

107TH CONGRESS
1ST SESSION

S. 1185

To amend title XVIII of the Social Security Act to assure access of medicare beneficiaries to prescription drug coverage through the SPICE drug benefit program.

IN THE SENATE OF THE UNITED STATES

JULY 17, 2001

Mr. WYDEN (for himself and Ms. SNOWE) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend title XVIII of the Social Security Act to assure access of medicare beneficiaries to prescription drug coverage through the SPICE drug benefit 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 “Seniors Prescription Insurance Coverage Equity
6 (SPICE) Act of 2001”.

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

- Sec. 1. Short title; table of contents.
- Sec. 2. SPICE drug benefit program.

“PART D—SPICE DRUG BENEFIT PROGRAM

- “Sec. 1860A. Establishment of SPICE drug benefit program.
- “Sec. 1860B. SPICE prescription drug coverage.
- “Sec. 1860C. Enrollment under SPICE drug benefit program.
- “Sec. 1860D. Enrollment in a policy or plan.
- “Sec. 1860E. Medicare Drug Plan for Noncompetitive Areas.
- “Sec. 1860F. Selection of private entities to provide basic coverage.
- “Sec. 1860G. Providing information to beneficiaries.
- “Sec. 1860H. Premiums.
- “Sec. 1860I. Approval for entities offering SPICE prescription drug coverage.
- “Sec. 1860J. Payments to entities.
- “Sec. 1860K. Financial assistance to obtain SPICE prescription drug coverage.
- “Sec. 1860L. Employer incentive program for employment-based retiree drug coverage.
- “Sec. 1860M. SPICE Board.
- “Sec. 1860N. SPICE Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.”.

Sec. 3. SPICE prescription drug coverage under Medicare+Choice plans.

Sec. 4. Medigap revisions and transition provisions.

Sec. 5. Provision of information on SPICE drug benefit program under health insurance information, counseling, and assistance grants.

Sec. 6. Personal Digital Access Technology Demonstration Project.

1 SEC. 2. SPICE DRUG BENEFIT PROGRAM.

2 (a) IN GENERAL.—Title XVIII of the Social Security
3 Act (42 U.S.C. 1395 et seq.) is amended by redesignating
4 part D as part E and by inserting after part C the fol-
5 lowing new part:

6 “PART D—SPICE DRUG BENEFIT PROGRAM

7 “ESTABLISHMENT OF SPICE DRUG BENEFIT PROGRAM

8 “SEC. 1860A. (a) ACCESS TO SPICE PRESCRIPTION
9 DRUG COVERAGE.—

10 “(1) IN GENERAL.—Beginning in 2003, the
11 SPICE Board (established under section 1860M)
12 shall provide for a SPICE drug benefit program
13 under which all eligible medicare beneficiaries who
14 voluntarily enroll under this part shall be entitled to

1 obtain SPICE prescription drug coverage (meeting
2 the terms and conditions under this part) as follows:

3 “(A) MEDICARE+CHOICE PLAN.—If the el-
4 igible medicare beneficiary is eligible to enroll in
5 a Medicare+Choice plan, the beneficiary may
6 enroll in the plan and obtain SPICE prescrip-
7 tion drug coverage (as defined in section
8 1860B(a)) through such plan.

9 “(B) MEDICARE SUPPLEMENTAL POL-
10 ICY.—If the eligible medicare beneficiary is not
11 enrolled in a Medicare+Choice plan but is en-
12 rolled in a medicare supplemental policy, the
13 beneficiary may—

14 “(i) obtain SPICE prescription drug
15 coverage through such policy; or

16 “(ii) waive basic coverage (as defined
17 in section 1860B(b)) pursuant to section
18 1860C(a)(3) and obtain financial assist-
19 ance pursuant to section 1860K(c) for
20 stop-loss coverage (as defined in section
21 1860B(c)) provided under such policy.

22 “(C) MEDICARE DRUG PLAN FOR NON-
23 COMPETITIVE AREAS.—If the eligible medicare
24 beneficiary is not enrolled in a
25 Medicare+Choice plan, a medicare supple-

1 mental policy, or a basic coverage plan under
 2 section 1860F, and there is a Medicare Drug
 3 Plan for Noncompetitive Areas available in the
 4 area in which the beneficiary resides, the bene-
 5 ficiary may obtain SPICE prescription drug
 6 coverage under this part through enrollment in
 7 such plan.

8 “(D) BASIC COVERAGE ONLY THROUGH A
 9 PRIVATE ENTITY.—If the eligible medicare ben-
 10 eficiary is not enrolled in a Medicare+Choice
 11 plan, a medicare supplemental policy, or a
 12 Medicare Drug Plan for Noncompetitive Areas,
 13 the beneficiary may obtain basic coverage (in-
 14 cluding financial assistance for such coverage
 15 under section 1860K(b) and access to nego-
 16 tiated prices under section 1860B(d)) through
 17 enrollment in a plan offered by a private entity
 18 with a contract to offer such plan under section
 19 1860F.

20 “(2) VOLUNTARY NATURE OF PROGRAM.—
 21 Nothing in this part shall be construed as requiring
 22 an eligible medicare beneficiary to enroll in the pro-
 23 gram established under this part.

24 “(3) ADMINISTRATION OF BENEFITS.—In pro-
 25 viding SPICE prescription drug coverage to an eligi-

1 ble medicare beneficiary under this part, an entity
2 offering a medicare supplemental policy, a
3 Medicare+Choice plan, a Medicare Drug Plan for
4 Noncompetitive Areas, or a basic coverage plan
5 under section 1860F may—

6 “(A) directly administer the benefits under
7 such coverage; or

8 “(B) contract with an entity that meets
9 the applicable requirements under this part to
10 administer such benefits.

11 “(b) ACCESS TO ALTERNATIVE PRESCRIPTION DRUG
12 COVERAGE.—In the case of an eligible medicare bene-
13 ficiary who has creditable prescription drug coverage (as
14 defined in section 1860C(b)(4)) under a policy or plan,
15 such beneficiary—

16 “(1) may continue to receive such coverage
17 under such policy or plan and not enroll under this
18 part; and

19 “(2) pursuant to section 1860C(b)(3), is per-
20 mitted to subsequently enroll under this part and
21 obtain SPICE prescription drug coverage without
22 any penalty if such policy or plan terminated, ceased
23 to provide, or substantially reduced the value of the
24 prescription drug coverage under such plan or pol-
25 icy.

1 “(c) FINANCIAL ASSISTANCE.—

2 “(1) UNDER SPICE DRUG BENEFIT PROGRAM.—

3 Under the SPICE drug benefit program, the SPICE
4 Board shall provide financial assistance, with such
5 assistance varying depending upon the income of
6 such beneficiary, for any eligible medicare bene-
7 ficiary enrolled under this part who voluntarily
8 obtains—

9 “(A) basic coverage (pursuant to sub-
10 section (b) of section 1860K); or

11 “(B) stop-loss coverage (pursuant to sub-
12 section (c) of such section).

13 “(2) ASSISTANCE TO GROUP HEALTH PLANS
14 THAT PROVIDE PRESCRIPTION DRUG COVERAGE TO
15 ELIGIBLE MEDICARE BENEFICIARIES.—Pursuant to
16 the Employer Incentive Program established under
17 section 1860L, the SPICE Board shall make pay-
18 ments to employers and other sponsors of employ-
19 ment-based health care coverage to encourage such
20 employers and sponsors to provide adequate pre-
21 scription drug coverage to retired individuals.

22 “(d) ELIGIBLE MEDICARE BENEFICIARY DE-
23 FINED.—For purposes of this part, the term ‘eligible
24 medicare beneficiary’ means an individual who is entitled
25 to benefits under part A and enrolled under part B.

1 “(e) FINANCING.—The costs of providing benefits
 2 under this part shall be payable from the SPICE Prescrip-
 3 tion Drug Account (as established under section 1860N)
 4 within the Federal Supplementary Medical Insurance
 5 Trust Fund under section 1841.

6 “SPICE PRESCRIPTION DRUG COVERAGE

7 “SEC. 1860B. (a) IN GENERAL.—For purposes of
 8 this part, the term ‘SPICE prescription drug coverage’
 9 means coverage consisting of the following:

10 “(1) BASIC COVERAGE.—Basic coverage (as de-
 11 fined in subsection (b)) and access to negotiated
 12 prices under subsection (d), except as waived pursu-
 13 ant to section 1860C(a)(3).

14 “(2) STOP-LOSS COVERAGE.—Stop-loss cov-
 15 erage (as defined in subsection (c)).

16 “(b) BASIC COVERAGE.—For purposes of this part,
 17 the term ‘basic coverage’ means coverage of covered out-
 18 patient drugs (as defined in subsection (e)) that meets the
 19 following requirements:

20 “(1) DEDUCTIBLE.—The coverage has an an-
 21 nual deductible—

22 “(A) for 2003, that is equal to \$350; or

23 “(B) for a subsequent year, that is equal
 24 to the amount specified under this paragraph
 25 for the previous year increased by the percent-

1 age specified in paragraph (4) for the year in-
2 volved.

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

6 “(2) COINSURANCE.—The coverage has coin-
7 surance (for the cost of a covered outpatient drug
8 above the annual deductible specified in paragraph
9 (1) for the year and up to the initial coverage limit
10 specified in paragraph (3) for the year) that does
11 not exceed 25 percent of the cost of such drug.

12 “(3) INITIAL COVERAGE LIMIT.—

13 “(A) IN GENERAL.—The coverage has an
14 initial coverage limit for covered outpatient
15 drugs in a year that is reached when the eligi-
16 ble medicare beneficiary has incurred the appli-
17 cable amount of out-of-pocket expenses in the
18 year.

19 “(B) APPLICABLE AMOUNT DEFINED.—
20 For purposes of subparagraph (A), the term
21 ‘applicable amount’ means—

22 “(i) for 2003, \$3,000; or

23 “(ii) for a subsequent year, the
24 amount specified in this subparagraph for
25 the previous year, increased by the annual

1 percentage increase described in paragraph
 2 (4) for the year involved.

3 Any amount determined under clause (ii) that
 4 is not a multiple of \$25 shall be rounded to the
 5 nearest multiple of \$25.

6 “(C) APPLICATION.—In applying para-
 7 graph (1)—

8 “(i) incurred out-of-pocket expenses
 9 shall only include expenses incurred for the
 10 annual deductible (described in paragraph
 11 (1)) and coinsurance (described in para-
 12 graph (2)); and

13 “(ii) such expenses shall be treated as
 14 incurred without regard to whether the in-
 15 dividual or another person, including a
 16 State program or other third-party cov-
 17 erage, has paid for such expenses.

18 “(4) ANNUAL PERCENTAGE INCREASE.—For
 19 purposes of this part, the annual percentage increase
 20 specified in this paragraph for a year is equal to the
 21 annual percentage increase in average per capita ag-
 22 gregate expenditures for benefits under this title, as
 23 determined by the Secretary for the 12-month period
 24 ending in July of the previous year.

1 “(c) STOP-LOSS COVERAGE.—For purposes of this
 2 part, the term ‘stop-loss coverage’ means coverage of cov-
 3 ered outpatient drugs in a year without any coinsurance
 4 after the eligible medicare beneficiary has reached the ini-
 5 tial coverage limit specified in subsection (b)(3) for the
 6 year.

7 “(d) ACCESS TO NEGOTIATED PRICES.—Under
 8 SPICE prescription drug coverage offered under a policy
 9 or plan, the entity offering the policy or plan (or the ad-
 10 ministering entity pursuant to subsection (a)(3)(B)) shall
 11 provide beneficiaries with access to negotiated prices (in-
 12 cluding applicable discounts) used for payment for covered
 13 outpatient drugs, regardless of the fact that no benefits
 14 may be payable under the coverage with respect to such
 15 drugs because of the application of the annual deductible.

16 “(e) COVERED OUTPATIENT DRUGS DEFINED.—

17 “(1) IN GENERAL.—Except as provided in this
 18 subsection, for purposes of this part, the term ‘cov-
 19 ered outpatient drug’ means—

20 “(A) a drug that may be dispensed only
 21 upon a prescription and that is described in
 22 subparagraph (A)(i) or (A)(ii) of section
 23 1927(k)(2); or

24 “(B) a biological product described in
 25 clauses (i) through (iii) of subparagraph (B) of

1 such section or insulin described in subpara-
 2 graph (C) of such section,
 3 and such term includes any use of a covered out-
 4 patient drug for a medically accepted indication (as
 5 defined in section 1927(k)(6)).

