount
22 paid shall be 100 percent of the lesser of the
23 actual charge for the services or the amount de-
24 termined by a fee schedule established by the

1 Secretary for the purposes of this subpara-
 2 graph;”.

3 (2) ELIMINATION OF DEDUCTIBLE.—The first
 4 sentence of section 1833(b) of such Act (42 U.S.C.
 5 1395l(b)) (as amended by section 102(c)(2)) is
 6 amended—

7 (A) by striking “and” before “(8)”; and

8 (B) by inserting before the period the fol-
 9 lowing: “, and (9) such deductible shall not
 10 apply with respect to counseling for hormone
 11 replacement therapy (as defined in section
 12 1861(xx))”.

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

16 **SEC. 104. SCREENING FOR DIMINISHED VISUAL ACUITY.**

17 (a) COVERAGE.—Section 1861(s)(2) of the Social Se-
 18 curity Act (42 U.S.C. 1395x(s)(2)) (as amended by sec-
 19 tion 103(a)) is amended—

20 (1) in subparagraph (X), by striking “and” at
 21 the end;

22 (2) in subparagraph (Y), by inserting “and” at
 23 the end; and

24 (3) by adding at the end the following new sub-
 25 paragraph:

1 “(Z) screening for diminished visual acuity (as
2 defined in subsection (yy));”.

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

7 “Screening for Diminished Visual Acuity
8 “(yy) The term ‘screening for diminished visual acu-
9 ity’ means diagnostic services for screening for diminished
10 visual acuity which are furnished by or under the super-
11 vision of an optometrist or ophthalmologist who is legally
12 authorized to furnish such services under State law (or
13 the State regulatory mechanism provided by State law) of
14 the State in which the services are furnished, as would
15 otherwise be covered if furnished by a physician or as an
16 incident to a physician’s professional service.”.

17 (c) ELIMINATION OF COST-SHARING.—

18 (1) ELIMINATION OF COINSURANCE.—Section
19 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as
20 amended by section 103(c)(1)) is amended—

21 (A) by striking “and” before “(X)”; and

22 (B) by inserting before the semicolon at
23 the end the following: “, and (Y) with respect
24 to screening for diminished visual acuity (as de-
25 fined in section 1861(yy)), the amount paid

1 shall be 100 percent of the lesser of the actual
 2 charge for the services or the amount deter-
 3 mined by a fee schedule established by the Sec-
 4 retary for the purposes of this subparagraph;”.

5 (2) **ELIMINATION OF DEDUCTIBLE.**—The first
 6 sentence of section 1833(b) of such Act (42 U.S.C.
 7 1395l(b)) (as amended by section 103(c)(2)) is
 8 amended—

9 (A) by striking “and” before “(9)”; and

10 (B) by inserting before the period the fol-
 11 lowing: “, and (10) such deductible shall not
 12 apply with respect to screening for diminished
 13 visual acuity (as defined in section 1861(yy))”.

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

17 **SEC. 105. SCREENING FOR HEARING IMPAIRMENT.**

18 (a) **COVERAGE.**—Section 1861(s)(2) of the Social Se-
 19 curity Act (42 U.S.C. 1395x(s)(2)) (as amended by sec-
 20 tion 104(a)) is amended—

21 (1) in subparagraph (Y), by striking “and” at
 22 the end;

23 (2) in subparagraph (Z), by inserting “and” at
 24 the end; and

1 (3) by adding at the end the following new sub-
2 paragraph:

3 “(AA) screening for hearing impairment (as de-
4 fined in subsection (zz));”.

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

9 “Screening for Hearing Impairment

10 “(zz) The term ‘screening for hearing impairment’
11 means diagnostic services for hearing impairment by use
12 of periodic questions, otoscopic examination and audio
13 metric testing if such questions indicate potential hearing
14 impairment, and counseling about hearing aid devices
15 which are furnished—

16 “(1) by or under the supervision of a physician;
17 or

18 “(2) by any other health care professional who
19 is legally authorized to furnish such services under
20 State law (or the State regulatory mechanism pro-
21 vided by State law) of the State in which the serv-
22 ices are furnished, as would otherwise be covered if
23 furnished by a physician or as an incident to a phy-
24 sician’s professional service.”.

25 (c) ELIMINATION OF COST-SHARING.—

1 (1) ELIMINATION OF COINSURANCE.—Section
2 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as
3 amended by section 104(c)(1)) is amended—

4 (A) by striking “and” before “(Y)”; and

5 (B) by inserting before the semicolon at
6 the end the following: “, and (Z) with respect
7 to screening for hearing impairment (as defined
8 in section 1861(zz)), the amount paid shall be
9 100 percent of the lesser of the actual charge
10 for the services or the amount determined by a
11 fee schedule established by the Secretary for the
12 purposes of this subparagraph;”.

13 (2) ELIMINATION OF DEDUCTIBLE.—The first
14 sentence of section 1833(b) of such Act (42 U.S.C.
15 1395l(b)) (as amended by section 104(c)(2)) is
16 amended—

17 (A) by striking “and” before “(10)”; and

18 (B) by inserting before the period the fol-
19 lowing: “, and (11) such deductible shall not
20 apply with respect to screening for hearing im-
21 pairment (as defined in section 1861(zz))”.

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

1 **SEC. 106. SCREENING AND COUNSELING FOR**
2 **OSTEOPOROSIS.**

3 (a) **COVERAGE.**—Section 1861(s)(2) of the Social Se-
4 curity Act (42 U.S.C. 1395x(s)(2)) (as amended by sec-
5 tion 105(a)) is amended—

6 (1) in subparagraph (Z), by striking “and” at
7 the end;

8 (2) in subparagraph (AA), by inserting “and”
9 at the end; and

10 (3) by adding at the end the following new sub-
11 paragraph:

12 “(BB) screening and counseling for
13 osteoporosis (as defined in subsection (aaa)) for—

14 “(i) women; and

15 “(ii) men with fractures;”.

16 (b) **SERVICES DESCRIBED.**—Section 1861 of such
17 Act (42 U.S.C. 1395x) (as amended by section 105(b))
18 is amended by adding at the end the following new sub-
19 section:

20 “Screening and Counseling for Osteoporosis

21 “(aaa) The term ‘screening and counseling for
22 osteoporosis’ means diagnostic and counseling services for
23 osteoporosis in addition to a bone mass measurement (as
24 defined in subsection (rr)) which are furnished in accord-
25 ance with methods approved by the Food and Drug
26 Administration—

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

3 “(2) by any other health care professional who
4 is legally authorized to furnish such services under
5 State law (or the State regulatory mechanism pro-
6 vided by State law) of the State in which the serv-
7 ices are furnished, as would otherwise be covered if
8 furnished by a physician or as an incident to a phy-
9 sician’s professional service.”.

10 (c) ELIMINATION OF COST-SHARING.—

11 (1) ELIMINATION OF COINSURANCE.—Section
12 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as
13 amended by section 105(c)(1)) is amended—

14 (A) by striking “and” before “(Z)”; and

15 (B) by inserting before the semicolon at
16 the end and inserting the following: “, and
17 (AA) with respect to screening and counseling
18 for osteoporosis (as defined in section
19 1861(aaa)), the amount paid shall be 100 per-
20 cent of the lesser of the actual charge for the
21 services or the amount determined by a fee
22 schedule established by the Secretary for the
23 purposes of this subparagraph;”.

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

1 1395l(b)) (as amended by section 105(c)(2)) is
2 amended—

3 (A) by striking “and” before “(11)”; and

4 (B) by inserting before the period the fol-
5 lowing: “, and (12) such deductible shall not
6 apply with respect to screening and counseling
7 for osteoporosis (as defined in section
8 1861(aaa))”.

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

12 **SEC. 107. SCREENING FOR CHOLESTEROL.**

13 (a) COVERAGE.—Section 1861(s)(2) of the Social Se-
14 curity Act (42 U.S.C. 1395x(s)(2)) (as amended by sec-
15 tion 106(a)) is amended—

16 (1) in subparagraph (AA), by striking “and” at
17 the end;

18 (2) in subparagraph (BB), by inserting “and”
19 at the end; and

20 (3) by adding at the end the following new sub-
21 paragraph:

22 “(CC) screening for cholesterol (as defined in
23 subsection (bbb)) for individuals between the ages of
24 65 and 75 that exhibit major risk factors for coro-

1 nary heart disease, including smoking, hypertension,
2 and diabetes;”.

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

7 “Screening for Cholesterol

8 “(bbb) The term ‘screening for cholesterol’ means di-
9 agnostic services for cholesterol that are furnished—

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

11 or

12 “(2) by any other health care professional who
13 is legally authorized to furnish such services under
14 State law (or the State regulatory mechanism pro-
15 vided by State law) of the State in which the serv-
16 ices are furnished, as would otherwise be covered if
17 furnished by a physician or as an incident to a phy-
18 sician’s professional service.”.

19 (c) ELIMINATION OF COST-SHARING.—

20 (1) ELIMINATION OF COINSURANCE.—Section
21 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as
22 amended by section 106(c)(1)) is amended—

23 (A) by striking “and” before “(AA)”; and

24 (B) by inserting before the semicolon at

25 the end the following: “, and (BB) with respect

1 to screening for cholesterol (as defined in sec-
 2 tion 1861(bbb)), the amount paid shall be 100
 3 percent of the lesser of the actual charge for
 4 the services or the amount determined by a fee
 5 schedule established by the Secretary for the
 6 purposes of this subparagraph;”.

7 (2) ELIMINATION OF DEDUCTIBLE.—The first
 8 sentence of section 1833(b) of such Act (42 U.S.C.
 9 1395l(b)) (as amended by section 106(c)(2)) is
 10 amended—

11 (A) by striking “and” before “(12)”; and

12 (B) by inserting before the period the fol-
 13 lowing: “, and (13) such deductible shall not
 14 apply with respect to screening and counseling
 15 for osteoporosis (as defined in section
 16 1861(bbb))”.