6 “(2) EXCLUSIONS.—

7 “(A) IN GENERAL.—Such term does not
 8 include drugs or classes of drugs, or their med-
 9 ical uses, which may be excluded from coverage
 10 or otherwise restricted under section
 11 1927(d)(2), other than subparagraph (E) there-
 12 of (relating to smoking cessation agents) and
 13 except to the extent otherwise specifically pro-
 14 vided by the SPICE Board with respect to a
 15 drug in any of such classes.

16 “(B) AVOIDANCE OF DUPLICATE COV-
 17 ERAGE.—A drug prescribed for an individual
 18 that would otherwise be a covered outpatient
 19 drug under this part shall not be so considered
 20 if payment for such drug is available under part
 21 A or B or would be available under part B but
 22 for the application of a deductible under such
 23 part (but shall be so considered if such payment
 24 is not available because benefits under part A
 25 or B have been exhausted).

1 “(3) APPLICATION OF FORMULARY RESTRIC-
 2 TIONS.—A drug prescribed for an individual that
 3 would otherwise be a covered outpatient drug under
 4 this part shall not be so considered under a policy
 5 or plan if the policy or plan excludes the drug under
 6 a formulary that meets the requirements of section
 7 1860I(c)(3) (including providing an appeal process).

8 “(4) APPLICATION OF GENERAL EXCLUSION
 9 PROVISIONS.—An entity may exclude from SPICE
 10 prescription drug coverage any covered outpatient
 11 drug—

12 “(A) for which payment would not be
 13 made if section 1862(a) applied to part D; or

14 “(B) which are not prescribed in accord-
 15 ance with the policy or plan or this part.

16 Such exclusions are determinations subject to recon-
 17 sideration and appeal pursuant to section
 18 1860I(c)(6).

19 “ENROLLMENT UNDER SPICE DRUG BENEFIT PROGRAM

20 “SEC. 1860C. (a) ESTABLISHMENT OF PROCESS.—

21 “(1) ESTABLISHMENT.—

22 “(A) IN GENERAL.—The SPICE Board, in
 23 consultation with the Secretary, the National
 24 Association of Insurance Commissioners,
 25 issuers of medicare supplemental policies, and
 26 Medicare+Choice organizations, shall establish

1 a process through which an eligible medicare
 2 beneficiary (including an eligible medicare bene-
 3 ficiary enrolled in a Medicare+Choice plan)
 4 may enroll under this part.

5 “(B) SIMILAR TO PART B.—

6 “(i) IN GENERAL.—Except as pro-
 7 vided in clause (ii), the process established
 8 under subparagraph (A) shall be similar to
 9 the process for enrollment in part B under
 10 section 1837.

11 “(ii) BENEFICIARY MUST AFFIRMA-
 12 TIVELY ENROLL.—Notwithstanding section
 13 1837(f), such process shall require that an
 14 eligible medicare beneficiary affirmatively
 15 enroll under this part rather than deeming
 16 the beneficiary to be so enrolled if certain
 17 requirements are met.

18 “(2) REQUIREMENT OF ENROLLMENT.—An eli-
 19 gible medicare beneficiary must enroll under this
 20 part in order to be eligible to receive SPICE pre-
 21 scription drug coverage, including financial assist-
 22 ance for basic and stop-loss coverage under section
 23 1860K.

24 “(3) WAIVER OF BASIC COVERAGE FOR
 25 MEDIGAP ENROLLEES.—

“(A) IN GENERAL.—The process established under paragraph (1) shall permit a beneficiary enrolled under this part and enrolled under a medicare supplemental policy to—

“(i) waive the basic coverage available under this part; and

“(ii) rescind such waiver in order to obtain such coverage.

“(B) RULES.—If a beneficiary waives basic coverage pursuant to subparagraph (A)(i), the following rules shall apply:

“(i) Such waiver shall not effect the stop-loss coverage that the beneficiary receives under the medicare supplemental policy, including the entitlement to financial assistance under section 1860K(c) for such coverage.

“(ii) The beneficiary shall not be liable for the basic monthly premium under section 1860H(a).

“(iii) The beneficiary shall not receive basic coverage but shall be entitled to negotiated prices for covered outpatient drugs as if the beneficiary had not waived such coverage.

1 “(iv) If the beneficiary subsequently
 2 rescinds such waiver pursuant to subpara-
 3 graph (A)(ii), the beneficiary shall be sub-
 4 ject to the late enrollment penalty under
 5 subsection (b).

6 “(b) LATE ENROLLMENT PENALTY.—

7 “(1) IN GENERAL.—Subject to the succeeding
 8 provisions of this subsection, in the case of an eligi-
 9 ble medicare beneficiary whose coverage period
 10 under this part began pursuant to an enrollment
 11 after the beneficiary’s initial enrollment period under
 12 part B (determined pursuant to section 1837(d))
 13 and not pursuant to the open enrollment period de-
 14 scribed in subsection (c), the SPICE Board shall es-
 15 tablish procedures for increasing the amount of the
 16 basic monthly premium under section 1860H(a) ap-
 17 plicable to such beneficiary—

18 “(A) by an amount that is equal to 25 per-
 19 cent of such premium for each full 12-month
 20 period (in the same continuous period of eligi-
 21 bility) in which the eligible medicare beneficiary
 22 could have been enrolled under this part but
 23 was not so enrolled; or

24 “(B) if determined appropriate by the
 25 SPICE Board, by an amount that the SPICE

1 Board determines is actuarially sound for each
2 such period.

3 “(2) PERIODS TAKEN INTO ACCOUNT.—For
4 purposes of calculating any 12-month period under
5 paragraph (1), there shall be taken into account—

6 “(A) the months which elapsed between
7 the close of the eligible medicare beneficiary’s
8 initial enrollment period and the close of the en-
9 rollment period in which the beneficiary en-
10 rolled;

11 “(B) in the case of an eligible medicare
12 beneficiary who reenrolls under this part, the
13 months which elapsed between the date of ter-
14 mination of a previous coverage period and the
15 close of the enrollment period in which the ben-
16 eficiary reenrolled; and

17 “(C) in the case of an eligible medicare
18 beneficiary who is enrolled under this part but
19 has waived basic coverage pursuant to sub-
20 section (a)(3), the months which elapsed be-
21 tween the effective date of such waiver and the
22 effective date of the rescission of such waiver.

23 “(3) PERIODS NOT TAKEN INTO ACCOUNT.—

24 “(A) IN GENERAL.—For purposes of calcu-
25 lating any 12-month period under paragraph

(1), subject to subparagraph (B), there shall not be taken into account months for which the eligible medicare beneficiary can demonstrate that the beneficiary—

“(i) met such exceptional conditions (including conditions recognized under section 1851(e)(4)(D)) as the SPICE Board may provide; or

“(ii) had creditable prescription drug coverage (as defined in paragraph (4)).

“(B) APPLICATION.—The exception described in subparagraph (A)(ii) shall only apply with respect to a coverage period the enrollment for which occurs before the end of the 63-day period that begins on the first day of the month which includes the date on which the policy or plan involved terminates, ceases to provide, or substantially reduces the value of the prescription drug coverage under such policy or plan.

“(4) PRESCRIPTION DRUG COVERAGE.—For purposes of this part, the term ‘creditable prescription drug coverage’ means any of the following:

“(A) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including

1 through the Program of All-inclusive Care for
 2 the Elderly (PACE) under section 1934,
 3 through a social health maintenance organiza-
 4 tion (referred to in section 4104(c) of the Bal-
 5 anced Budget Act of 1997), or through a
 6 Medicare+Choice project that demonstrates the
 7 application of capitation payment rates for frail
 8 elderly medicare beneficiaries through the use
 9 of a interdisciplinary team and through the pro-
 10 vision of primary care services to such bene-
 11 ficiaries by means of such a team at the nurs-
 12 ing facility involved.

13 “(B) PRESCRIPTION DRUG COVERAGE
 14 UNDER GROUP HEALTH PLAN.—Any outpatient
 15 prescription drug coverage under a group
 16 health plan, including a health benefits plan
 17 under the Federal Employees Health Benefit
 18 Plan under chapter 89 of title 5, United States
 19 Code, and a qualified retiree prescription drug
 20 plan as defined in section 1860L(e)(3).

21 “(C) PRESCRIPTION DRUG COVERAGE
 22 UNDER CERTAIN MEDIGAP POLICIES.—Coverage
 23 under a medicare supplemental policy under
 24 section 1882 that provides benefits for prescrip-
 25 tion drugs but only if the policy was in effect

1 on December 31, 2002, and only until the date
2 such coverage is terminated.

3 “(D) STATE PHARMACEUTICAL ASSIST-
4 ANCE PROGRAM.—Coverage of prescription
5 drugs under a State pharmaceutical assistance
6 program.

7 “(E) VETERANS’ COVERAGE OF PRESCRIP-
8 TION DRUGS.—Coverage of prescription drugs
9 for veterans under chapter 17 of title 38,
10 United States Code.

11 “(5) PERIODS TREATED SEPARATELY.—Any in-
12 crease in an eligible medicare beneficiary’s basic
13 monthly premium under paragraph (1) with respect
14 to a particular continuous period of eligibility shall
15 not be applicable with respect to any other contin-
16 uous period of eligibility which the beneficiary may
17 have.

18 “(6) CONTINUOUS PERIOD OF ELIGIBILITY.—

19 “(A) IN GENERAL.—Subject to subpara-
20 graph (B), for purposes of this subsection, an
21 eligible medicare beneficiary’s ‘continuous pe-
22 riod of eligibility’ is the period that begins with
23 the first day on which the beneficiary is eligible
24 to enroll under section 1836 and this part and
25 ends with the beneficiary’s death.

1 “(B) SEPARATE PERIOD.—Any period dur-
 2 ing all of which an eligible medicare beneficiary
 3 satisfied paragraph (1) of section 1836 and
 4 which terminated during or before the month
 5 preceding the month in which the beneficiary
 6 attained age 65 shall be a separate ‘continuous
 7 period of eligibility’ with respect to the bene-
 8 ficiary (and each such period which terminates
 9 shall be deemed not to have existed for pur-
 10 poses of subsequently applying this subpara-
 11 graph).

12 “(c) OPEN ENROLLMENT PERIOD FOR CURRENT
 13 BENEFICIARIES IN WHICH LATE ENROLLMENT PROCE-
 14 DURES DO NOT APPLY.—The SPICE Board shall estab-
 15 lish an applicable period, which shall begin on the date
 16 on which the SPICE Board first begins to accept enroll-
 17 ments under this part, during which any eligible medicare
 18 beneficiary may enroll under this part without the applica-
 19 tion of the late enrollment procedures established under
 20 subsection (b)(1).

21 “(d) PERIOD OF COVERAGE.—

22 “(1) IN GENERAL.—Except as provided in para-
 23 graph (2), an eligible medicare beneficiary’s coverage
 24 under the program under this part shall be effective

1 for the period provided in section 1838, as if that
 2 section applied to the program under this part.

3 “(2) OPEN ENROLLMENT.—An eligible medi-
 4 care beneficiary who enrolls under the program
 5 under this part pursuant to subsection (c) shall be
 6 entitled to the benefits under this part beginning on
 7 the first day of the month following the month in
 8 which such enrollment occurs.

9 “(3) RESCISSION OF WAIVER.—The SPICE
 10 Board shall establish procedures regarding coverage
 11 periods for an eligible medicare beneficiary enrolled
 12 under this part who previously waived basic coverage
 13 under subsection (a)(3) and now wishes to rescind
 14 such waiver.

15 “(4) LIMITATION.—Coverage under this part
 16 shall not begin prior to January 1, 2003.

17 “(e) TERMINATION.—

18 “(1) IN GENERAL.—The causes of termination
 19 specified in section 1838 shall apply to this part in
 20 the same manner as they apply to part B.

21 “(2) COVERAGE TERMINATED BY TERMINATION
 22 OF COVERAGE UNDER PARTS A AND B.—

23 “(A) IN GENERAL.—In addition to the
 24 causes of termination described in paragraph
 25 (1), the SPICE Board shall terminate an indi-

1 vidual’s coverage under this part if the indi-
 2 vidual is no longer enrolled in either part A or
 3 B.

4 “(B) EFFECTIVE DATE.—The termination
 5 described in subparagraph (A) shall be effective
 6 on the effective date of termination of coverage
 7 under part A or (if earlier) under part B.

8 “(3) PROCEDURES REGARDING TERMINATION
 9 OF A BENEFICIARY UNDER A PLAN OR POLICY.—The
 10 SPICE Board shall establish procedures for deter-
 11 mining the status of an eligible medicare bene-
 12 ficiary’s enrollment under this part if the bene-
 13 ficiary’s enrollment in a medicare supplemental pol-
 14 icy, a Medicare+Choice plan, a Medicare Drug Plan
 15 for Noncompetitive Areas, or a basic coverage plan
 16 under section 1860F is terminated by the entity of-
 17 fering such policy or plan for cause (under the appli-
 18 cable requirements established under this title).

19 “ENROLLMENT IN A POLICY OR PLAN

20 “SEC. 1860D. (a) ENROLLMENT IN MEDICARE DRUG
 21 PLAN FOR NONCOMPETITIVE AREAS.—The SPICE Board
 22 shall establish a process through which an eligible medi-
 23 care beneficiary who is enrolled under this part (but not
 24 enrolled in a medicare supplemental policy, a
 25 Medicare+Choice plan, or a basic coverage plan under sec-
 26 tion 1860F) and resides in an area in which a Medicare

1 Drug Plan for Noncompetitive Areas is available may en-
 2 roll in such plan. Such process shall include rules for en-
 3 rollment, disenrollment, and termination of enrollment in
 4 such plan.

5 “(b) ENROLLMENT IN A MEDICARE SUPPLEMENTAL
 6 POLICY OR A MEDICARE+CHOICE PLAN.—Enrollment in
 7 a medicare supplemental policy or a Medicare+Choice
 8 plan is subject to the rules for enrollment in such policy
 9 or plan under sections 1882 and 1851, respectively.

10 “(c) ENROLLMENT IN A BASIC COVERAGE PLAN OF-
 11 FERED BY A PRIVATE ENTITY WITH A CONTRACT UNDER
 12 THIS PART.—The SPICE Board shall establish a process
 13 through which an eligible medicare beneficiary who is en-
 14 rolled under this part (but not enrolled in a medicare sup-
 15 plemental policy, a Medicare+Choice plan, or a Medicare
 16 Drug Plan for Noncompetitive Areas) may enroll in a
 17 basic coverage plan offered by a private entity with a con-
 18 tract under section 1860F to offer such plan. Such process
 19 shall include rules for enrollment, disenrollment, and ter-
 20 mination of enrollment in such plan.

21 “(d) COORDINATION OF ENROLLMENTS,
 22 DISENROLLMENTS, AND TERMINATIONS OF ENROLL-
 23 MENTS.—The SPICE Board shall establish procedures for
 24 coordinating enrollments, disenrollments and terminations
 25 of enrollments under plans described in subsections (a)

1 and (c) with enrollments, disenrollments and terminations
 2 of enrollments under part C.

3 “MEDICARE DRUG PLAN FOR NONCOMPETITIVE AREAS

4 “SEC. 1860E. (a) IN GENERAL.—The SPICE Board
 5 shall provide for a Medicare Drug Plan for Noncompeti-
 6 tive Areas that—

7 “(1) provides enrollees with SPICE prescription
 8 drug coverage; and

9 “(2) is available to eligible medicare bene-
 10 ficiaries residing in an area that has been designated
 11 by the SPICE Board as a noncompetition area.

12 “(b) DESIGNATION OF NONCOMPETITION AREA.—

13 “(1) IN GENERAL.—The SPICE Board shall es-
 14 tablish procedures for designating areas as noncom-
 15 petition areas.

16 “(2) NONCOMPETITION AREA DEFINED.—

17 “(A) IN GENERAL.—For purposes of this
 18 section, the term ‘noncompetition area’ means
 19 an area in which only 1 or no medicare supple-
 20 mental policy is available to eligible medicare
 21 beneficiaries residing in the area.

22 “(B) CONSTRUCTION REGARDING MUL-
 23 TIPLE POLICIES OFFERED BY SINGLE
 24 ISSUER.—If there is an entity that offers more
 25 that 1 type of medicare supplemental policy in

1 an area, then that area is not a noncompetition
2 area for purposes of this section.

3 “(c) CONTRACTS.—In order to provide the Medicare
4 Drug Plan for Noncompetitive Areas under this section,
5 the SPICE Board shall do 1 of the following:

6 “(1) SINGLE CONTRACT THAT COVERS ALL
7 NONCOMPETITION AREAS.—Enter into a contract
8 with 1 entity to administer and deliver the benefits
9 under the plan in every designated noncompetition
10 area.

11 “(2) MULTIPLE CONTRACTS.—Enter into a con-
12 tract with 1 entity to administer and deliver the ben-
13 efits under the plan in 1 or more (but less than all)
14 of the designated noncompetition areas.

15 “(d) BIDDING PROCESS.—

16 “(1) IN GENERAL.—The SPICE Board shall es-
17 tablish procedures under which the SPICE Board
18 accepts bids submitted by entities and awards a con-
19 tract (or contracts pursuant to subsection (c)(2)) to
20 an entity in order to administer and deliver the ben-
21 efits under the Medicare Drug Plan for Noncompeti-
22 tive Areas to eligible medicare beneficiaries.

23 “(2) COMPETITIVE PROCEDURES.—Competitive
24 procedures (as defined in section 4(5) of the Office
25 of Federal Procurement Policy Act (41 U.S.C.

1 403(5))) shall be used to enter into contracts under
 2 this section.

3 “(e) REQUIREMENTS FOR ENTITIES.—

4 “(1) IN GENERAL.—The SPICE Board may not
 5 award a contract to an entity under this section un-
 6 less the entity meets such terms and conditions as
 7 the SPICE Board shall specify, including the fol-
 8 lowing:

9 “(A) The terms and conditions described
 10 in section 1860I(c).

11 “(B) The entity meets the quality and fi-
 12 nancial standards specified by the SPICE
 13 Board.

14 “(C) The entity meets applicable State li-
 15 censure requirements.

16 “(2) PREMIUMS.—The terms and conditions
 17 specified under paragraph (1) shall—

18 “(A) permit an entity with a contract
 19 under this section to require that beneficiaries
 20 enrolled in the plan covered by the contract pay
 21 a premium for benefits provided under the con-
 22 tract; and

23 “(B) except as provided in section
 24 1860H(b)(3) (relating to an increased premium
 25 for delayed enrollment under this part), require

“SELECTION OF PRIVATE ENTITIES TO PROVIDE BASIC
COVERAGE PLANS

6 “(1) IN GENERAL.—The SPICE Board shall es-
7 tablish procedures under which the SPICE Board—

“(B) awards contracts to such entities to provide such plans to eligible medicare beneficiaries in the area.

20 “(b) AREAS FOR CONTRACTS.—

24 “(2) NO ADMINISTRATIVE OR JUDICIAL RE-
25 VIEW.—The determination of contract areas under

1 paragraph (1) shall not be subject to administrative
2 or judicial review.

3 “(3) MULTIPLE CONTRACTS.—If determined
4 appropriate, the SPICE Board may award more
5 than 1 contract in a contract area.

6 “(c) REQUIREMENTS FOR ENTITIES.—

7 “(1) IN GENERAL.—The SPICE Board may not
8 award a contract to a private entity under this sec-
9 tion unless the entity meets such terms and condi-
10 tions as the SPICE Board shall specify, including
11 the following:

12 “(A) The terms and conditions described
13 in section 1860I(c).

14 “(B) The entity meets the quality and fi-
15 nancial standards specified by the SPICE
16 Board.

17 “(C) The entity meets applicable State li-
18 censure requirements.

19 “(D) Under the plan, the entity will pro-
20 vide basic coverage with access to negotiated
21 prices.

22 “(d) PRIVATE ENTITY DEFINED.—For purposes of
23 this part, the term ‘private entity’ means any private enti-
24 ty that the SPICE Board determines to be appropriate

1 to provide basic coverage plans to eligible medicare bene-
 2 ficiaries under this part, including—

3 “(1) a pharmacy benefit management company;

4 “(2) a retail pharmacy delivery system;

5 “(3) a health plan or insurer;

6 “(4) any other private entity approved by the
 7 SPICE Board; or

8 “(5) any combination of the entities described
 9 in paragraphs (1) through (4) approved by the
 10 SPICE Board.

11 “PROVIDING INFORMATION TO BENEFICIARIES

12 “SEC. 1860G. (a) ACTIVITIES.—

13 “(1) IN GENERAL.—The SPICE Board shall
 14 provide for activities that are designed to broadly
 15 disseminate information to eligible medicare bene-
 16 ficiaries (and prospective eligible medicare bene-
 17 ficiaries) on the SPICE drug benefit program under
 18 this part.

19 “(2) LATE ENROLLMENT PENALTIES TO BE
 20 WELL PUBLICIZED.—The SPICE Board shall ensure
 21 that information on the sanctions for delayed enroll-
 22 ment under section 1860C(b) and on the possibility
 23 of increased premiums for stop-loss coverage under
 24 section 1860H(b)(3) are well publicized.

25 “(3) SPECIAL RULE FOR INITIAL ENROLLMENT
 26 UNDER THE PROGRAM.—

1 “(A) CONSULTATION.—The SPICE Board
2 shall consult with the Secretary, issuers of
3 medicare supplemental policies, State insurance
4 commissioners, Medicare+Choice organizations,
5 and interested consumer organizations in devel-
6 oping the activities described in paragraph (1)
7 that will be used to provide information regard-
8 ing the initial enrollment under this part during
9 the period described in section 1860C(c).

10 “(B) TIMEFRAME.—The activities de-
11 scribed in paragraph (1) shall ensure that eligi-
12 ble medicare beneficiaries (and prospective eligi-
13 ble medicare beneficiaries) are provided with
14 such information not later than December 1,
15 2002, in order to ensure that coverage under
16 this part may be effective as of January 1,
17 2003.

18 “(4) COORDINATION WITH ACTIVITIES PER-
19 FORMED BY THE SECRETARY.—The SPICE Board
20 shall work with the Secretary to ensure that the ac-
21 tivities provided under this subsection are coordi-
22 nated with the activities performed by the Secretary
23 that provide information with respect to benefits
24 under this title to eligible medicare beneficiaries and
25 prospective eligible medicare beneficiaries.

1 “(b) REQUIREMENTS.—

2 “(1) IN GENERAL.—The activities described in
3 subsection (a) shall—

4 “(A) be similar to the activities performed
5 under section 1851 (including the approval of
6 policy marketing materials and maintaining a
7 toll-free number and an Internet site); and

8 “(B) include provisions to ensure that con-
9 sumer counselors are available to provide face-
10 to-face counseling to eligible medicare bene-
11 ficiaries (and prospective eligible medicare bene-
12 ficiaries) on the SPICE drug benefit program
13 under this part.

14 “(2) CONTRACTS TO PROVIDE CONSUMER
15 COUNSELING.—The SPICE Board may contract
16 with private entities to provide the consumer coun-
17 seling described in paragraph (1)(B).

18 “(c) COORDINATION WITH OTHER INFORMATION.—
19 The SPICE Board shall, in cooperation with the Sec-
20 retary, enter into such arrangements as may be appro-
21 priate to disseminate the information referred to in sub-
22 section (a) in coordination with materials distributed by
23 the Secretary to medicare beneficiaries, including the
24 medicare handbook under section 1804 and materials dis-
25 tributed under section 1851(d).

1 “PREMIUMS

2 “SEC. 1860H. (a) PREMIUM FOR BASIC COVERAGE
3 FOR ALL BENEFICIARIES.—

4 “(1) ANNUAL ESTABLISHMENT OF BASIC
5 MONTHLY PREMIUM RATES.—The SPICE Board
6 shall, during September of each year (beginning in
7 2002), determine and promulgate a basic monthly
8 premium rate for the succeeding year in accordance
9 with the provisions of this subsection.