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

20 **SEC. 108. EXPANSION OF COVERAGE OF MEDICAL NUTRI-**
 21 **TION THERAPY SERVICES.**

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

1 and SCHIP Benefits Improvement and Protection Act of
2 2000 (as enacted into law by section 1(a)(6) of Public Law
3 106–554), is amended by inserting “, a cardiovascular dis-
4 ease (including congestive heart failure, arteriosclerosis,
5 hyperlipidemia, hypertension, and hypercholesterolemia),”
6 after “diabetes”.

7 (b) ELIMINATION OF COST-SHARING.—

8 (1) ELIMINATION OF COINSURANCE.—Section
9 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as
10 amended by section 107(c)(1)) is amended—

11 (A) by striking “and” before “(BB)”; and

12 (B) by inserting before the semicolon at
13 the end the following: “, and (CC) with respect
14 to medical nutrition therapy services (as defined
15 in section 1861(vv)(1)), the amount paid shall
16 be 85 percent of the lesser of the actual charge
17 for the services or the amount determined
18 under the fee schedule established under section
19 1848(b) for the same services if furnished by a
20 physician”.

21 (2) ELIMINATION OF DEDUCTIBLE.—The first
22 sentence of section 1833(b) of such Act (42 U.S.C.
23 1395l(b)) (as amended by section 107(c)(2)) is
24 amended—

25 (A) by striking “and” before “(13)”; and

1 (B) by inserting before the period the fol-
 2 lowing: “, and (14) such deductible shall not
 3 apply with respect to nutrition therapy services
 4 (as defined in section 1861(vv)(1))”.

5 (c) EFFECTIVE DATE.—The amendments made by
 6 this section apply to services furnished on or after Janu-
 7 ary 1, 2002.

8 **SEC. 109. EXPANSION OF COVERAGE OF GLAUCOMA**
 9 **SCREENING.**

10 (a) EXPANSION OF GLAUCOMA SCREENING TO
 11 COVER INDIVIDUALS WITH MYOPIA.—Section
 12 1861(s)(2)(U) of the Social Security Act, as added by sec-
 13 tion 101(a) of the Medicare, Medicaid, and SCHIP Bene-
 14 fits Improvement and Protection Act of 2000 (as enacted
 15 into law by section 1(a)(6) of Public Law 106–554), is
 16 amended by inserting “or myopia” after “diabetes”.

17 (b) ELIMINATION OF COST-SHARING.—

18 (1) ELIMINATION OF COINSURANCE.—Section
 19 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as
 20 amended by section 108(b)(1) is amended—

21 (A) by striking “and” before “(BB)”; and

22 (B) by inserting before the semicolon at
 23 the end the following: “, and (CC) with respect
 24 to screening for glaucoma (as defined in section
 25 1861(uu)), the amount paid shall be 100 per-

1 cent of the lesser of the actual charge for the
 2 services or amount determined by a fee schedule
 3 established by the Secretary for the purposes of
 4 this subparagraph;”.

5 (2) **ELIMINATION OF DEDUCTIBLE.**—The first
 6 sentence of section 1833(b) of such Act (42 U.S.C.
 7 1395l(b)) (as amended by section 108(b)(2)) is
 8 amended—

9 (A) by striking “and” before “(14)”; and

10 (B) by inserting before the period the fol-
 11 lowing: “, and (15) such deductible shall not
 12 apply with respect to screening for glaucoma
 13 (as defined in section 1861(uu))”.

14 (c) **EFFECTIVE DATE.**—The amendments made by
 15 this section apply to services furnished on or after Janu-
 16 ary 1, 2002.

17 **SEC. 110. ROUTINE ANNUAL PHYSICAL CHECKUPS.**

18 (a) **IN GENERAL.**—Section 1862 of the Social Secu-
 19 rity Act (42 U.S.C. 1395y) is amended—

20 (1) in subsection (a)(7), by inserting “subject
 21 to subsection (h),” after “(7)”; and

22 (2) by inserting after subsection (g) the fol-
 23 lowing new subsection:

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

4 (b) ELIMINATION OF COST-SHARING.—

5 (1) ELIMINATION OF COINSURANCE.—Section
 6 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as
 7 amended by section 109(b)(1)) is amended—

8 (A) by striking “and” before “(CC)”; and

9 (B) by inserting before the semicolon at
 10 the end the following: “, and (DD) with respect
 11 to routine annual physical checkups described
 12 in section 1862(h)(1), the amount paid shall be
 13 100 percent of the lesser of the actual charge
 14 for the services or amount determined by a fee
 15 schedule established by the Secretary for the
 16 purposes of this subparagraph;”.

17 (2) ELIMINATION OF DEDUCTIBLE.—The first
 18 sentence of section 1833(b) of such Act (42 U.S.C.
 19 1395l(b)) (as amended by section 109(b)(2)) is
 20 amended—

21 (A) by striking “and” before “(15)”; and

22 (B) by inserting before the period the fol-
 23 lowing: “, and (16) such deductible shall not
 24 apply with respect to routine annual physical
 25 checkups described in section 1862(h)(1)”.

1 (c) EFFECTIVE DATE.—The amendments made by
 2 this section apply to services furnished on or after Janu-
 3 ary 1, 2002.

4 **SEC. 111. ROUTINE ANNUAL DENTAL EXAMINATIONS AND**
 5 **CLEANING.**

6 (a) IN GENERAL.—Section 1862 of the Social Secu-
 7 rity Act (42 U.S.C. 1395y), as amended by section 110(a),
 8 is amended—

9 (1) in subsection (a)(2), by inserting “subject
 10 to subsection (h),” after “(7)”; and

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

13 “(2) The exclusion subsection (a)(12) shall not in-
 14 clude coverage of a routine annual dental examination and
 15 cleaning, including coverage of oral gum disease screen-
 16 ing.”.

17 (b) ELIMINATION OF COST-SHARING.—

18 (1) ELIMINATION OF COINSURANCE.—Section
 19 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as
 20 amended by section 110(b)(1)) is amended—

21 (A) by striking “and” before “(DD)”; and

22 (B) by inserting before the semicolon at
 23 the end the following: “, and (EE) with respect
 24 to routine annual dental examination and clean-
 25 ing described in section 1862(h)(2), the amount

1 paid shall be 100 percent of the lesser of the
 2 actual charge for the services or amount deter-
 3 mined by a fee schedule established by the Sec-
 4 retary for the purposes of this subparagraph;”.

5 (2) **ELIMINATION OF DEDUCTIBLE.**—The first
 6 sentence of section 1833(b) of such Act (42 U.S.C.
 7 1395l(b)) (as amended by section 110(b)(2)) is
 8 amended—

9 (A) by striking “and” before “(16)”; and

10 (B) by inserting before the period the fol-
 11 lowing: “, and (17) such deductible shall not
 12 apply with respect to routine annual dental ex-
 13 amination and cleaning described in section
 14 1862(h)(2)”.

15 (c) **EFFECTIVE DATE.**—The amendments made by
 16 this section apply to services furnished on or after Janu-
 17 ary 1, 2002.

18 **SEC. 112. ROUTINE ANNUAL EYE EXAMINATIONS.**

19 (a) **IN GENERAL.**—Section 1862(h) of the Social Se-
 20 curity Act (42 U.S.C. 1395y(h)), as inserted by section
 21 111(a), is amended by adding at the end the following new
 22 paragraph:

23 “(3) The exclusion under subsection (a)(7) shall not
 24 include coverage of a routine annual eye examination, in-
 25 cluding a refraction, and of coverage per year of 1 pair

1 of glasses (or coverage of contract or other correctible
 2 lenses, up to the financial equivalence of a pair of glass-
 3 es).”.

4 (b) ELIMINATION OF COST-SHARING.—

5 (1) ELIMINATION OF COINSURANCE.—Section
 6 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as
 7 amended by section 111(b)(1)) is amended—

8 (A) by striking “and” before “(EE)”; and

9 (B) by inserting before the semicolon at
 10 the end the following: “, and (FF) with respect
 11 to routine annual eye examinations and cov-
 12 erage of eyeglasses (or other lense equivalents)
 13 described in section 1862(h)(3), the amount
 14 paid shall be 100 percent of the lesser of the
 15 actual charge for the services or amount deter-
 16 mined by a fee schedule established by the Sec-
 17 retary for the purposes of this subparagraph;”.

18 (2) ELIMINATION OF DEDUCTIBLE.—The first
 19 sentence of section 1833(b) of such Act (42 U.S.C.
 20 1395l(b)) (as amended by section 111(b)(2)) is
 21 amended—

22 (A) by striking “and” before “(17)”; and

23 (B) by inserting before the period the fol-
 24 lowing: “, and (18) such deductible shall not
 25 apply with respect to routine annual eye exami-

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

3 (c) EFFECTIVE DATE.—The amendments made by
4 this section apply to services furnished on or after Janu-
5 ary 1, 2002.

6 **TITLE II—MEDICARE PRESCRIP-**
7 **TION DRUG AND SUPPLE-**
8 **MENTAL BENEFIT PROGRAM**

9 **SEC. 201. ESTABLISHMENT OF PROGRAM.**

10 (a) IN GENERAL.—The Social Security Act is amend-
11 ed by adding at the end the following new title:

12 “TITLE XXII—MEDICARE PRESCRIPTION DRUG
13 BENEFIT PROGRAM

14 “ESTABLISHMENT OF PRESCRIPTION DRUG AND
15 SUPPLEMENTAL BENEFIT PROGRAM

16 “SEC. 2201. (a) PROVISION OF BENEFIT.—The Sec-
17 retary shall establish a Prescription Drug and Supple-
18 mental Benefit Program under which an eligible bene-
19 ficiary may voluntarily enroll and receive access to covered
20 outpatient prescription drugs and other benefits through
21 enrollment in a Medicare Prescription Plus plan offered
22 by a private entity or a Medicare+Choice plan offered by
23 a Medicare+Choice organization.