10 “(2) ACTUARIAL DETERMINATIONS.—

11 “(A) DETERMINATION OF ANNUAL BEN-
12 EFIT AND ADMINISTRATIVE COSTS FOR BASIC
13 COVERAGE.—The SPICE Board shall estimate
14 annually for the succeeding year the amount
15 equal to the total of the benefits (including fi-
16 nancial assistance provided under subsections
17 (b) and (c) of section 1860K and payments
18 made to sponsors under section 1860L) and ad-
19 ministrative costs that will be payable from the
20 SPICE Prescription Drug Account within the
21 Federal Supplementary Medical Insurance
22 Trust Fund for providing benefits under this
23 part in such calendar year.

24 “(B) DETERMINATION OF BASIC MONTHLY
25 PREMIUM RATES.—

1 “(i) IN GENERAL.—The SPICE
 2 Board shall determine the basic monthly
 3 premium rate for such succeeding year,
 4 which shall be $\frac{1}{12}$ of the amount deter-
 5 mined under subparagraph (A), divided by
 6 the average total number of enrollees
 7 under this part who have not waived basic
 8 coverage under section 1860C(a)(3) (as es-
 9 timated for the year), and rounded (if such
 10 rate is not a multiple of 10 cents) to the
 11 nearest multiple of 10 cents.

12 “(ii) PREMIUM REDUCED BY AMOUNT
 13 OF FINANCIAL ASSISTANCE.—The amount
 14 that shall be charged a beneficiary for
 15 basic coverage under this part is the basic
 16 monthly premium determined under clause
 17 (i), reduced by the amount of the financial
 18 assistance for basic coverage determined
 19 for the beneficiary under section 1860K(b).

20 “(3) PUBLICATION OF ASSUMPTIONS.—The
 21 SPICE Board shall publish, together with the pro-
 22 mulgation of the basic monthly premium rates for
 23 the succeeding year, a statement setting forth the
 24 actuarial assumptions and bases employed in arriv-

1 ing at the amounts and rates determined under
2 paragraphs (1) and (2).

3 “(4) COLLECTION OF PREMIUMS.—Any basic
4 monthly premium applicable to an eligible medicare
5 beneficiary pursuant to this subsection, after appli-
6 cation of the reduction described in paragraph
7 (2)(B)(ii) and any increase for late enrollment under
8 section 1860C(b), shall be collected and credited to
9 the SPICE Prescription Drug Account in the same
10 manner as the monthly premium determined under
11 section 1839 is collected and credited to the Federal
12 Supplementary Medical Insurance Trust Fund under
13 section 1840.

14 “(b) PREMIUMS FOR STOP-LOSS COVERAGE.—

15 “(1) BENEFICIARY RESPONSIBLE FOR MAKING
16 PAYMENT DIRECTLY TO ENTITY.—Subject to para-
17 graph (2), any eligible medicare beneficiary who is
18 receiving stop-loss coverage, either through enroll-
19 ment in a medicare supplemental policy, a
20 Medicare+Choice plan, or a Medicare Drug Plan for
21 Noncompetitive Areas, shall be responsible for mak-
22 ing payments for any premiums required under the
23 policy or plan for such coverage directly to the entity
24 offering such policy or plan.

1 “(2) PREMIUM REDUCED BY AMOUNT OF FI-
 2 NANCIAL ASSISTANCE.—The entity offering such pol-
 3 icy or plan shall reduce the premium described in
 4 paragraph (1) by the amount of the financial assist-
 5 ance for stop-loss coverage determined for the bene-
 6 ficiary under section 1860K(c).

7 “(3) INCREASE IN PREMIUM FOR LATE EN-
 8 ROLLMENT OR FOR LACK OF CONTINUOUS STOP-
 9 LOSS COVERAGE.—In the case of an eligible medi-
 10 care beneficiary who is subject to a late enrollment
 11 penalty under section 1860C or who has not had
 12 continuous stop-loss coverage under this part be-
 13 cause the beneficiary was enrolled in a basic cov-
 14 erage plan under section 1860F, the entity offering
 15 the medicare supplemental policy, the
 16 Medicare+Choice plan, or the Medicare Drug Plan
 17 for Noncompetitive Areas in which the beneficiary is
 18 enrolled may, notwithstanding any provision in this
 19 title, increase the portion of the premium attrib-
 20 utable to stop-loss coverage that is otherwise appli-
 21 cable to such beneficiary for such enrollment in a
 22 manner that reflects the additional actuarial risk in-
 23 volved. Such a risk shall be established through an
 24 appropriate actuarial opinion of the type described

1 in subparagraphs (A) through (C) of section
2 2103(c)(4).

3 “APPROVAL FOR ENTITIES OFFERING SPICE

4 PRESCRIPTION DRUG COVERAGE

5 “SEC. 1860I. (a) APPROVAL.—No payments may be
6 made to an entity offering a policy or plan that provides
7 SPICE prescription drug coverage under section 1860J
8 unless the entity has been approved by the SPICE Board.

9 “(b) PROCEDURES.—

10 “(1) IN GENERAL.—The SPICE Board shall es-
11 tablish procedures for approving entities that offer
12 policies and plans that provide SPICE prescription
13 drug coverage under this part, including an entity
14 with a contract under section 1860F.

15 “(2) COORDINATION.—The procedures estab-
16 lished under subparagraph (A) shall be coordinated
17 with—

18 “(A) in the case of the approval of medi-
19 care supplemental policies, the procedures for
20 approval of such policies under State law; and

21 “(B) in the case of the approval of
22 Medicare+Choice plans, the procedures estab-
23 lished by the Secretary for approval of such
24 plans under part C.

25 “(c) TERMS AND CONDITIONS.—The SPICE Board
26 may not approve an entity under subsection (b) unless the

1 entity, with respect to such policy or plan, meets such
 2 terms and conditions as the SPICE Board shall specify,
 3 including the following:

4 “(1) DISSEMINATION OF INFORMATION.—

5 “(A) GENERAL INFORMATION.—The entity
 6 shall disclose, in a clear, accurate, and stand-
 7 ardized form to each enrollee under the policy
 8 or plan at the time of enrollment and at least
 9 annually thereafter, the information described
 10 in section 1852(c)(1) relating to such policy or
 11 plan. Such information shall include the fol-
 12 lowing:

13 “(i) Access to covered outpatient
 14 drugs, including access through pharmacy
 15 networks.

16 “(ii) How any formulary used by the
 17 entity functions.

18 “(iii) Coinsurance and deductible re-
 19 quirements.

20 “(iv) Grievance and appeals proce-
 21 dures.

22 “(B) DISCLOSURE UPON REQUEST OF
 23 GENERAL COVERAGE, UTILIZATION, AND GRIEV-
 24 ANCE INFORMATION.—Upon request of an indi-
 25 vidual eligible to enroll under the policy or plan,

the entity shall provide the information described in section 1852(c)(2) (other than subparagraph (D)) to such individual.

“(C) RESPONSE TO BENEFICIARY QUESTIONS.—The entity shall have a mechanism for providing specific information regarding the policy or plan to enrollees upon request and shall make available, through the Internet website described in paragraph (7) and in writing upon request, information on specific changes in its formulary.

“(D) CLAIMS INFORMATION.—The entity shall furnish to each enrollee under the plan or policy in a form easily understandable to such enrollees an explanation of benefits (in accordance with section 1806(a) or in a comparable manner) and a notice regarding how close the enrollee is to getting stop-loss coverage for the year, whenever prescription drug benefits are provided under this part (except that such notice need not be provided more often than monthly).

“(2) ACCESS TO COVERED BENEFITS.—

“(A) ASSURING PHARMACY ACCESS.—The entity shall secure the participation of sufficient

1 numbers of pharmacies to ensure convenient ac-
2 cess (including adequate emergency access) for
3 enrollees under the policy or plan. Nothing in
4 the preceding sentence shall be construed as re-
5 quiring the participation of all pharmacies in
6 any area under a policy or plan.

7 “(B) ACCESS TO NEGOTIATED PRICES FOR
8 PRESCRIPTION DRUGS.—The entity shall issue a
9 card that may be used by an enrollee under the
10 policy or plan to assure access to negotiated
11 prices pursuant to section 1860B(d).

12 “(3) FORMULARIES.—If an eligible entity uses
13 a formulary under the policy or plan, such entity
14 shall—

15 “(A) establish the formulary based on the
16 medical needs of eligible medicare beneficiaries;

17 “(B) ensure that the formulary includes
18 drugs within all therapeutic categories and
19 classes of covered outpatient drugs (although
20 not necessarily for all drugs within such cat-
21 egories and classes);

22 “(C) have in place an appeals process—

23 “(i) under which any eligible medicare
24 beneficiary could receive any medically nec-

1 necessary covered outpatient drug that is not
2 on the formulary;

3 “(ii) that does not impose a signifi-
4 cant financial burden on an eligible medi-
5 care beneficiary or delay the provision of
6 medically necessary covered outpatient
7 drugs to such a beneficiary; and

8 “(iii) that provides for at least a level
9 of protection that is similar to or better
10 than the level of protection provided with
11 respect to benefits under Medicare+Choice
12 plans under part C; and

13 “(D) provide notification to enrollees of
14 any change in the formulary at least 60 days
15 prior to such change.

16 “(4) COST AND UTILIZATION MANAGEMENT;
17 QUALITY ASSURANCE; MEDICATION THERAPY MAN-
18 AGEMENT PROGRAM.—

19 “(A) IN GENERAL.—The entity shall have
20 in place—

21 “(i) an effective cost and drug utiliza-
22 tion management program, including ap-
23 propriate incentives to use generic drugs
24 when appropriate;

1 “(ii) quality assurance measures and
 2 systems to reduce medical errors and ad-
 3 verse drug interactions, including a medi-
 4 cation therapy management program de-
 5 scribed in subparagraph (B); and

6 “(iii) a program to control fraud,
 7 abuse, and waste.

8 “(B) MEDICATION THERAPY MANAGEMENT
 9 PROGRAM.—

10 “(i) IN GENERAL.—A medication
 11 therapy management program described in
 12 this subparagraph is a program of drug
 13 therapy management and medication ad-
 14 ministration that is designed to assure that
 15 covered outpatient drugs under the policy
 16 or plan are appropriately used to achieve
 17 therapeutic goals and reduce the risk of
 18 adverse events, including adverse drug
 19 interactions.

20 “(ii) ELEMENTS.—Such program may
 21 include—

22 “(I) enhanced beneficiary under-
 23 standing of such appropriate use
 24 through beneficiary education, coun-

1 seling, and other appropriate means;
2 and

3 “(II) increased beneficiary adher-
4 ence with prescription medication
5 regimens through medication refill re-
6 minders, special packaging, and other
7 appropriate means.

8 “(iii) DEVELOPMENT OF PROGRAM IN
9 COOPERATION WITH LICENSED PHAR-
10 MACISTS.—The program shall be developed
11 in cooperation with licensed pharmacists
12 and physicians.

13 “(iv) CONSIDERATIONS IN PHARMACY
14 FEES.—The entity shall take into account,
15 in establishing fees for pharmacists and
16 others providing services under the medica-
17 tion therapy management program, the re-
18 sources and time used in implementing the
19 program.

20 “(C) TREATMENT OF ACCREDITATION.—
21 Section 1852(e)(4) (relating to treatment of ac-
22 creditation) shall apply to policies and plans
23 under this part with respect to the following re-
24 quirements, in the same manner as they apply
25 to Medicare+Choice plans under part C with

1 respect to the requirements described in a
2 clause of section 1852(e)(4)(B):

3 “(i) Subparagraph (A) (including
4 quality assurance), including medication
5 therapy management program under sub-
6 paragraph (B).

7 “(ii) Paragraph (2)(A) (relating to ac-
8 cess to covered benefits).

9 “(iii) Paragraph (8) (relating to con-
10 fidentiality and accuracy of enrollee
11 records).

12 “(5) GRIEVANCE MECHANISM.—The entity shall
13 provide meaningful procedures for hearing and re-
14 solving grievances between the entity (including any
15 entity or individual through which the entity pro-
16 vides covered benefits) and enrollees of the policy or
17 plan under this part in accordance with section
18 1852(f).

19 “(6) COVERAGE DETERMINATIONS, RECONSID-
20 ERATIONS, AND APPEALS.—The entity shall meet
21 the requirements of section 1852(g) with respect to
22 covered benefits under the policy or plan it offers
23 under this part in the same manner as such require-
24 ments apply to a Medicare+Choice organization

1 with respect to benefits it offers under a
 2 Medicare+Choice plan under part C.