24 “(b) PROGRAM TO BEGIN IN 2003.—The Secretary
25 shall establish the program under this part in a manner

1 so that benefits are first provided for months beginning
2 with January 2003.

3 “(c) VOLUNTARY NATURE OF PROGRAM.—Nothing
4 in this part shall be construed as requiring an eligible ben-
5 efiary to enroll in the program under this part.

6 “(d) FINANCING.—The costs of providing benefits
7 under this part shall be payable from the Medicare Pre-
8 scription Drug Account.

9 “(e) NO EFFECT ON TITLE XVIII BENEFITS.—The
10 program under this part shall have no effect on the entitle-
11 ment to benefits under title XVIII.

12 “ENROLLMENT UNDER PROGRAM

13 “SEC. 2202. (a) ESTABLISHMENT OF PROCESS.—

14 “(1) IN GENERAL.—The Secretary shall estab-
15 lish a process through which an eligible beneficiary
16 (including an eligible beneficiary enrolled in a
17 Medicare+Choice plan offered by a
18 Medicare+Choice organization) may make an elec-
19 tion to enroll under the program under this part.
20 Except as otherwise provided in this section, such
21 process shall be similar to the process for enrollment
22 in part B under section 1837.

23 “(2) REQUIREMENT OF ENROLLMENT.—An eli-
24 gible beneficiary must enroll under this part in order
25 to be eligible to receive benefits under this part.

26 “(b) ENROLLMENT PERIOD.—

1 “(1) IN GENERAL.—Except as provided in para-
 2 graph (2) or (3), an eligible beneficiary may not en-
 3 roll in the program under this part during any pe-
 4 riod after the beneficiary’s initial enrollment period.

5 “(2) OPEN ENROLLMENT PERIOD FOR BENE-
 6 FICIARIES CURRENTLY COVERED.—In the case of an
 7 individual who is entitled to part A of title XVIII
 8 and enrolled under part B of such title as of Novem-
 9 ber 1, 2002, there shall be an open enrollment pe-
 10 riod of 6 months beginning on that date.

11 “(3) SPECIAL ENROLLMENT PERIOD FOR BENE-
 12 FICIARIES THAT LOSE OTHER DRUG COVERAGE.—

13 “(A) IN GENERAL.—Subject to subpara-
 14 graph (D), in the case of an applicable eligible
 15 beneficiary, the Secretary shall establish proce-
 16 dures for permitting such beneficiary to enroll
 17 under the program under this part.

18 “(B) APPLICABLE ELIGIBLE BENE-
 19 FICIARY.—For purposes of this paragraph, the
 20 term ‘applicable eligible beneficiary’ means an
 21 eligible beneficiary who—

22 “(i) had applicable drug coverage; and

23 “(ii) involuntarily lost such coverage.

24 “(C) APPLICABLE DRUG COVERAGE DE-
 25 FINED.—For purposes of subparagraph (B),

1 the term ‘applicable drug coverage’ means any
2 of the following prescription drug coverage:

3 “(i) MEDICAID PRESCRIPTION DRUG
4 COVERAGE.—Prescription drug coverage
5 under a medicaid plan under title XIX, in-
6 cluding through the Program of All-inclu-
7 sive Care for the Elderly (PACE) under
8 section 1934, through a social health main-
9 tenance organization (referred to in section
10 4104(c) of the Balanced Budget Act of
11 1997), or through a Medicare+Choice
12 project that demonstrates the application
13 of capitation payment rates for frail elderly
14 medicare beneficiaries through the use of a
15 interdisciplinary team and through the
16 provision of primary care services to such
17 beneficiaries by means of such a team at
18 the nursing facility involved.

19 “(ii) PRESCRIPTION DRUG COVERAGE
20 UNDER GROUP HEALTH PLAN.—Any out-
21 patient prescription drug coverage under a
22 group health plan, including a health bene-
23 fits plan under the Federal Employees
24 Health Benefit Plan under chapter 89 of
25 title 5, United States Code, and a qualified

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

3 “(iii) PRESCRIPTION DRUG COVERAGE
4 UNDER CERTAIN MEDIGAP POLICIES.—
5 Coverage under a medicare supplemental
6 policy under section 1882 that provides
7 benefits for prescription drugs (whether or
8 not such coverage conforms to the stand-
9 ards for packages of benefits under section
10 1882(p)(1)), but only if the policy was in
11 effect on January 1, 2003.

12 “(iv) STATE PHARMACEUTICAL AS-
13 SISTANCE PROGRAM.—Coverage of pre-
14 scription drugs under a State pharma-
15 ceutical assistance program.

16 “(v) VETERANS’ COVERAGE OF PRE-
17 SCRIPTON DRUGS.—Coverage of prescrip-
18 tion drugs for veterans under chapter 17
19 of title 38, United States Code.

20 “(D) REQUIREMENTS.—The procedures
21 established under subparagraph (A) shall re-
22 quire that an applicable eligible beneficiary—

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

1 the beneficiary lost applicable drug cov-
2 erage; and

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

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

9 “(A) STUDY.—The Secretary shall conduct
10 a study on the need for rules relating to permit-
11 ting individuals who are enrolled under part B
12 of title XVIII but are not entitled to benefits
13 under part A to buy into the program under
14 this part.

15 “(B) REPORT.—Not later than January 1,
16 2002, the Secretary shall submit a report to
17 Congress on the study conducted under sub-
18 paragraph (A), together with any recommenda-
19 tions for legislation that the Secretary deter-
20 mines to be appropriate as a result of such
21 study.

22 “(c) PERIOD OF COVERAGE.—

23 “(1) IN GENERAL.—Except as provided in para-
24 graph (2) and subject to paragraph (3), an eligible
25 beneficiary’s coverage under the program under this

1 part shall be effective for the period provided in sec-
 2 tion 1838, as if that section applied to the program
 3 under this part.

4 “(2) ENROLLMENT DURING OPEN AND SPECIAL
 5 ENROLLMENT.—Subject to paragraph (3), an eligi-
 6 ble beneficiary who enrolls under the program under
 7 this part pursuant to paragraph (2) or (3) of sub-
 8 section (b) shall be entitled to the benefits under
 9 this part beginning on the first day of the month fol-
 10 lowing the month in which such enrollment occurs.

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

13 “(d) PROGRAM COVERAGE TERMINATED BY TERMI-
 14 NATION OF COVERAGE UNDER PARTS A AND B OF TITLE
 15 XVIII.—

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

21 “(2) EFFECTIVE DATE.—The termination de-
 22 scribed in paragraph (1) shall be effective on the ef-
 23 fective date of termination of coverage under part A
 24 of title XVIII or (if earlier) under part B of such
 25 title.

1 “(e) FIRST ENROLLMENT PERIOD.—The Secretary
 2 shall ensure that eligible beneficiaries are permitted to en-
 3 roll under this part prior to January 1, 2003, in order
 4 to ensure that coverage under this part is effective as of
 5 such date.

6 “ELECTION OF A MEDICARE PRESCRIPTION PLUS PLAN

7 “SEC. 2203. (a) IN GENERAL.—

8 “(1) PROCESS.—

9 “(A) IN GENERAL.—Subject to paragraph
 10 (2), the Secretary shall establish a process
 11 through which an eligible beneficiary who is en-
 12 rolled under this part shall make an annual
 13 election to enroll in a Medicare Prescription
 14 Plus plan offered by an eligible entity that
 15 serves the geographic area in which the bene-
 16 ficiary resides.

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

23 “(i) annual, coordinated election peri-
 24 ods, which shall be coordinated with such
 25 periods under part C of title XVIII;

1 “(ii) special election periods under
2 subsection (e)(4) of section 1851; and

3 “(iii) the guaranteed issue require-
4 ments under subsection (g) of such section.

5 “(2) MEDICARE+CHOICE ENROLLEES.—An eli-
6 gible beneficiary who is enrolled under this part and
7 enrolled in a Medicare+Choice plan offered by a
8 Medicare+Choice organization shall receive coverage
9 of benefits under this part through such plan if such
10 plan provides qualified prescription drug coverage. If
11 the Medicare+Choice plan in which the beneficiary
12 is enrolled does not provide such coverage, the bene-
13 ficiary shall receive such coverage through the elec-
14 tion of a Medicare Prescription Plus plan offered by
15 an eligible entity under this part.

16 “(b) ASSURING ACCESS TO PRESCRIPTION DRUG
17 COVERAGE IN AREAS WITH NO MEDICARE PRESCRIPTION
18 PLUS PLAN OR MEDICARE+CHOICE PLAN PROVIDING
19 DRUG COVERAGE AVAILABLE.—The Secretary shall de-
20 velop procedures for the provision of the benefits required
21 under section 2205(a) to each eligible beneficiary that re-
22 sides in an area where there are no Medicare Prescription
23 Plus plans or Medicare+Choice plans available that pro-
24 vide qualified prescription drug coverage.

1 “BENEFICIARY INFORMATION

2 “SEC. 2204. (a) IN GENERAL.—The Secretary shall
3 conduct activities that are designed to broadly disseminate
4 information to eligible beneficiaries (and prospective eligi-
5 ble beneficiaries) regarding the coverage provided under
6 this part.

7 “(b) REQUIREMENTS.—The activities conducted
8 under this subsection shall be—

9 “(1) similar to the activities performed by the
10 Secretary under section 1851(d), including the dis-
11 semination of comparative information; and

12 “(2) coordinated with the activities performed
13 by the Secretary under such section and under sec-
14 tion 1804.