3 “(7) PROVIDE INFORMATION ON THE INTER-
 4 NET.—The entity shall maintain a web site on the
 5 Internet that provides eligible medicare beneficiaries
 6 with information regarding any policy or plan of-
 7 fered by the entity that provides SPICE prescription
 8 drug coverage.

9 “(8) CONFIDENTIALITY AND ACCURACY OF EN-
 10 ROLLEE RECORDS.—The entity shall meet the re-
 11 quirements of section 1852(h) with respect to enroll-
 12 ees under this part in the same manner as such re-
 13 quirements apply to a Medicare+Choice organiza-
 14 tion with respect to enrollees under part C.

15 “(d) SPICE BOARD MODELS FOR FORMULARIES.—

16 “(1) MODEL.—The SPICE Board may issue
 17 models for formularies for use in providing covered
 18 outpatient drugs under this part. Such models, and
 19 any revised models (pursuant to paragraph (3)) shall
 20 meet the requirements of subparagraphs (A) and
 21 (B) of subsection (c)(3).

22 “(2) EFFECT OF COMPLIANCE WITH A
 23 MODEL.—If the SPICE Board determines that a
 24 formulary used by an entity offering a policy or plan
 25 that provides SPICE prescription drug coverage is

1 in compliance with a model formulary issued under
 2 paragraph (1), or the revised model (as the case may
 3 be), then the entity shall be deemed to meet the re-
 4 quirements of subparagraphs (A) and (B) of sub-
 5 section (c)(3).

6 “(3) REVISIONS OF MODELS.—

7 “(A) IN GENERAL.—The SPICE Board
 8 may periodically (but not more frequently than
 9 annually) revise any model established under
 10 this subsection.

11 “(B) PERIOD TO COMPLY WITH REVI-
 12 SION.—If the SPICE Board revises a model
 13 formulary pursuant to subparagraph (A), the
 14 SPICE Board shall provide for an appropriate
 15 period of time for entities who were in compli-
 16 ance with such model before such revision to
 17 comply with the revised model.

18 “(e) RULE OF CONSTRUCTION REGARDING COST-EF-
 19 FECTIVE PROVISION OF BENEFITS.—Nothing in this part
 20 shall be construed as preventing an entity that provides
 21 SPICE prescription drug coverage under a policy or plan
 22 from employing mechanisms to provide such coverage eco-
 23 nomically, including the use of—

24 “(1) formularies (pursuant to subsection
 25 (c)(3));

1 “(2) alternative methods of distribution;

2 “(3) generic drug substitution;

3 “(4) pharmacy networks; and

4 “(4) mail order pharmacies.

5 “PAYMENTS TO ENTITIES

6 “SEC. 1860J. (a) PAYMENTS FOR ADMINISTERING

7 BASIC COVERAGE.—

8 “(1) IN GENERAL.—The SPICE Board shall es-
 9 tablish procedures for making payments to an entity
 10 offering a medicare supplemental policy, a
 11 Medicare+Choice plan, a Medicare Drug Plan for
 12 Noncompetitive Areas, or a basic coverage plan
 13 under section 1860F for—

14 “(A) in accordance with the provisions of
 15 this part, the costs of covered outpatient drugs
 16 provided under basic coverage to eligible medi-
 17 care beneficiaries—

18 “(i) enrolled under such policy or plan
 19 and under this part; and

20 “(ii) entitled to such coverage; and

21 “(B) pursuant to paragraph (2), admin-
 22 istering the basic coverage on behalf of bene-
 23 ficiaries described in subparagraph (A).

24 “(2) ADMINISTRATIVE FEE.—

25 “(A) PROCEDURES.—The procedures es-
 26 tablished pursuant to paragraph (1) shall pro-

1 vide for payment to the entity of an administra-
 2 tive fee for each prescription filled by the entity
 3 for an eligible medicare beneficiary enrolled in
 4 the policy or plan offered by such entity. Sub-
 5 ject to paragraph (3), the entity shall not be at
 6 risk for providing basic coverage for a bene-
 7 ficiary.

8 “(B) AMOUNT.—The fee described in para-
 9 graph (1) shall be—

10 “(i) negotiated by the SPICE Board;
 11 and

12 “(ii) consistent with such fees paid
 13 under private sector pharmaceutical benefit
 14 contracts.

15 “(C) REDUCTION OF ADMINISTRATIVE
 16 COSTS.—The SPICE Board shall work with en-
 17 tities receiving payments under this section on
 18 ways to control the administrative costs associ-
 19 ated with providing basic coverage under this
 20 part.

21 “(3) RISK CORRIDORS TIED TO PERFORMANCE
 22 MEASURES AND OTHER INCENTIVES FOR ENTITY
 23 PROVIDING MEDICARE DRUG PLAN FOR NON-
 24 COMPETITIVE AREAS.—In the case of payments to
 25 an entity with a contract to provide a Medicare

1 Drug Plan for Noncompetitive Areas, the procedures
 2 established under paragraph (1) may include the use
 3 of—

4 “(A) risk corridors tied to performance
 5 measures that have been agreed to between the
 6 entity and the SPICE Board under the con-
 7 tract; and

8 “(B) any other incentives that the SPICE
 9 Board determines appropriate.

10 “(4) SECONDARY PAYER PROVISIONS.—The
 11 provisions of section 1862(b) shall apply to basic
 12 coverage provided under this part.

13 “(b) PAYMENT OF FINANCIAL ASSISTANCE TO ENTI-
 14 TIES FOR PROVISION OF STOP-LOSS COVERAGE.—

15 “(1) IN GENERAL.—The SPICE Board shall es-
 16 tablish procedures for making financial assistance
 17 payments for stop-loss coverage to an entity offering
 18 a medicare supplemental policy, a Medicare+Choice
 19 plan, or a Medicare Drug Plan for Noncompetitive
 20 Areas on behalf of an eligible medicare beneficiary
 21 enrolled in such policy or plan and under this part.

22 “(2) AMOUNT OF FINANCIAL ASSISTANCE PAY-
 23 MENT.—The amount of the financial assistance pay-
 24 ments on behalf of an eligible medicare beneficiary

1 for stop-loss coverage is equal to the amount deter-
 2 mined for the beneficiary under section 1860K(c).

3 “(3) ENTITY PROVIDING STOP-LOSS COVERAGE
 4 AT RISK.—The entity providing stop-loss coverage,
 5 and not the SPICE Board, shall be at risk for the
 6 provision of such coverage.

7 “FINANCIAL ASSISTANCE TO OBTAIN SPICE
 8 PRESCRIPTION DRUG COVERAGE

9 “SEC. 1860K. (a) IN GENERAL.—The SPICE Board
 10 shall provide financial assistance, in accordance with this
 11 section, with respect to eligible medicare beneficiaries who
 12 have SPICE prescription drug coverage through enroll-
 13 ment in a medicare supplemental policy, a
 14 Medicare+Choice plan, a Medicare Drug Plan for Non-
 15 competitive Areas, or a basic coverage plan under section
 16 1860F.

17 “(b) ASSISTANCE FOR BASIC COVERAGE.—

18 “(1) IN GENERAL.—The amount of financial
 19 assistance with respect to an eligible medicare bene-
 20 ficiary for basic coverage is equal to the following
 21 percentage of the basic monthly premium deter-
 22 mined under subsection (a) of section 1860H (with-
 23 out regard to any increase for late enrollment under
 24 subsection (b) of such section):

25 “(A) 100 PERCENT IF INCOME BELOW 150
 26 PERCENT OF POVERTY.—In the case of an eligi-

ble medicare beneficiary who applies for enhanced financial assistance under subsection (d) and whose income (as determined under such subsection) does not exceed 150 percent of the poverty line, the percentage is 100 percent.

“(B) OTHER PERCENT IF INCOME BETWEEN 150 AND 175 PERCENT OF POVERTY.—

In the case of an eligible medicare beneficiary who applies for enhanced financial assistance under subsection (d) and whose income (as determined under such subsection) is greater than 150 percent, but does not exceed 175 percent, of the poverty line, the SPICE Board shall specify the percentage consistent with the following rules:

“(i) RANGE.—The percentage may not exceed 100 percent nor be less than 25 percent.

“(ii) SLIDING SCALE.—The percentage may not be higher for eligible medicare beneficiaries whose income is higher.

“(C) 25 PERCENT FOR OTHER BENEFICIARIES.—In the case of any other eligible medicare beneficiary, the percentage is 25 percent.

1 “(2) FORM OF ASSISTANCE.—Financial assist-
 2 ance under this subsection shall be provided in the
 3 form of a reduction of the basic monthly premium
 4 pursuant to section 1860H(a)(2)(B)(ii).

5 “(c) ASSISTANCE FOR STOP-LOSS COVERAGE.—

6 “(1) AMOUNT.—

7 “(A) IN GENERAL.—The amount of finan-
 8 cial assistance for stop-loss coverage with re-
 9 spect to an eligible medicare beneficiary en-
 10 rolled under this part and in a medicare supple-
 11 mental policy, a Medicare+Choice plan, or a
 12 Medicare Drug Plan for Noncompetitive Areas
 13 for stop-loss coverage is equal to the following
 14 percentage of the national average medigap
 15 stop-loss monthly premium for the region in
 16 which the beneficiary resides (as determined
 17 under paragraph (2)):

18 “(i) 100 PERCENT IF INCOME BELOW
 19 150 PERCENT OF POVERTY.—In the case of
 20 an eligible medicare beneficiary described
 21 in subsection (b)(1)(A), the percentage is
 22 100 percent.

23 “(ii) OTHER PERCENT IF INCOME BE-
 24 TWEEN 150 AND 175 PERCENT OF POV-
 25 ERTY.—In the case of an eligible medicare

1 beneficiary described in subsection
 2 (b)(1)(B), the SPICE Board shall specify
 3 the percentage consistent with the rules
 4 described in clauses (i) and (ii) of such
 5 subsection.

6 “(iii) 25 PERCENT FOR OTHER BENE-
 7 FICIARIES.—In the case of any other eligi-
 8 ble medicare beneficiary, the percentage is
 9 25 percent.

10 “(B) FORM OF ASSISTANCE.—Financial
 11 assistance under this subsection for bene-
 12 ficiaries shall be provided in the form of a pay-
 13 ment to the entity offering the policy or plan in
 14 which the beneficiary is receiving stop-loss cov-
 15 erage pursuant to section 1860J(b).

16 “(2) ESTABLISHMENT OF NATIONAL AVERAGE
 17 MEDIGAP STOP-LOSS MONTHLY PREMIUM.—

18 “(A) IN GENERAL.—The SPICE Board
 19 shall, during September of each year (beginning
 20 in 2002), estimate a national average medigap
 21 stop-loss monthly premium for each region (as
 22 determined by the Board) of the total geo-
 23 graphic area served by the programs under this
 24 part that will be applicable for the succeeding
 25 year.

1 “(B) DEFINITION OF NATIONAL AVERAGE
 2 MEDIGAP STOP-LOSS MONTHLY PREMIUM.—For
 3 purposes of subparagraph (A), the term ‘na-
 4 tional average medigap stop-loss monthly pre-
 5 mium’ means, with respect to a region, the av-
 6 erage of the portion of the monthly premiums
 7 charged by medicare supplemental policies in
 8 that region for providing stop-loss coverage to
 9 beneficiaries enrolled under this part.

10 “(3) LIMITATIONS.—

11 “(A) FINANCIAL ASSISTANCE MAY NOT EX-
 12 CEED PREMIUM.—In the case of financial as-
 13 sistance provided under this subsection with re-
 14 spect to stop-loss coverage provided under a
 15 policy or plan, the amount of the financial as-
 16 sistance may not exceed the amount of the por-
 17 tion of the premium charged for enrollment in
 18 the policy or plan that is related to the provi-
 19 sion of stop-loss coverage.

20 “(B) ENTITY MUST REDUCE PREMIUM.—
 21 No financial assistance shall be made available
 22 with respect to stop-loss coverage provided by
 23 an entity to an eligible medicare beneficiary un-
 24 less the entity provides assurances satisfactory
 25 to the SPICE Board that the entity shall re-

1 duce the amount otherwise charged the bene-
 2 ficiary for such coverage by an amount equal to
 3 the amount of such assistance.