15 “OUTPATIENT PRESCRIPTION DRUG AND OTHER

16 SUPPLEMENTAL BENEFITS

17 “SEC. 2205. (a) REQUIREMENTS.—

18 “(1) IN GENERAL.—For purposes of this part
19 and part C of title XVIII, the term ‘qualified pre-
20 scription drug coverage’ means either of the fol-
21 lowing:

22 “(A) STANDARD COVERAGE WITH ACCESS
23 TO NEGOTIATED PRICES.—Standard coverage
24 (as defined in subsection (d)) and access to ne-
25 gotiated prices under subsection (f).

1 “(B) ACTUARIALLY EQUIVALENT COV-
2 ERAGE WITH ACCESS TO NEGOTIATED
3 PRICES.—Coverage of covered outpatient drugs
4 which meets the alternative coverage require-
5 ments of subsection (e) and access to negotiated
6 prices under subsection (f).

7 “(2) PERMITTING ADDITIONAL OUTPATIENT
8 PRESCRIPTION DRUG COVERAGE.—

9 “(A) IN GENERAL.—Subject to subpara-
10 graph (B) and section 2209(c)(2), nothing in
11 this part shall be construed as preventing quali-
12 fied prescription drug coverage from including
13 coverage of covered outpatient drugs that ex-
14 ceeds the coverage required under paragraph
15 (1).

16 “(B) REQUIREMENT.—An eligible entity
17 may not offer a Medicare Prescription Plus
18 plan that provides additional benefits pursuant
19 to subparagraph (A) in an area unless the eligi-
20 ble entity offering such plan also offers a Medi-
21 care Prescription Plus plan in the area that
22 only provides the coverage of prescription drugs
23 that is required under subsection (a)(1).

24 “(3) COST CONTROL MECHANISMS.—In pro-
25 viding qualified prescription drug coverage, the enti-

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

9 “(b) PERMITTING BENEFITS IN ADDITION TO OUT-
10 PATIENT PRESCRIPTION DRUG COVERAGE.—

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

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

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

1 scription drugs that is required under sub-
2 section (a)(1); and

3 “(B) if the additional benefits include any
4 of the core group of basic benefits described in
5 section 1882(p)(2)(B), the Medicare Prescrip-
6 tion Plus plan provides all of such core group
7 of basic benefits.

8 “(c) APPLICATION OF SECONDARY PAYOR PROVI-
9 SIONS.—The provisions of section 1852(a)(4) shall apply
10 under this part in the same manner as they apply under
11 part C of title XVIII.

12 “(d) STANDARD COVERAGE.—For purposes of this
13 part and part C of title XVIII, the ‘standard coverage’
14 is coverage of covered outpatient drugs that meets the fol-
15 lowing requirements:

16 “(1) DEDUCTIBLE.—The coverage has an an-
17 nual deductible—

18 “(A) for 2003, that is equal to \$250; or

19 “(B) for a subsequent year, that is equal
20 to the amount specified under this paragraph
21 for the previous year increased by the percent-
22 age specified in paragraph (5) for the year in-
23 volved.

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

4 “(2) LIMITS ON COST-SHARING.—The coverage
5 has cost-sharing (for costs above the annual deduct-
6 ible specified in paragraph (1) and up to the initial
7 coverage limit under paragraph (3)) that is equal to
8 50 percent or that is actuarially consistent (using
9 processes established under subsection (g)) with an
10 average expected payment of 50 percent of such
11 costs.

12 “(3) INITIAL COVERAGE LIMIT.—Subject to
13 paragraph (4), the coverage has an initial coverage
14 limit on the maximum costs that may be recognized
15 for payment purposes (above the annual deduct-
16 ible)—

17 “(A) for 2003, that is equal to \$2,100; or

18 “(B) for a subsequent year, that is equal
19 to the amount specified in this paragraph for
20 the previous year, increased by the annual per-
21 centage increase described in paragraph (5) for
22 the year involved.

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

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

3 “(A) IN GENERAL.—Notwithstanding para-
4 graph (3), the coverage provides benefits with-
5 out any cost-sharing after the individual has in-
6 curred costs (as described in subparagraph (C))
7 for covered outpatient drugs in a year equal to
8 the annual out-of-pocket limit specified in sub-
9 paragraph (B).

10 “(B) ANNUAL OUT-OF-POCKET LIMIT.—
11 For purposes of this part, the ‘annual out-of-
12 pocket limit’ specified in this subparagraph—

13 “(i) for 2003, is equal to \$6,000; or

14 “(ii) for a subsequent year, is equal to
15 the amount specified in the subparagraph
16 for the previous year, increased by the an-
17 nual percentage increase described in para-
18 graph (5) for the year involved.

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

22 “(C) APPLICATION.—In applying subpara-
23 graph (A)—

24 “(i) incurred costs shall only include
25 costs incurred for the annual deductible

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

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

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

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

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

3 “(1) ASSURING AT LEAST ACTUARIALLY EQUIV-
4 ALENT COVERAGE.—

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

10 “(B) ASSURING EQUIVALENT UNSUB-
11 SIDIZED VALUE OF COVERAGE.—The unsub-
12 sidized value of the coverage is at least equal to
13 the unsubsidized value of standard coverage.
14 For purposes of this subparagraph, the unsub-
15 sidized value of coverage is the amount by
16 which the actuarial value of the coverage (as
17 determined under subsection (g)) exceeds the
18 actuarial value of the reinsurance subsidy pay-
19 ments under section 2212 with respect to such
20 coverage.

21 “(C) ASSURING STANDARD PAYMENT FOR
22 COSTS AT INITIAL COVERAGE LIMIT.—The cov-
23 erage is designed, based upon an actuarially
24 representative pattern of utilization (as deter-
25 mined under subsection (g)), to provide for the

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

7 Benefits other than qualified prescription drug cov-
8 erage shall not be taken into account for purposes
9 of this paragraph.

10 “(2) LIMITATION ON OUT-OF-POCKET EXPENDI-
11 TURES BY BENEFICIARIES.—The coverage provides
12 the limitation on out-of-pocket expenditures by bene-
13 ficiaries described in subsection (d)(4).

14 “(f) ACCESS TO NEGOTIATED PRICES.—Under quali-
15 fied prescription drug coverage offered by an eligible entity
16 or a Medicare+Choice organization, the entity or organi-
17 zation shall provide beneficiaries with access to negotiated
18 prices (including applicable discounts) used for payment
19 for covered outpatient drugs, regardless of the fact that
20 no benefits may be payable under the coverage with re-
21 spect to such drugs because of the application of cost-shar-
22 ing or an initial coverage limit (described in subsection
23 (d)(3)). In providing such access, the eligible entity or
24 Medicare+Choice organization shall issue a card pursuant
25 to section 2206(b)(1).

1 “(g) ACTUARIAL VALUATION; DETERMINATION OF
2 ANNUAL PERCENTAGE INCREASES.—

3 “(1) PROCESSES.—For purposes of this section,
4 the Secretary shall establish processes and
5 methods—

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

8 “(i) an actuarial valuation of standard
9 coverage and of the reinsurance subsidy
10 payments under section 2212;

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

13 “(iii) applying the same methodology
14 for determinations of alternative coverage
15 under subsection (e) as is used with re-
16 spect to determinations of standard cov-
17 erage under subsection (d); and

18 “(B) for determining annual percentage in-
19 creases described in subsection (d)(5).

20 “(2) USE OF OUTSIDE ACTUARIES.—Under the
21 processes under paragraph (1)(A), eligible entities
22 and Medicare+Choice organizations may use actu-
23 arial opinions certified by independent, qualified ac-
24 tuaries to establish actuarial values.

1 “BENEFICIARY PROTECTIONS

2 “SEC. 2206. (a) DISSEMINATION OF INFORMA-
3 TION.—

4 “(1) GENERAL INFORMATION.—An eligible enti-
5 ty offering a Medicare Prescription Plus plan shall
6 disclose, in a clear, accurate, and standardized form
7 to each enrollee at the time of enrollment and at
8 least annually thereafter, the information described
9 in section 1852(c)(1) relating to such plan. Such in-
10 formation includes the following:

11 “(A) Access to covered outpatient drugs.

12 “(B) How any formulary used by the enti-
13 ty functions.

14 “(C) Co-payments, coinsurance, and de-
15 ductible requirements.

16 “(D) Grievance and appeals procedures.

17 “(2) DISCLOSURE UPON REQUEST OF GENERAL
18 COVERAGE, UTILIZATION, AND GRIEVANCE INFORMA-
19 TION.—Upon request of an individual eligible to en-
20 roll in a Medicare Prescription Plus plan, the eligible
21 entity offering such plan shall provide the informa-
22 tion described in section 1852(c)(2) to such indi-
23 vidual.

24 “(3) RESPONSE TO BENEFICIARY QUESTIONS.—

25 An eligible entity offering a Medicare Prescription

1 Plus plan shall have a mechanism for providing spe-
2 cific information to enrollees upon request, including
3 information on specific changes in its formulary.

4 “(4) CLAIMS INFORMATION.—An eligible entity
5 offering a Medicare Prescription Plus plan must fur-
6 nish to enrolled individuals in a form easily under-
7 standable to such individuals an explanation of bene-
8 fits (in accordance with section 1806(a) or in a com-
9 parable manner) and a notice of the benefits in rela-
10 tion to initial coverage limit and annual out-of-pock-
11 et limit for the current year, whenever prescription
12 drug benefits are provided under this part (except
13 that such notice need not be provided more often
14 than monthly).