4 “(d) APPLICATION FOR ENHANCED FINANCIAL AS-
 5 SISTANCE.—

6 “(1) IN GENERAL.—The SPICE Board shall es-
 7 tablish procedures under which a beneficiary who de-
 8 sires enhanced financial assistance under this section
 9 may voluntarily apply for an income determination.

10 “(2) REQUIREMENTS REGARDING INFORMA-
 11 TION.—

12 “(A) INFORMATION FROM BENEFICIARY.—
 13 The procedures established under paragraph (1)
 14 shall require the beneficiary to submit with the
 15 application for enhanced financial assistance
 16 such information that the SPICE Board deter-
 17 mines necessary to make the income determina-
 18 tion with respect to such beneficiary.

19 “(B) INFORMATION FROM OTHER GOVERN-
 20 MENT AGENCIES.—Under the procedures estab-
 21 lished under paragraph (1), if an individual vol-
 22 untarily applies for enhanced financial assist-
 23 ance under this section, the individual is
 24 deemed to have consented to the SPICE Board
 25 seeking and using income-related information

1 from other Government agencies in order to
 2 make the income determination with respect to
 3 such beneficiary.

4 “(C) RESTRICTION ON USE OF INFORMA-
 5 TION.—Information obtained under subpara-
 6 graph (A) or (B) may be used by officers and
 7 employees of the SPICE Board only for the
 8 purposes of, and to the extent necessary in, car-
 9 rying out their responsibilities under this part.

10 “(3) PERIODIC REDETERMINATIONS.—Such in-
 11 come determinations shall be valid for a period (of
 12 not less than 1 year) specified by the SPICE Board.

13 “(e) INCOME DETERMINATIONS.—The SPICE Board
 14 shall establish procedures for making income determina-
 15 tions under this section.

16 “(f) POVERTY LINE.—In this section, the term ‘pov-
 17 erty line’ means the income official poverty line (as defined
 18 by the Office of Management and Budget, and revised an-
 19 nually in accordance with section 673(2) of the Omnibus
 20 Budget Reconciliation Act of 1981) applicable to a family
 21 of the size involved.

22 “EMPLOYER INCENTIVE PROGRAM FOR EMPLOYMENT-
 23 BASED RETIREE DRUG COVERAGE

24 “SEC. 1860L. (a) PROGRAM AUTHORITY.—The
 25 SPICE Board shall develop and implement a program
 26 under this section to be known as the ‘Employer Incentive

1 Program’ that encourages employers and other sponsors
 2 of employment-based health care coverage to provide ade-
 3 quate prescription drug benefits to retired individuals by
 4 subsidizing, in part, the sponsor’s cost of providing cov-
 5 erage under qualifying plans.

6 “(b) SPONSOR REQUIREMENTS.—In order to be eligi-
 7 ble to receive an incentive payment under this section with
 8 respect to coverage of an individual under a qualified re-
 9 tiree prescription drug plan (as defined in subsection
 10 (e)(3)), a sponsor shall meet the following requirements:

11 “(1) ASSURANCES.—The sponsor shall—

12 “(A) annually attest, and provide such as-
 13 surances as the SPICE Board may require,
 14 that the coverage offered by the sponsor is a
 15 qualified retiree prescription drug plan, and will
 16 remain such a plan for the duration of the
 17 sponsor’s participation in the program under
 18 this section; and

19 “(B) guarantee that it will give notice to
 20 the SPICE Board and covered retirees—

21 “(i) at least 120 days before termi-
 22 nating its plan; and

23 “(ii) immediately upon determining
 24 that the actuarial value of the prescription
 25 drug benefit under the plan falls below the

1 actuarial value of the basic coverage under
2 the SPICE prescription drug coverage
3 under this part.

4 “(2) BENEFICIARY INFORMATION.—The spon-
5 sor shall report to the SPICE Board, for each cal-
6 endar quarter for which it seeks an incentive pay-
7 ment under this section, the names and social secu-
8 rity numbers of all retirees (and their spouses and
9 dependents) covered under such plan during such
10 quarter and the dates (if less than the full quarter)
11 during which each such individual was covered.

12 “(3) AUDITS.—The sponsor and the employ-
13 ment-based retiree health coverage plan seeking in-
14 centive payments under this section shall agree to
15 maintain, and to afford the SPICE Board access to,
16 such records as the SPICE Board may require for
17 purposes of audits and other oversight activities nec-
18 essary to ensure the adequacy of prescription drug
19 coverage, the accuracy of incentive payments made,
20 and such other matters as may be appropriate.

21 “(4) OTHER REQUIREMENTS.—The sponsor
22 shall provide such other information, and comply
23 with such other requirements, as the SPICE Board
24 may find necessary to administer the program under
25 this section.

1 “(c) INCENTIVE PAYMENTS.—

2 “(1) IN GENERAL.—A sponsor that meets the
 3 requirements of subsection (b) with respect to a
 4 quarter in a calendar year shall be entitled to have
 5 payment made by the SPICE Board on a quarterly
 6 basis (to the sponsor or, at the sponsor’s direction,
 7 to the appropriate employment-based health plan) of
 8 an incentive payment, in the amount determined in
 9 paragraph (2), for each retired individual (or
 10 spouse) who—

11 “(A) was covered under the sponsor’s
 12 qualified retiree prescription drug plan during
 13 such quarter; and

14 “(B) was eligible for, but was not enrolled
 15 in, the SPICE drug benefit program under this
 16 part.

17 “(2) AMOUNT OF INCENTIVE.—The payment
 18 under this section with respect to each individual de-
 19 scribed in paragraph (1) for a month shall be equal
 20 to 25 percent of the basic monthly premium amount
 21 payable by an eligible medicare beneficiary enrolled
 22 under this part, as set for the calendar year pursu-
 23 ant to section 1860H(a) and without application of
 24 and financial assistance for such premium under
 25 section 1860K(b).

1 “(3) PAYMENT DATE.—The incentive under
 2 this section with respect to a calendar quarter shall
 3 be payable as of the end of the next succeeding cal-
 4 endar quarter.

5 “(d) CIVIL MONEY PENALTIES.—A sponsor, health
 6 plan, or other entity that the SPICE Board determines
 7 has, directly or through its agent, provided information
 8 in connection with a request for an incentive payment
 9 under this section that the entity knew or should have
 10 known to be false shall be subject to a civil monetary pen-
 11 alty in an amount up to 3 times the total incentive
 12 amounts under subsection (c) that were paid (or would
 13 have been payable) on the basis of such information.

14 “(e) DEFINITIONS.—In this section:

15 “(1) EMPLOYMENT-BASED RETIREE HEALTH
 16 COVERAGE.—The term ‘employment-based retiree
 17 health coverage’ means health insurance coverage or
 18 other coverage of health care costs for retired indi-
 19 viduals (or for such individuals and their spouses
 20 and dependents) based on their status as former em-
 21 ployees or labor union members.

22 “(2) EMPLOYER.—The term ‘employer’ has the
 23 meaning given the term in section 3(5) of the Em-
 24 ployee Retirement Income Security Act of 1974 (ex-

1 cept that such term shall include only employers of
2 2 or more employees).

3 “(3) QUALIFIED RETIREE PRESCRIPTION DRUG
4 PLAN.—The term ‘qualified retiree prescription drug
5 plan’ means health insurance coverage or other cov-
6 erage of health care costs included in employment-
7 based retiree health coverage that—

8 “(A) provides coverage of the cost of pre-
9 scription drugs whose actuarial value (as de-
10 fined by the SPICE Board) to each retired ben-
11 eficiary equals or exceeds the actuarial value of
12 the basic coverage provided to an individual en-
13 rolled in the SPICE drug benefit program
14 under this part; and

15 “(B) does not deny, limit, or condition the
16 coverage or provision of prescription drug bene-
17 fits for retired individuals based on age or any
18 health status-related factor described in section
19 2702(a)(1) of the Public Health Service Act.

20 “(4) SPONSOR.—The term ‘sponsor’ has the
21 meaning given the term ‘plan sponsor’ in section
22 3(16)(B) of the Employer Retirement Income Secu-
23 rity Act of 1974.

24 “SPICE BOARD

25 “SEC. 1860M. (a) ESTABLISHMENT.—There is estab-
26 lished within the Department of Health and Human Serv-

1 ices, a Seniors Prescription Insurance Coverage Equity
 2 Office, which shall be—

3 “(1) outside of the Centers for Medicare &
 4 Medicaid Services; and

5 “(2) run by a board to be known as the SPICE
 6 Board.

7 “(b) DUTIES.—

8 “(1) ADMINISTRATION OF SPICE DRUG BEN-
 9 EFIT PROGRAM.—

10 “(A) IN GENERAL.—The SPICE Board
 11 shall administer the SPICE drug benefit pro-
 12 gram under this part.

13 “(B) NONINTERFERENCE.—In carrying
 14 out its duty under subparagraph (A), the
 15 SPICE Board may not—

16 “(i) require a particular formulary or
 17 institute a price structure for the reim-
 18 bursement of covered outpatient drugs;

19 “(ii) interfere in any way with nego-
 20 tiations between entities providing SPICE
 21 prescription drug coverage under part D
 22 and drug manufacturers, wholesalers, or
 23 other suppliers of covered outpatient
 24 drugs; and

1 “(iii) otherwise interfere with the
2 competitive nature of providing such cov-
3 erage through such entities.

4 “(2) ONGOING STUDIES.—The SPICE Board
5 shall conduct ongoing studies of the following issues:

6 “(A) The administration of this part.

7 “(B) The provision of information about
8 the program under the health insurance infor-
9 mation, counseling, and assistance grants under
10 section 4360 of the Omnibus Budget Reconcili-
11 ation Act of 1990.

12 “(C) Ways in which drug utilization can be
13 used to provide better overall care for eligible
14 medicare beneficiaries.

15 “(D) Savings and potential savings in Fed-
16 eral health care programs which may occur, or
17 can be attributed to, eligible medicare bene-
18 ficiary access to, and utilization of, covered out-
19 patient drugs.

20 “(E) Trends in premium increases and fac-
21 tors that contribute to changes in premiums.

22 “(F) Integration of the SPICE drug ben-
23 efit program into a reformed medicare program.

1 “(G) The ability of eligible medicare bene-
2 ficiaries to afford SPICE prescription drug cov-
3 erage.

4 “(H) The impact of the program on the
5 prescription drug benefits offered under group
6 health plans.

7 “(I) The appropriateness of the levels of fi-
8 nancial assistance provided under this part.

9 “(3) ANNUAL REPORT.—

10 “(A) IN GENERAL.—Not later than June 1
11 of each year (beginning with 2004), the SPICE
12 Board shall submit an annual report to Con-
13 gress on the program under this part.

14 “(B) INFORMATION ON STUDIES.—Such
15 report shall include a detailed statement on the
16 issues studied under paragraph (2).

17 “(C) RECOMMENDATIONS.—Such report
18 shall include such recommendations for legisla-
19 tion and administrative actions as the SPICE
20 Board considers appropriate.

21 “(4) PROVISION OF RECOMMENDATIONS AND
22 INFORMATION TO SECRETARY.—The SPICE Board
23 shall provide recommendations and necessary infor-
24 mation regarding the SPICE drug benefit program
25 to the Secretary in order for the Secretary to—

1 “(A) integrate such information with infor-
 2 mation regarding the other programs under this
 3 title; and

4 “(B) provide health insurance information,
 5 counseling, and assistance grants under section
 6 4360 of the Omnibus Budget Reconciliation Act
 7 of 1990.

8 “(c) DEMONSTRATION PROJECT AUTHORITY.—

9 “(1) IN GENERAL.—Subject to paragraph (2),
 10 the SPICE Board shall have the authority to con-
 11 duct demonstration projects for the purpose of dem-
 12 onstrating ways to improve the quality of services
 13 provided under the SPICE drug benefit program, in-
 14 cluding ways to reduce medical errors.

15 “(2) CONSULTATION WITH SECRETARY.—The
 16 SPICE Board shall consult with the Secretary be-
 17 fore conducting any demonstration project.

18 “(d) MEMBERSHIP OF SPICE BOARD.—

19 “(1) NUMBER AND APPOINTMENT.—

20 “(A) IN GENERAL.—The SPICE Board
 21 shall be composed of 7 members appointed by
 22 the President, by and with the advice and con-
 23 sent of the Senate.

24 “(B) SPECIFIC REPRESENTATIVES.—In
 25 making appointments under subparagraph (A),

1 the President shall ensure that the following
2 groups are represented on the SPICE Board:

3 “(i) Consumers.

4 “(ii) Private health plan insurers (in-
5 cluding insurers that offer fee-for-service
6 and managed care plans) with expertise in
7 the quality, scope, and marketing of health
8 care services.

9 “(iii) Certified geriatric pharmacists.

10 “(iv) The Centers for Medicare &
11 Medicaid Services.

12 “(v) State insurance commissioners.

13 “(C) SECRETARY OF HHS.—In addition to
14 the 7 members appointed under subparagraph
15 (A), the Secretary shall be a nonvoting, ex offi-
16 cio member of the SPICE Board.

17 “(2) DEADLINE FOR INITIAL APPOINTMENT.—
18 The initial members of the SPICE Board shall be
19 appointed by not later than 6 months after the date
20 of enactment of this section.

21 “(3) TERMS.—

22 “(A) IN GENERAL.—The terms of the
23 members of the SPICE Board shall be for 6
24 years, except that of the members first
25 appointed—

1 “(i) three shall be appointed for terms
2 of 6 years;

3 “(ii) two shall be appointed for terms
4 of 4 years; and

5 “(iii) two shall be appointed for terms
6 of 2 years.

7 “(B) VACANCIES.—Any member appointed
8 to fill a vacancy occurring before the expiration
9 of the term for which the member’s predecessor
10 was appointed shall be appointed only for the
11 remainder of that term. A member may serve
12 after the expiration of that member’s term until
13 a successor has taken office.

14 “(4) CHAIRPERSON.—The President shall des-
15 ignate the chairperson of the SPICE Board, except
16 that the representative from the Centers for Medi-
17 care & Medicaid Services may not be designated as
18 chairperson.

19 “(e) OPERATION OF THE BOARD.—

20 “(1) MEETINGS.—The SPICE Board shall meet
21 at the call of the chairperson or upon the written re-
22 quest of a majority of its members.

23 “(2) QUORUM.—A majority of the members of
24 the SPICE Board shall constitute a quorum, but a
25 lesser number of members may hold hearings.

1 “(f) POWERS OF THE SPICE BOARD.—

2 “(1) HEARINGS.—The SPICE Board may hold
3 such hearings, sit and act at such times and places,
4 take such testimony, and receive such evidence as
5 the SPICE Board considers advisable to carry out
6 the purposes of this part.

7 “(2) INFORMATION FROM FEDERAL AGEN-
8 CIES.—Upon request of the chairperson of the
9 SPICE Board, the head of any Federal department
10 or agency shall furnish such information to the
11 SPICE Board as is necessary to carry out the func-
12 tions of the SPICE Board under this part.

13 “(3) POSTAL SERVICES.—The SPICE Board
14 may use the United States mails in the same man-
15 ner and under the same conditions as other depart-
16 ments and agencies of the Federal Government.

17 “(4) GIFTS.—The SPICE Board may accept,
18 use, and dispose of gifts or donations of services or
19 property.

20 “(g) BOARD PERSONNEL MATTERS.—

21 “(1) MEMBERS.—

22 “(A) COMPENSATION.—Each member of
23 the SPICE Board who is not an officer or em-
24 ployee of the Federal Government shall be com-
25 pensated at a rate equal to the daily equivalent

1 of the annual rate of basic pay prescribed for
 2 level IV of the Executive Schedule under section
 3 5315 of title 5, United States Code, for each
 4 day (including travel time) during which such
 5 member is engaged in the performance of the
 6 duties of the SPICE Board. All members of the
 7 SPICE Board who are officers or employees of
 8 the United States shall serve without compensa-
 9 tion in addition to that received for their serv-
 10 ices as officers or employees of the United
 11 States.

12 “(B) TRAVEL EXPENSES.—The members
 13 of the SPICE Board shall be allowed travel ex-
 14 penses, including per diem in lieu of subsist-
 15 ence, at rates authorized for employees of agen-
 16 cies under subchapter I of chapter 57 of title 5,
 17 United States Code, while away from their
 18 homes or regular places of business in the per-
 19 formance of services for the SPICE Board.

20 “(C) REMOVAL.—The President may re-
 21 move a member of the SPICE Board only for
 22 neglect of duty or malfeasance in office.

23 “(2) STAFF.—

24 “(A) IN GENERAL.—The chairperson of
 25 the SPICE Board may, without regard to the

1 civil service laws and regulations, appoint and
2 terminate an executive director and such other
3 additional personnel as may be necessary to en-
4 able the SPICE Board to perform its duties.
5 The employment of an executive director shall
6 be subject to confirmation by the SPICE
7 Board.

8 “(B) COMPENSATION.—The chairperson of
9 the SPICE Board may fix the compensation of
10 the executive director and other personnel with-
11 out regard to the provisions of chapter 51 and
12 subchapter III of chapter 53 of title 5, United
13 States Code, relating to classification of posi-
14 tions and General Schedule pay rates, except
15 that the rate of pay for the executive director
16 and other personnel may not exceed the rate
17 payable for level V of the Executive Schedule
18 under section 5316 of such title.

19 “(C) DETAIL OF GOVERNMENT EMPLOY-
20 EES.—Any Federal Government employee may
21 be detailed to the SPICE Board without further
22 reimbursement, and such detail shall be without
23 interruption or loss of civil service status or
24 privilege.

1 “(D) PROCUREMENT OF TEMPORARY AND
 2 INTERMITTENT SERVICES.—The chairperson of
 3 the SPICE Board may procure temporary and
 4 intermittent services under section 3109(b) of
 5 title 5, United States Code, at rates for individ-
 6 uals which do not exceed the daily equivalent of
 7 the annual rate of basic pay prescribed for level
 8 V of the Executive Schedule under section 5316
 9 of such title.

10 “SPICE PRESCRIPTION DRUG ACCOUNT IN THE FEDERAL
 11 SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

12 “SEC. 1860N. (a) ESTABLISHMENT.—

13 “(1) IN GENERAL.—There is created within the
 14 Federal Supplementary Medical Insurance Trust
 15 Fund established by section 1841 an account to be
 16 known as the ‘SPICE Prescription Drug Account’
 17 (in this section referred to as the ‘Account’).

18 “(2) FUNDS.—The Account shall consist of
 19 such gifts and bequests as may be made as provided
 20 in section 201(i)(1), and such amounts as may be
 21 deposited in, or appropriated to, such fund as pro-
 22 vided in this part.

23 “(3) SEPARATE FROM REST OF TRUST FUND.—
 24 Funds provided under this part to the Account shall
 25 be kept separate from all other funds within the

1 Federal Supplementary Medical Insurance Trust
2 Fund.

3 “(b) PAYMENTS FROM ACCOUNT.—

4 “(1) IN GENERAL.—The Managing Trustee
5 shall pay from time to time from the Account such
6 amounts as the SPICE Board certifies are necessary
7 to make payments to operate the program under this
8 part, including payments to entities under section
9 1860J, payments to sponsors under section 1860L,
10 and payments with respect to administrative ex-
11 penses under this part in accordance with section
12 201(g).

13 “(2) TREATMENT IN RELATION TO PART B PRE-
14 MIUM.—Amounts payable from the Account shall not
15 be taken into account in computing actuarial rates
16 or premium amounts under section 1839.

17 “(c) APPROPRIATIONS TO COVER GOVERNMENT
18 CONTRIBUTION.—There are authorized to be appropriated
19 from time to time, out of any moneys in the Treasury not
20 otherwise appropriated, to the Account an amount equal
21 to the amount by which the benefits and administrative
22 costs of providing the benefits under this part exceed the
23 premiums collected under section 1860H(a)(4).”.

24 (b) CONFORMING AMENDMENTS TO FEDERAL SUP-
25 PLEMENTARY MEDICAL INSURANCE TRUST FUND.—Sec-

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

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

(A) by striking “and” before “such
amounts”; and

(B) by inserting before the period the fol-
lowing: “, and such amounts as may be depos-
ited in, or appropriated to, the SPICE Pre-
scription Drug Account established by section
1860N”; and

(2) in subsection (g), by inserting after “by this
part,” the following: “the payments provided for
under part D (in which case the payments shall be
made from the SPICE Prescription Drug Account in
the Trust Fund),”.

(c) ADDITIONAL CONFORMING CHANGES.—

(1) CONFORMING REFERENCES TO PREVIOUS
PART D.—Any reference in law (in effect before the
date of enactment of this Act) to part D of title
XVIII of the Social Security Act is deemed a ref-
erence to part E of such title (as in effect after such
date).

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

1 and Human Services shall submit to the appropriate
 2 committees of Congress a legislative proposal pro-
 3 viding for such technical and conforming amend-
 4 ments in the law as are required by the provisions
 5 of this Act.

6 **SEC. 3. SPICE PRESCRIPTION DRUG COVERAGE UNDER**
 7 **MEDICARE+CHOICE PLANS.**

8 (a) SPECIAL RULES.—Section 1851 of the Social Se-
 9 curity Act (42 U.S.C. 1395w–21) is amended by adding
 10 at the end the following new subsection:

11 “(j) RULES FOR PROVISION OF SPICE PRESCRIP-
 12 TION DRUG COVERAGE.—

13 “(1) PLAN REQUIRED TO PROVIDE COVERAGE
 14 IF BENEFICIARY ENROLLED IN PART D.—

15 “(A) IN GENERAL.—In the case of an indi-
 16 vidual that is enrolled in a Medicare+Choice
 17 plan and enrolled under part D, the basic bene-
 18 fits required to be provided under section
 19 1852(a)(1)(A) shall include SPICE prescription
 20 drug coverage (as defined in section 1860B(a))
 21 under the terms and conditions for such cov-
 22 erage established under part D, including the
 23 terms and conditions described in section
 24 1860I(c).

1 “(B) VOLUNTARY ENROLLMENT IN PART
 2 D.—An individual enrolled in a
 3 Medicare+Choice plan shall not be required to
 4 enroll under part D.

5 “(2) LIMITATION ON ENROLLEE LIABILITY.—In
 6 the case of an individual described in paragraph
 7 (1)(A), with respect to SPICE prescription drug cov-
 8 erage, a Medicare+Choice organization may not re-
 9 quire that such individual pay a deductible or a coin-
 10 surance percentage that exceeds the deductible or
 11 coinsurance percentage applicable for such coverage
 12 pursuant to part D.

13 “(3) PREMIUM FOR STOP-LOSS COVERAGE.—

14 “(A) IN GENERAL.—Subject to subpara-
 15 graph (B), a Medicare+Choice organization of-
 16 fering a Medicare+Choice plan on behalf of an
 17 individual described in paragraph (1)(A) may
 18 require the individual to pay a premium for
 19 stop-loss coverage (as defined in section
 20 1860B(c). Any such premium shall be consid-
 21 ered to be part of the Medicare+Choice month-
 22 ly basic premium (as defined in section
 23 1854(b)(2)(A)) that the individual is respon-
 24 sible for.

1 “(B) ORGANIZATION REQUIRED TO RE-
 2 DUCE PREMIUM BY AMOUNT OF FINANCIAL AS-
 3 SISTANCE.—A Medicare+Choice organization
 4 receiving a payment for financial assistance for
 5 stop-loss coverage on behalf of an individual de-
 6 scribed in paragraph (1)(A) pursuant to sub-
 7 section (b) of section 1860J shall reduce any
 8 premium described in subparagraph (A) by the
 9 amount of such financial assistance.

10 “(4) PAYMENTS TO ORGANIZATION FOR SPICE
 11 PRESCRIPTION DRUG COVERAGE PURSUANT TO PART
 12 D RULES.—The SPICE Board (established under
 13 section 1860M) shall make payments to a
 14 Medicare+Choice organization offering a
 15 Medicare+Choice plan on behalf of an individual de-
 16 scribed in paragraph (1)(A) pursuant to the pay-
 17 ment mechanisms described in subsections (a) and
 18 (b) of section 1860J. Such payments shall be coordi-
 19 nated with payments made to such organization
 20 under section 1853.