15 “(b) ACCESS TO COVERED OUTPATIENT DRUGS.—

16 “(1) ACCESS TO NEGOTIATED PRICES FOR PRE-
17 SCRIPTION DRUGS.—An eligible entity offering a
18 Medicare Prescription Plus plan shall issue such a
19 card that may be used by an enrolled beneficiary to
20 assure access to negotiated prices under section
21 2205(f) for the purchase of prescription drugs for
22 which coverage is not otherwise provided under the
23 Medicare Prescription Plus plan.

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

1 gible entity offering a Medicare Prescription Plus
2 plan uses a formulary with respect to qualified pre-
3 scription drug coverage, the following requirements
4 must be met:

5 “(A) INCLUSION OF DRUGS IN ALL THERA-
6 PEUTIC CATEGORIES.—The formulary must in-
7 clude drugs within all therapeutic categories
8 and classes of covered outpatient drugs (al-
9 though not necessarily for all drugs within such
10 categories and classes).

11 “(B) APPEALS AND EXCEPTIONS TO AP-
12 PLICATION.—The eligible entity must have, as
13 part of the appeals process under subsection
14 (e)(2), a process for appeals for denials of cov-
15 erage based on such application of the for-
16 mulary.

17 “(c) COST AND UTILIZATION MANAGEMENT.—

18 “(1) IN GENERAL.—An eligible entity shall have
19 in place—

20 “(A) an effective cost and drug utilization
21 management program, including appropriate in-
22 centives to use generic drugs, when appropriate;

23 “(B) quality assurance measures to reduce
24 medical errors and adverse drug interactions,

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

3 “(C) a program to control fraud, abuse,
4 and waste.

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

9 “(d) GRIEVANCE MECHANISM.—An eligible entity
10 shall provide meaningful procedures for hearing and re-
11 solving grievances between the eligible entity (including
12 any entity or individual through which the eligible entity
13 provides covered benefits) and enrollees in a Medicare Pre-
14 scription Plus plan offered by the eligible entity in accord-
15 ance with section 1852(f).

16 “(e) COVERAGE DETERMINATIONS, RECONSIDER-
17 ATIONS, AND APPEALS.—

18 “(1) IN GENERAL.—An eligible entity shall
19 meet the requirements of section 1852(g) with re-
20 spect to covered benefits under the Medicare Pre-
21 scription Plus plan it offers under this part in the
22 same manner as such requirements apply to a
23 Medicare+Choice organization with respect to bene-
24 fits it offers under a Medicare+Choice plan under
25 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.

17 “SEC. 2207. (a) GENERAL REQUIREMENTS.—An eli-
18 gible entity offering a Medicare Prescription Plus plan
19 shall meet the following requirements:

25 “(2) ASSUMPTION OF FULL FINANCIAL RISK.—

1 “(A) IN GENERAL.—Subject to subpara-
2 graph (B), the entity assumes full financial risk
3 on a prospective basis for the benefits that it
4 offers under a Medicare Prescription Plus plan
5 and that is not covered under reinsurance
6 under section 2212.

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

11 “(3) SOLVENCY FOR UNLICENSED ENTITIES.—
12 In the case of an eligible entity that is not described
13 in paragraph (1), the entity shall meet solvency
14 standards established by the Secretary under sub-
15 section (d).

16 “(b) CONTRACT REQUIREMENTS.—The Secretary
17 shall not permit an eligible beneficiary to elect a Medicare
18 Prescription Plus plan offered by an eligible entity under
19 this part, and the entity shall not be eligible for payments
20 under section 2210, 2211(e), or 2212, unless the Sec-
21 retary has entered into a contract under this subsection
22 with the entity with respect to the offering of such plan.
23 Such a contract with an entity may cover more than 1
24 Medicare Prescription Plus plan. Such contract shall pro-
25 vide that the entity agrees to comply with the applicable

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

3 “(c) WAIVER OF CERTAIN REQUIREMENTS TO EX-
4 PAND CHOICE.—

5 “(1) IN GENERAL.—In the case of an eligible
6 entity that seeks to offer a Medicare Prescription
7 Plus plan in a State, the Secretary shall waive the
8 requirement of subsection (a)(1) that the entity be
9 licensed in that State if the Secretary determines,
10 based on the application and other evidence pre-
11 sented to the Secretary, that any of the grounds for
12 approval of the application described in paragraph
13 (2) have been met.

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

20 “(3) APPLICATION OF MEDICARE+CHOICE PSO
21 WAIVER PROCEDURES.—With respect to an applica-
22 tion for a waiver (or a waiver granted) under this
23 subsection, the provisions of subparagraphs (E), (F),
24 and (G) of section 1855(a)(2) shall apply.

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

7 “(5) REFERENCES TO CERTAIN PROVISIONS.—
 8 For purposes of this subsection, in applying the pro-
 9 visions of section 1855(a)(2) under this subsection
 10 to Medicare Prescription Plus plans and eligible
 11 entities—

12 “(A) any reference to a waiver application
 13 under section 1855 shall be treated as a ref-
 14 erence to a waiver application under paragraph
 15 (1); and

16 “(B) any reference to solvency standards
 17 were treated as a reference to solvency stand-
 18 ards established under subsection (d).

19 “(d) SOLVENCY STANDARDS FOR NON-LICENSED
 20 ENTITIES.—

21 “(1) ESTABLISHMENT.—The Secretary shall es-
 22 tablish, by not later than October 1, 2001, financial
 23 solvency and capital adequacy standards that an en-
 24 tity that does not meet the requirements of sub-

1 section (a)(1) must meet to qualify as an eligible en-
2 tity under this part.

3 “(2) COMPLIANCE WITH STANDARDS.—An eligi-
4 ble entity that is not licensed by a State under sub-
5 section (a)(1) and for which a waiver application has
6 been approved under subsection (c) shall meet sol-
7 vency and capital adequacy standards established
8 under paragraph (1). The Secretary shall establish
9 certification procedures for such eligible entities with
10 respect to such solvency standards in the manner de-
11 scribed in section 1855(c)(2).

12 “(e) OTHER STANDARDS.—The Secretary shall es-
13 tablish by regulation other standards (not described in
14 subsection (d)) for eligible entities and Medicare Prescrip-
15 tion Plus plans consistent with, and to carry out, this part.
16 The Secretary shall publish such regulations by October
17 1, 2001.

18 “(f) RELATION TO STATE LAWS.—

19 “(1) IN GENERAL.—The standards established
20 under this section shall supersede any State law or
21 regulation (including standards described in para-
22 graph (2)) with respect to Medicare Prescription
23 Plus plans which are offered by eligible entities
24 under this part to the extent such law or regulation
25 is inconsistent with such standards, in the same

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

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

6 “(A) Benefit requirements.

7 “(B) Requirements relating to inclusion or
8 treatment of providers.

9 “(C) Coverage determinations (including
10 related appeals and grievance processes).

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

18 “SUBMISSION OF MEDICARE PRESCRIPTION PLUS PLANS

19 “SEC. 2208. (a) IN GENERAL.—Each eligible entity
20 that intends to offer a Medicare Prescription Plus plan
21 in a year (beginning with 2003) shall submit to the Sec-
22 retary, at such time and in such manner as the Secretary
23 may specify, such information as the Secretary may re-
24 quire, including the information described in subsection
25 (b).

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

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

7 “(2) Information on the actuarial value of the
8 qualified prescription drug coverage.

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

12 “(A) the actuarial basis for such premium;

13 “(B) the portion of such premium attrib-
14 utable to benefits in excess of standard cov-
15 erage; and

16 “(C) the reduction in such premium result-
17 ing from the reinsurance subsidy payments pro-
18 vided under section 2212.

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

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

22 “APPROVAL OF MEDICARE PRESCRIPTION PLUS PLANS

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

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

8 “(c) SPECIAL RULES FOR APPROVAL.—

9 “(1) SERVICE AREA.—The Secretary may ap-
 10 prove a service area submitted under section
 11 2208(b)(4) only if the Secretary finds that—

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

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

18 “(2) AVOIDANCE OF FAVORABLE SELECTION.—

19 The Secretary may approve a Medicare Prescription
 20 Plus plan submitted under section 2208 only if the
 21 benefits under such plan—

22 “(A) include the required benefits under
 23 section 2205(a)(1); and

6 “SEC. 2210. (a) IN GENERAL.—Subject to subsection
7 (b), for each year (beginning with 2003), the Secretary
8 shall pay to each eligible entity offering a Medicare Pre-
9 scription Plus plan in which an eligible beneficiary is en-
10 rolled an amount equal to—

“(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).

24 “SEC. 2211. (a) COMPUTATION.—

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

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

7 “(B) the amount of the discount deter-
 8 mined under subsection (b).

9 “(2) COLLECTION OF PREMIUM AMOUNT IN
 10 SAME MANNER AS PART B PREMIUM.—

11 “(A) IN GENERAL.—The amount of the
 12 annual beneficiary premium determined under
 13 paragraph (1) shall be collected and credited to
 14 the Medicare Prescription Drug Account in the
 15 same manner as the monthly premium deter-
 16 mined under section 1839 is collected and cred-
 17 ited to the Federal Supplementary Medical In-
 18 surance Trust Fund under section 1840.

19 “(B) INFORMATION NECESSARY FOR COL-
 20 LECTION.—In order to carry out subparagraph
 21 (A), the Secretary shall transmit to the Sec-
 22 retary of Social Security—

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

1 individual enrolled in a Medicare Prescrip-
2 tion Plus plan for each month during the
3 year; and

4 “(ii) periodically throughout the year,
5 information to update the information pre-
6 viously transmitted under this paragraph
7 for the year.

8 “(b) DISCOUNTS FOR REQUIRED DRUG PORTION OF
9 PREMIUM.—

10 “(1) FULL PREMIUM DISCOUNT AND REDUC-
11 TION OF COST-SHARING FOR INDIVIDUALS WITH IN-
12 COME BELOW 135 PERCENT OF FEDERAL POVERTY
13 LEVEL.—In the case of a low-income individual (as
14 defined in paragraph (5)(A)) who is determined to
15 have income that does not exceed 135 percent of the
16 Federal poverty level, the individual is entitled under
17 this section—

18 “(A) to a premium discount equal to 100
19 percent of the amount described in subsection
20 (c); and

21 “(B) subject to subsection (d), to the sub-
22 stitution for the beneficiary cost-sharing de-
23 scribed in paragraphs (1) and (2) of section
24 2205(d) (up to the initial coverage limit speci-

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

3 “(2) SLIDING SCALE PREMIUM DISCOUNT FOR
4 INDIVIDUALS WITH INCOME ABOVE 135, BUT BELOW
5 150 PERCENT, OF FEDERAL POVERTY LEVEL.—In
6 the case of a low-income individual who is deter-
7 mined to have income that exceeds 135 percent, but
8 does not exceed 150 percent, of the Federal poverty
9 level, the individual is entitled under this section to
10 a premium discount determined on a linear sliding
11 scale ranging from 100 percent of the amount de-
12 scribed in subsection (c) for individuals with incomes
13 at 135 percent of such level to 25 percent of such
14 amount for individuals with incomes at 150 percent
15 of such level.

16 “(3) PARTIAL PREMIUM DISCOUNT FOR INDI-
17 VIDUALS WITH INCOME ABOVE 150 PERCENT OF
18 FEDERAL POVERTY LEVEL.—In the case of an eligi-
19 ble beneficiary who is not a low-income individual,
20 the beneficiary is entitled under this section to a
21 premium discount equal to 25 percent of the amount
22 described in subsection (c).

23 “(4) TAX TREATMENT OF PREMIUM DIS-
24 COUNT.—

1 “(A) IN GENERAL.—For purposes of the
2 Internal Revenue Code of 1986, the premium
3 discount determined under this subsection for
4 an eligible beneficiary for a year shall be in-
5 cluded in the gross income of the beneficiary for
6 the year.

7 “(B) STATEMENT OF TAXABLE AMOUNT.—
8 Not later than January 31 of each year (begin-
9 ning with 2004), the Secretary shall provide—

10 “(i) each eligible beneficiary enrolled
11 under this part with a statement that de-
12 scribes the amount of the discount that is
13 required to be included in the gross income
14 of the beneficiary for the previous year
15 pursuant to subparagraph (A); and

16 “(ii) the Secretary of the Treasury
17 with the information described in clause
18 (i).

19 “(5) DETERMINATION OF ELIGIBILITY.—

20 “(A) LOW-INCOME INDIVIDUAL DE-
21 FINED.—For purposes of this section, subject
22 to subparagraph (D), the term ‘low-income indi-
23 vidual’ means an individual who—

24 “(i) is eligible to enroll, and has en-
25 rolled, under this part;

1 “(ii) has income below 150 percent of
2 the Federal poverty line; and

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

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

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

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

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

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

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

10 “(c) PREMIUM DISCOUNT AMOUNT.—The premium
11 discount amount described in this subsection for an eligi-
12 ble beneficiary residing in an area is an amount equal to—

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

18 “(2) in the case of an individual enrolled in a
19 Medicare+Choice plan that provides qualified pre-
20 scription drug coverage, the standard premium com-
21 puted under section 1851(j)(5)(A)(iii).

22 “(d) RULES IN APPLYING COST-SHARING SUB-
23 SIDIES.—

24 “(1) IN GENERAL.—In applying subsection
25 (b)(1)(B)—

1 “(A) the maximum amount of subsidy that
2 may be provided with respect to an enrollee for
3 a year may not exceed 95 percent of the max-
4 imum cost-sharing described in such subsection
5 that may be incurred for standard coverage;

6 “(B) the Secretary shall determine what is
7 ‘nominal’ taking into account the rules applied
8 under section 1916(a)(3); and

9 “(C) nothing in this part shall be con-
10 strued as preventing a plan or provider from
11 waiving or reducing the amount of cost-sharing
12 otherwise applicable.

13 “(2) LIMITATION ON CHARGES.—In the case of
14 a low-income individual receiving cost-sharing sub-
15 sidies under subsection (b)(1)(B), the eligible entity
16 may not charge more than a nominal amount in
17 cases in which the cost-sharing subsidy is provided
18 under such subsection.

19 “(e) ADMINISTRATION OF COST-SHARING PRO-
20 GRAM.—The Secretary shall provide a process whereby, in
21 the case of a low-income individual who is eligible for re-
22 duced cost-sharing under subsection (b)(1)(B) and is en-
23 rolled in a Medicare Prescription Plus plan or a
24 Medicare+Choice plan under which qualified prescription
25 drug coverage is provided—

1 “(1) the Secretary provides for a notification of
2 the eligible entity or Medicare+Choice organization
3 involved that the individual is eligible for such re-
4 duced cost-sharing;

5 “(2) the entity or organization involved reduces
6 the cost-sharing pursuant to this section and sub-
7 mits to the Secretary information on the amount of
8 such reduction; and

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

12 The reimbursement under paragraph (3) may be com-
13 puted on a capitated basis, taking into account the actu-
14 arial value of the reductions and with appropriate adjust-
15 ments to reflect differences in the risks actually involved.

16 “(f) RELATION TO MEDICAID PROGRAM.—

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

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

1 “ADDITIONAL PRESCRIPTION DRUG SUBSIDIES THROUGH
2 REINSURANCE

3 “SEC. 2212. (a) REINSURANCE SUBSIDY PAY-
4 MENT.—In order to reduce premium levels applicable to
5 qualified prescription drug coverage for all medicare bene-
6 ficiaries, to reduce adverse selection among Medicare Pre-
7 scription Plus plans and Medicare+Choice plans that pro-
8 vide qualified prescription drug coverage, and to promote
9 the participation of eligible entities under this part, the
10 Secretary shall provide in accordance with this section for
11 payment to a qualifying entity (as defined in subsection
12 (b)) of the reinsurance payment amount (as defined in
13 subsection (c)) for excess costs incurred in providing quali-
14 fied prescription drug coverage—

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

17 “(2) for individuals enrolled with a
18 Medicare+Choice plan that provides qualified pre-
19 scription drug coverage under part C of title XVIII;
20 and

21 “(3) for medicare secondary payer eligible indi-
22 viduals (described in subsection (e)(3)(D)) who are
23 enrolled in a qualified retiree prescription drug plan.

24 This section constitutes budget authority in advance of ap-
25 propriations Acts and represents the obligation of the Sec-

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

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

8 “(1) An eligible entity offering a Medicare Pre-
9 scription Plus plan under this part.

10 “(2) A Medicare+Choice organization that pro-
11 vides qualified prescription drug coverage under a
12 Medicare+Choice plan under part C of title XVIII.

13 “(3) The sponsor of a qualified retiree prescrip-
14 tion drug plan (as defined in subsection (e)).

15 “(c) REINSURANCE PAYMENT AMOUNT.—

16 “(1) IN GENERAL.—Subject to subsection (e)(2)
17 and paragraph (4), the reinsurance payment amount
18 under this subsection for a qualified beneficiary (as
19 defined in subsection (f)(1)) for a coverage year (as
20 defined in subsection (f)(2)) is an amount equal to
21 80 percent of the allowable costs attributable to the
22 portion of the individual’s gross covered prescription
23 drug costs for the year that exceeds \$7,050.

24 “(2) ALLOWABLE COSTS.—For purposes of this
25 section, the term ‘allowable costs’ means, with re-

1 spect to gross covered prescription drug costs under
2 a plan described in subsection (b) offered by a quali-
3 fying entity, the part of such costs that are actually
4 paid under the plan, but in no case more than the
5 part of such costs that would have been paid under
6 the plan if the prescription drug coverage under the
7 plan were standard coverage.

8 “(3) GROSS COVERED PRESCRIPTION DRUG
9 COSTS.—For purposes of this section, the term
10 ‘gross covered prescription drug costs’ means, with
11 respect to an enrollee with a qualifying entity under
12 a plan described in subsection (b) during a coverage
13 year, the costs incurred under the plan for covered
14 prescription drugs dispensed during the year, includ-
15 ing costs relating to the deductible, whether paid by
16 the enrollee or under the plan, regardless of whether
17 the coverage under the plan exceeds standard cov-
18 erage and regardless of when the payment for such
19 drugs is made.

20 “(4) INDEXING DOLLAR AMOUNT.—

21 “(A) AMOUNT FOR 2003.—The dollar
22 amount applied under paragraph (1) for 2003
23 shall be the dollar amount specified in such
24 paragraph.

1 “(B) FOR 2004.—The dollar amount ap-
2 plied under paragraph (1) for 2004 shall be the
3 dollar amount specified in such paragraph in-
4 creased by the annual percentage increase de-
5 scribed in section 2205(d)(5) for 2004.

6 “(C) FOR SUBSEQUENT YEARS.—The dol-
7 lar amount applied under paragraph (1) for a
8 year after 2004 shall be the dollar amount
9 (under this paragraph) applied under para-
10 graph (1) for the preceding year increased by
11 the annual percentage increase described in sec-
12 tion 2205(d)(5) for the year involved.

13 “(D) ROUNDING.—Any amount, deter-
14 mined under the preceding provisions of this
15 paragraph for a year, which is not a multiple of
16 \$5 shall be rounded to the nearest multiple of
17 \$5.

18 “(d) PAYMENT METHODS.—

19 “(1) IN GENERAL.—Payments under this sec-
20 tion shall be based on such a method as the Sec-
21 retary determines. The Secretary may establish a
22 payment method by which interim payments of
23 amounts under this section are made during a year
24 based on the Secretary’s best estimate of amounts

1 that will be payable after obtaining all of the infor-
2 mation.

3 “(2) SOURCE OF PAYMENTS.—Payments under
4 this section shall be made from the Medicare Pre-
5 scription Drug Account.

6 “(e) QUALIFIED RETIREE PRESCRIPTION DRUG
7 PLAN DEFINED.—

8 “(1) IN GENERAL.—For purposes of this sec-
9 tion, the term ‘qualified retiree prescription drug
10 plan’ means employment-based retiree health cov-
11 erage (as defined in paragraph (3)(A)) if, with re-
12 spect to an individual enrolled (or eligible to be en-
13 rolled) under this part who is covered under the
14 plan, the following requirements are met:

15 “(A) ASSURANCE.—The sponsor of the
16 plan shall annually attest, and provide such as-
17 surances as the Secretary may require, that the
18 coverage meets the requirements for qualified
19 prescription drug coverage.

20 “(B) AUDITS.—The sponsor (and the plan)
21 shall maintain, and afford the Secretary access
22 to, such records as the Secretary may require
23 for purposes of audits and other oversight ac-
24 tivities necessary to ensure the adequacy of pre-
25 scription drug coverage, the accuracy of pay-

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

3 “(C) OTHER REQUIREMENTS.—The spon-
4 sor of the plan shall comply with such other re-
5 quirements as the Secretary finds necessary to
6 administer the program under this section.

7 “(2) LIMITATION ON BENEFIT ELIGIBILITY.—
8 No payment shall be provided under this section
9 with respect to an individual who is enrolled under
10 a qualified retiree prescription drug plan unless the
11 individual is a medicare secondary payer eligible in-
12 dividual who—

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

14 “(B) is eligible to obtain qualified prescrip-
15 tion drug coverage under this part but did not
16 elect such coverage (either through a Medicare
17 Prescription Plus plan or through a
18 Medicare+Choice plan).

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

20 “(A) EMPLOYMENT-BASED RETIREE
21 HEALTH COVERAGE.—The term ‘employment-
22 based retiree health coverage’ means health in-
23 surance or other coverage of health care costs
24 for medicare secondary payer eligible individ-
25 uals (or for such individuals and their spouses

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

3 “(B) EMPLOYER.—The term ‘employer’
4 has the meaning given such term by section
5 3(5) of the Employee Retirement Income Secu-
6 rity Act of 1974 (except that such term shall
7 include only employers of 2 or more employees).

8 “(C) SPONSOR.—The term ‘sponsor’
9 means a plan sponsor, as defined in section
10 3(16)(B) of the Employee Retirement Income
11 Security Act of 1974.

12 “(D) MEDICARE SECONDARY PAYER INDIVIDUAL.—The term ‘medicare secondary payer
13 eligible individual’ means, with respect to a
14 plan, an individual who is covered under the
15 plan and with respect to whom the plan is not
16 a primary plan (as defined in section
17 1862(b)(2)(A)).

18
19 “(f) GENERAL DEFINITIONS.—For purposes of this
20 section:

21 “(1) QUALIFIED BENEFICIARY.—The term
22 ‘qualified beneficiary’ means an individual who—

23 “(A) is enrolled with a Medicare Prescrip-
24 tion Plus plan under this part;

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

4 “(C) is covered as a medicare secondary
5 payer eligible individual under a qualified re-
6 tiree prescription drug plan.

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

12 “PLAN FEES FOR ADMINISTRATIVE COSTS

13 “SEC. 2213. (a) IN GENERAL.—The Secretary may
14 levy on Medicare Prescription Plus plans and
15 Medicare+Choice plans that provide drug coverage pursu-
16 ant to this part an assessment sufficient to pay the esti-
17 mated expenses of the Secretary for administering the pro-
18 gram under this part.

19 “(b) DEPOSITS AND USE.—The assessments de-
20 scribed in subsection (a) shall be—

21 “(1) deposited into the Medicare Prescription
22 Drug Account; and

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

1 “MEDICARE PRESCRIPTION DRUG ACCOUNT

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

6 “(b) AMOUNTS IN ACCOUNT.—

7 “(1) IN GENERAL.—The Medicare Prescription
8 Drug Account shall consist of—

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

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

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

19 “(c) PAYMENTS FROM ACCOUNT.—

20 “(1) IN GENERAL.—The Managing Trustee
21 shall pay from time to time from the Medicare Pre-
22 scription Drug Account such amounts as the Sec-
23 retary certifies are necessary to make the payments
24 provided for by this part, and the payments with re-

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

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

11 “(d) DEPOSITS INTO ACCOUNT.—

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

18 “(2) APPROPRIATIONS TO COVER GOVERNMENT
19 CONTRIBUTIONS.—There are authorized to be appro-
20 priated from time to time, out of any moneys in the
21 Treasury not otherwise appropriated, to the Ac-
22 count, an amount equivalent to the amount of pay-
23 ments made from the Account, reduced by—

24 “(1) the amount transferred to the Ac-
25 count under paragraph (1);

1 “(2) the beneficiary premiums collected
2 and credited to the account under section
3 2211(b)(2); and

4 “(3) fees collected and credited to the ac-
5 count under section 2213.

6 “SECONDARY PAYER PROVISIONS

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

9 “DEFINITIONS; TREATMENT OF REFERENCES TO
10 PROVISIONS IN MEDICARE+CHOICE PROGRAM

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

12 “(1) COVERED OUTPATIENT DRUG.—

13 “(A) IN GENERAL.—Except as provided in
14 this subparagraph (B), the term ‘covered out-
15 patient drug’ means—

16 “(i) a drug that may be dispensed
17 only upon a prescription and that is de-
18 scribed in clause (i) or (ii) of section
19 1927(k)(2)(A); or

20 “(ii) a biological product or insulin de-
21 scribed in subparagraph (B) or (C) of such
22 section.

23 “(B) EXCLUSIONS.—

24 “(i) IN GENERAL.—The term ‘covered
25 outpatient drug’ does not include drugs or
26 classes of drugs, or their medical uses,

1 which may be excluded from coverage or
2 otherwise restricted under section
3 1927(d)(2), other than subparagraph (E)
4 thereof (relating to smoking cessation
5 agents).

6 “(ii) AVOIDANCE OF DUPLICATE COV-
7 ERAGE.—A drug prescribed for an indi-
8 vidual that would otherwise be a covered
9 outpatient drug under this part shall not
10 be so considered if payment for such drug
11 is available under part A or B of title
12 XVIII (but shall be so considered if such
13 payment is not available because benefits
14 under part A or B of title XVIII have been
15 exhausted), without regard to whether the
16 individual is entitled to benefits under such
17 part A or enrolled under such part B.

18 “(3) ELIGIBLE BENEFICIARY.—The term ‘eligi-
19 ble beneficiary’ means an individual that is entitled
20 to benefits under part A of title XVIII and enrolled
21 under part B of such title.

22 “(4) ELIGIBLE ENTITY.—The term ‘eligible en-
23 tity’ means any risk-bearing entity that the Sec-
24 retary determines to be appropriate to provide eligi-

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

3 “(A) a pharmaceutical benefit management
4 company;

5 “(B) a wholesale or retail pharmacist deliv-
6 ery system;

7 “(C) an insurer (including an insurer that
8 offers medicare supplemental policies under sec-
9 tion 1882);

10 “(D) another entity; or

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

13 “(5) INITIAL COVERAGE LIMIT.—The term ‘ini-
14 tial coverage limit’ means the limit as established
15 under section 2205(d)(3), or, in the case of coverage
16 that is not standard coverage, the comparable limit
17 (if any) established under the coverage.

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

1 “(7) MEDICARE PRESCRIPTION DRUG AC-
2 COUNT.—The term ‘Medicare Prescription Drug Ac-
3 count’ means the Medicare Prescription Drug Ac-
4 count established under section 2214 and located
5 within the Federal Supplementary Medical Insur-
6 ance Trust Fund established under section 1841.

7 “(8) MEDICARE PRESCRIPTION PLUS PLAN.—
8 The term ‘Medicare Prescription Plus plan’ means a
9 health benefits plan that the Secretary has approved
10 under section 2209.

11 “(9) STANDARD COVERAGE.—The term ‘stand-
12 ard coverage’ means the coverage described in sec-
13 tion 2205(d).

14 “(b) APPLICATION OF MEDICARE+CHOICE PROVI-
15 SIONS UNDER THIS PART.—For purposes of applying pro-
16 visions of part C of title XVIII under this part with re-
17 spect to a Medicare Prescription Plus plan and an eligible
18 entity, unless otherwise provided in this part such provi-
19 sions shall be applied as if—

20 “(1) any reference to a Medicare+Choice plan
21 included a reference to a Medicare Prescription Plus
22 plan;

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

1 “(3) any reference to a contract under section
 2 1857 included a reference to a contract under sec-
 3 tion 2207(b); and

4 “(4) any reference to part C of title XVIII in-
 5 cluded a reference to this part.”.

6 (b) SUBMISSION OF LEGISLATIVE PROPOSAL.—Not
 7 later than 6 months after the date of enactment of this
 8 Act, the Secretary of Health and Human Services shall
 9 submit to the appropriate committees of Congress a legis-
 10 lative proposal providing for such technical and con-
 11 forming amendments in the law as are required by the
 12 provisions of this Act.

13 **SEC. 202. AMENDMENTS TO FEDERAL SUPPLEMENTARY**
 14 **MEDICAL INSURANCE TRUST FUND.**

15 Section 1841 of the Social Security Act (42 U.S.C.
 16 1395t) is amended—

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

18 (A) by striking “and” after “section
 19 201(i)(1)”; and

20 (B) by inserting before the period the fol-
 21 lowing: “, and such amounts as may be depos-
 22 ited in, or appropriated to, the Medicare Pre-
 23 scription Drug Account established by section
 24 2214”;

1 (2) in subsection (g), by inserting after “by this
 2 part,” the following: “the payments provided for
 3 under the Prescription Drug and Supplemental Ben-
 4 efit Program under title XXII (in which case the
 5 payments shall come from the Medicare Prescription
 6 Drug Account in the Supplementary Medical Insur-
 7 ance Trust Fund),”;

8 (3) in the first sentence of subsection (h), by
 9 inserting “(or the Secretary by reason of section
 10 2215 (in which case the payments shall come from
 11 the Medicare Prescription Drug Account within such
 12 Trust Fund))” after “Human Services”; and

13 (4) in the first sentence of subsection (i), by in-
 14 serting “(or the Secretary by reason of section 2215
 15 (in which case the payments shall come from the
 16 Medicare Prescription Drug Account within such
 17 Trust Fund))” after “Human Services”.

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

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

23 “(j) AVAILABILITY OF PRESCRIPTION DRUG BENE-
 24 FITS.—

1 “(1) IN GENERAL.—A Medicare+Choice orga-
2 nization may not offer prescription drug coverage
3 (other than that required under parts A and B) to
4 an enrollee under a Medicare+Choice plan unless
5 such drug coverage is at least qualified prescription
6 drug coverage and unless the requirements of this
7 subsection with respect to such coverage are met.

8 “(2) COMPLIANCE WITH ADDITIONAL BENE-
9 FICIARY PROTECTIONS.—With respect to the offer-
10 ing of qualified prescription drug coverage by a
11 Medicare+Choice organization under a
12 Medicare+Choice plan, the organization and plan
13 shall meet the requirements of section 2206, includ-
14 ing requirements relating to information dissemina-
15 tion and grievance and appeals, in the same manner
16 as they apply to an eligible entity and a Medicare
17 Prescription Plus plan under title XXII. The Sec-
18 retary shall waive such requirements to the extent
19 the Administrator determines that such require-
20 ments duplicate requirements otherwise applicable to
21 the organization or plan under this part.

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

1 plemental health care benefits described in section
2 1852(a)(3)(A).

3 “(4) AVAILABILITY OF COST-SHARING SUB-
4 SIDIES FOR LOW-INCOME ENROLLEES AND REINSUR-
5 ANCE SUBSIDY PAYMENTS FOR ORGANIZATIONS.—
6 For provisions—

7 “(A) providing cost-sharing subsidies to
8 low-income individuals receiving qualified pre-
9 scription drug coverage through a
10 Medicare+Choice plan, see section 2211; and

11 “(B) providing a Medicare+Choice organi-
12 zation with reinsurance subsidy payments for
13 providing qualified prescription drug coverage
14 under this part, see section 2212.

15 “(5) SPECIFICATION OF SEPARATE AND STAND-
16 ARD PREMIUM.—

17 “(A) IN GENERAL.—For purposes of ap-
18 plying section 1854 and determining the pre-
19 mium discount under section 2211(c) with re-
20 spect to qualified prescription drug coverage of-
21 fered under this subsection under a plan, the
22 Medicare+Choice organization shall compute
23 and publish the following:

24 “(i) SEPARATE PRESCRIPTION DRUG
25 PREMIUM.—A premium for prescription

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

4 “(ii) PORTION OF COVERAGE ATTRIB-
5 UTABLE TO STANDARD BENEFITS.—The
6 ratio of the actuarial value of standard
7 coverage to the actuarial value of the
8 qualified prescription drug coverage offered
9 under the plan.

10 “(iii) PORTION OF PREMIUM ATTRIB-
11 UTABLE TO STANDARD BENEFITS.—A
12 standard premium equal to the product of
13 the premium described in clause (i) and
14 the ratio under clause (ii).

15 The premium under clause (i) shall be com-
16 puted without regard to any reduction in the
17 premium permitted under subparagraph (B).

18 “(B) REDUCTION OF PREMIUMS AL-
19 LOWED.—Nothing in this subsection shall be
20 construed as preventing a Medicare+Choice or-
21 ganization from reducing the amount of a pre-
22 mium charged for prescription drug coverage
23 because of the application of subsections
24 (f)(1)(A) and (i)(2)(A) of section 1854 to other
25 coverage.

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

6 “(7) QUALIFIED PRESCRIPTION DRUG COV-
 7 ERAGE; STANDARD COVERAGE.—For purposes of
 8 this part, the terms ‘qualified prescription drug cov-
 9 erage’ and ‘standard coverage’ have the meanings
 10 given such terms in section 2205.”.

11 (b) CONFORMING AMENDMENTS.—Section
 12 1851(a)(1) of such Act (42 U.S.C. 1395w–21(a)(1)) is
 13 amended—

14 (1) by inserting “(other than qualified prescrip-
 15 tion drug benefits)” after “benefits”;

16 (2) by striking the period at the end of sub-
 17 paragraph (B) and inserting a comma; and

18 (3) by adding at the end the following flush lan-
 19 guage:

20 “and may elect qualified prescription drug coverage
 21 in accordance with title XXII.”.

22 (c) EFFECTIVE DATE.—The amendments made by
 23 this section apply to coverage provided on or after January
 24 1, 2003.

1 **SEC. 205. MEDIGAP PROVISIONS.**

2 (a) IN GENERAL.—Notwithstanding any other provi-
3 sion of law, no new medicare supplemental policy that pro-
4 vides coverage of expenses for prescription drugs may be
5 issued under section 1882 of the Social Security Act on
6 or after January 1, 2003, to an individual unless it re-
7 places a medicare supplemental policy that was issued to
8 that individual and that provided some coverage of ex-
9 penses for prescription drugs.

10 (b) ISSUANCE OF SUBSTITUTE POLICIES IF OBTAIN-
11 ING PRESCRIPTION DRUG COVERAGE THROUGH MEDI-
12 CARE.—

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

15 (A) may not deny or condition the issuance
16 or effectiveness of a medicare supplemental pol-
17 icy that has a benefit package classified as “A”,
18 “B”, “C”, “D”, “E”, “F”, or “G” (under the
19 standards established under subsection (p)(2) of
20 section 1882 of the Social Security Act (42
21 U.S.C. 1395ss)) and that is offered and is
22 available for issuance to new enrollees by such
23 issuer;

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

1 perience, receipt of health care, or medical con-
2 dition; and

3 (C) may not impose an exclusion of bene-
4 fits based on a preexisting condition under such
5 policy,

6 in the case of an individual described in paragraph
7 (2) who seeks to enroll under the policy not later
8 than 63 days after the date of the termination of en-
9 rollment described in such paragraph and who sub-
10 mits evidence of the date of termination or
11 disenrollment along with the application for such
12 medicare supplemental policy.

13 (2) INDIVIDUAL COVERED.—An individual de-
14 scribed in this paragraph is an individual who—

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

18 (B) at the time of such enrollment was en-
19 rolled and terminates enrollment in a medicare
20 supplemental policy which has a benefit pack-
21 age classified as “H”, “I”, or “J” under the
22 standards referred to in paragraph (1)(A) or
23 terminates enrollment in a policy to which such
24 standards do not apply but which provides ben-
25 efits for prescription drugs.

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

5 (4) DEFINITIONS.—For purposes of this sub-
 6 section, the term “medicare supplemental policy”
 7 has the meaning given such term in section 1882(g)
 8 of the Social Security Act (42 U.S.C. 1395ss(g)).

9 (c) MEDIGAP PROTECTIONS FOR INDIVIDUALS WHO
 10 LOSE MEDICARE PRESCRIPTION PLUS PLAN COV-
 11 ERAGE.—Section 1882 of the Social Security Act (42
 12 U.S.C. 1395ss) is amended—

13 (1) in subsection (d)(3)—

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

16 “(ix) Nothing in this subparagraph shall be construed
 17 as preventing the sale of 1 medicare supplemental policy
 18 and 1 Medicare Prescription Plus plan to an individual,
 19 except that the sale of such a policy or plan may not dupli-
 20 cate any health benefits under any policy or plan owned
 21 by the individual.”; and

22 (B) in subparagraph (B)(iii)—

23 (i) in subclause (I), by striking “(II)
 24 and (III)” and inserting “(II), (III), and
 25 (IV)”;

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

3 (iii) by inserting after subclause (II)
 4 the following:

5 “(III) If the statement required by clause (i) is ob-
 6 tained and indicates that the individual is enrolled in 1
 7 medicare supplemental policy or 1 Medicare Prescription
 8 Plus plan, the sale of another policy or plan is not in viola-
 9 tion of clause (i) if such other policy or plan does not du-
 10 plicate health benefits under the policy or plan in which
 11 the individual is enrolled.”;

12 (2) in subsection (g)(1), by inserting “, Medi-
 13 care Prescription Plus plan,” after
 14 “Medicare+Choice plan”; and

15 (3) in subsection (s)(3)—
 16 (A) in subparagraph (B)—

17 (i) in clause (ii), by inserting “is en-
 18 rolled with an eligible entity under a Medi-
 19 care Prescription Plus plan under title
 20 XXII or” after “section 1851(e)(4) or the
 21 individual”;

22 (ii) in clause (v)(II), by inserting
 23 “with any eligible entity under a Medicare
 24 Prescription Plus plan under title XXII,”
 25 after “under part C,”; and

1 (iii) in clause (vi), by inserting “, in
2 a Medicare Prescription Plus plan under
3 title XXII,” after “under part C”; and
4 (B) in subparagraph (E)—

5 (i) in clause (i), by inserting “(or, in
6 the case of an individual enrolled under a
7 Medicare Prescription Plus plan, the date
8 on which the individual was notified by the
9 eligible entity of the impending termination
10 or discontinuance of the Medicare Pre-
11 scription Plus plan) after “it offers in the
12 area”; and

13 (ii) in clause (ii), by inserting “or
14 Medicare Prescription Plus plan” after
15 “Medicare+Choice plan”.

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