21 “(5) COORDINATED ENROLLMENT.—The Sec-
 22 retary shall work with the SPICE Board to coordi-
 23 nate enrollment under this part with enrollment
 24 under part D.”.

1 (b) EFFECTIVE DATE.—The amendment made by
 2 this section shall apply to items and services provided
 3 under a Medicare+Choice plan on or after January 1,
 4 2003.

5 **SEC. 4. MEDIGAP REVISIONS AND TRANSITION PROVI-**
 6 **SIONS.**

7 (a) ESTABLISHMENT OF SPICE MEDIGAP POLI-
 8 CIES.—Section 1882 of the Social Security Act (42 U.S.C.
 9 1395ss) is amended by adding at the end the following
 10 new subsection:

11 “(v) SPICE MEDIGAP POLICIES.—

12 “(1) REVISION OF BENEFIT PACKAGES.—

13 “(A) IN GENERAL.—Notwithstanding sub-
 14 section (p), the benefit packages established
 15 under such subsection shall be revised so that—

16 “(i) if the policyholder is enrolled
 17 under part D, basic coverage (as defined in
 18 section 1860B(b)) is available as part of
 19 each benefit package;

20 “(ii) each benefit package includes
 21 stop-loss coverage (as defined in section
 22 1860B(c)) in the core group of basic bene-
 23 fits described in subsection (p)(2)(B);

24 “(iii) no benefit package (including
 25 each benefit package classified as ‘H’, ‘I’,

1 or ‘J’ under the standards established by
2 such subsection (p)(2), and the benefit
3 package classified as ‘J’ with a high de-
4 ductible feature described in subsection
5 (p)(11)) includes prescription drug cov-
6 erage other than the basic coverage re-
7 quired under clause (i) (if applicable), or
8 the stop-loss coverage required under
9 clause (ii); and

10 “(iv) except as revised under the pre-
11 ceding clauses or pursuant to subsection
12 (p)(1)(E), the benefit packages are iden-
13 tical to the benefit packages that were
14 available on the date of enactment of the
15 Seniors Prescription Insurance Coverage
16 Equity (SPICE) Act of 2001.

17 “(B) ADMINISTRATION OF BENEFITS.—

18 Pursuant to section 1860A(a)(3), an issuer of
19 a medicare supplemental policy revised under
20 such subparagraph may directly administer the
21 prescription drug benefits required under the
22 policy or may contract with an entity that
23 meets the applicable requirements under part D
24 to administer such benefits.

1 “(C) MANNER OF REVISION.—The benefit
 2 packages revised under this section shall be re-
 3 vised in the manner described in subparagraph
 4 (E) of subsection (p)(1), except that for pur-
 5 poses of subparagraph (C) of such subsection,
 6 the standards established under this subsection
 7 shall take effect not later than January 1,
 8 2003.

9 “(2) GUARANTEED ISSUANCE AND RENEWAL
 10 OF NEW POLICIES.—The provisions of subsections
 11 (q) and (s) shall apply to medicare supplemental
 12 policies revised under this subsection in the same
 13 manner as such provisions apply to medicare supple-
 14 mental policies issued under the standards estab-
 15 lished under subsection (p).

16 “(3) OPPORTUNITY OF CURRENT POLICY-
 17 HOLDERS TO PURCHASE REVISED POLICIES.—

18 “(A) IN GENERAL.—No medicare supple-
 19 mental policy of an issuer with a benefit pack-
 20 age that is revised under paragraph (1) shall be
 21 deemed to meet the standards in subsection (c)
 22 unless the issuer—

23 “(i) provides written notice during the
 24 60-day period immediately preceding the
 25 period established under section 1860C(c),

1 to each policyholder or certificate holder of
 2 a medicare supplemental policy issued by
 3 that issuer (at the most recent available
 4 address) of the offer described in clause
 5 (ii) and of the fact that, so long as they re-
 6 tain coverage under such policy, they are
 7 unable to obtain SPICE prescription drug
 8 coverage (as defined in section 1860B(a))
 9 under part D; and

10 “(ii) offers the policyholder or certifi-
 11 cate holder under the terms described in
 12 subparagraph (B), during at least the pe-
 13 riod established under subsection (c) of
 14 section 1860C, institution of coverage ef-
 15 fective for the period described in sub-
 16 section (d) of such section, a medicare sup-
 17 plemental policy with the benefit package
 18 that has been revised under paragraph (1)
 19 of this subsection that the Secretary deter-
 20 mines is most comparable to the policy in
 21 which the individual is enrolled.

22 “(B) TERMS OF OFFER DESCRIBED.—The
 23 terms described under this subparagraph are
 24 terms which do not—

1 “(i) deny or condition the issuance or
 2 effectiveness of a medicare supplemental
 3 policy described in subparagraph (A)(ii)
 4 that is offered and is available for issuance
 5 to new enrollees by such issuer;

6 “(ii) discriminate in the pricing of
 7 such policy because of health status, claims
 8 experience, receipt of health care, or med-
 9 ical condition; or

10 “(iii) impose an exclusion of benefits
 11 based on a preexisting condition under
 12 such policy.

13 “(4) OPPORTUNITY OF OTHER ELIGIBLE INDIV-
 14 IDUALS TO PURCHASE REVISED POLICIES.—No
 15 medicare supplemental policy of an issuer with a
 16 benefit package that is revised under paragraph (1)
 17 shall be deemed to meet the standards in subsection
 18 (c) unless, during at least the period established
 19 under section 1860C(c), the issuer permits each eli-
 20 gible medicare beneficiary (as defined in section
 21 1860A(d), but who is not described in paragraph
 22 (3)) to purchase any medicare supplemental policy
 23 that has been revised under paragraph (1) with in-
 24 stitution of coverage effective for the period de-

1 scribed in section 1860C(d) under the terms of the
2 offer described in paragraph (3)(B).

3 “(5) GRANDFATHERING OF CURRENT POLICY-
4 HOLDERS.—

5 “(A) IN GENERAL.—Except as provided in
6 subparagraph (B), no person may sell, issue, or
7 renew a medicare supplemental policy with a
8 benefit package that has not been revised under
9 this subsection on or after January 1, 2003.

10 “(B) GRANDFATHERING.—Each policy-
11 holder or certificate holder of a medicare sup-
12 plemental policy as of December 31, 2002, may
13 continue to receive benefits under such policy
14 and may renew such policy as if this subsection
15 had not been enacted, except that such bene-
16 ficiary shall not be eligible to enroll for SPICE
17 prescription drug coverage (as defined in sec-
18 tion 1860B(a)) under part D during the period
19 in which such policy is in effect.

20 “(6) PENALTIES.—Each penalty under this sec-
21 tion shall apply with respect to policies revised under
22 this subsection as if such policies were issued under
23 the standards established under subsection (p), in-
24 cluding the penalties under subsections (a), (d),

1 (p)(8), (p)(9), (q)(5), (r)(6)(A), (s)(4), and
2 (t)(2)(D).”.

3 (b) NAIC STUDY AND REPORT.—

4 (1) STUDY.—The Secretary of Health and
5 Human Services (in this subsection referred to as
6 the “Secretary”) shall contract with the National
7 Association of Insurance Commissioners (in this
8 subsection referred to as the “NAIC”) to conduct a
9 study—

10 (A) to determine whether the portion of
11 the benefit packages revised under section
12 1882(v) of the Social Security Act (as added by
13 subsection (a)) relating to parts A and B of the
14 medicare program should be revised as a result
15 of the establishment of SPICE prescription
16 drug coverage (as defined in section 1860B(a)
17 of such Act, as added by section 2) and whether
18 the total number of such benefit packages
19 should be reduced;

20 (B) to identify methods to ensure that any
21 financial assistance paid to issuers of medicare
22 supplemental policies on behalf of enrollees for
23 providing stop-loss coverage (as defined in sec-
24 tion 1860B(c) of the Social Security Act, as
25 added by section 2) made available under the

1 benefit packages revised under section 1882(v)
 2 of such Act (as so added) is not used to sub-
 3 sidize any other benefits, including the benefits
 4 relating to parts A and B of the medicare pro-
 5 gram; and

6 (C) to assess the practicality and viability
 7 of establishing a medicare supplemental policy
 8 that only provides SPICE prescription drug
 9 coverage (as so defined).

10 (2) REPORT.—Not later than 6 months after
 11 the date of enactment of this Act, the NAIC shall
 12 submit to Congress and the Secretary a report on
 13 the study conducted under paragraph (1) together
 14 with such recommendations as the NAIC determines
 15 appropriate.

16 **SEC. 5. PROVISION OF INFORMATION ON SPICE DRUG BEN-**
 17 **EFIT PROGRAM UNDER HEALTH INSURANCE**
 18 **INFORMATION, COUNSELING, AND ASSIST-**
 19 **ANCE GRANTS.**

20 Section 4360(b)(2)(A)(ii) of the Omnibus Budget
 21 Reconciliation Act of 1990 (42 U.S.C. 1395b–
 22 4(b)(2)(A)(ii)) is amended by striking “and information”
 23 and inserting “, information regarding the SPICE drug
 24 benefit program under part D of title XVIII of the Social
 25 Security Act, and information”.

1 **SEC. 6. PERSONAL DIGITAL ACCESS TECHNOLOGY DEM-**
2 **ONSTRATION PROJECT.**

3 (a) DEMONSTRATION PROJECT.—

4 (1) IN GENERAL.—The SPICE Board (estab-
5 lished under section 1860M of the Social Security
6 Act (as added by section 2)) shall conduct a dem-
7 onstration project for the purpose of increasing the
8 use of Personal Digital Access Technology in pre-
9 scribing covered outpatient drugs (as defined in sec-
10 tion 1860B(e) (as so added)) for eligible medicare
11 beneficiaries receiving SPICE prescription drug cov-
12 erage under part D of title XVIII of such Act (as
13 so added).

14 (2) ASPECTS OF PROJECT.—The demonstration
15 project shall address ways in which the use of Per-
16 sonal Digital Access Technology can be used to—

17 (A) avoid adverse drug reactions among
18 such beneficiaries, including problems due to
19 therapeutic duplication, drug-disease contra-
20 indications, drug-drug interactions (including
21 serious interactions with nonprescription or
22 over-the-counter drugs), incorrect drug dosage
23 or duration of drug treatment, drug-allergy
24 interactions, and clinical abuse and misuse;

25 (B) transmit information about the cov-
26 erage of covered outpatient drugs under the

1 policy or plan in which such a beneficiary is re-
2 ceiving SPICE prescription drug coverage to
3 prescribing physicians;

4 (C) increase the use of generic drugs by
5 such beneficiaries; and

6 (D) increase the compliance of entities of-
7 fering policies or plans that provide SPICE pre-
8 scription drug coverage with the requirements
9 under part D of title XVIII of the Social Secu-
10 rity Act (as added by section 2).

11 (3) INCLUSION OF PROVIDERS.—In conducting
12 the demonstration project, the SPICE Board shall
13 include—

14 (A) physicians;

15 (B) pharmacists;

16 (C) entities that offer policies or plans that
17 provide SPICE prescription drug coverage; and

18 (D) any entity (including a pharmacy ben-
19 efits management company) that contracts with
20 an entity described in subparagraph (C) to pro-
21 vide benefits under such policies or plans.

22 (4) DURATION OF PROJECTS.—The demonstra-
23 tion project shall be conducted over a 3-year period.

24 (b) REPORTS TO CONGRESS.—

25 (1) IN GENERAL.—

1 (A) INITIAL REPORT.—Not later than 18
2 months after the SPICE Board implements the
3 demonstration project, the SPICE Board shall
4 submit to Congress an initial report on the
5 demonstration project.

6 (B) FINAL REPORT.—Not later than 6
7 months after the conclusion of the project, the
8 SPICE Board shall submit to Congress a final
9 report on the demonstration project.

10 (2) CONTENTS OF REPORTS.—The reports de-
11 scribed in paragraph (1) shall include the following:

12 (A) A detailed description of the dem-
13 onstration project.

14 (B) An evaluation of the demonstration
15 project.

16 (C) Recommendations for legislation that
17 the SPICE Board determines to be appropriate
18 as a result of the demonstration project.

19 (D) Any other information regarding the
20 demonstration project that the SPICE Board
21 determines to be appropriate.

22 (c) FUNDING.—Expenditures made for carrying out
23 the demonstration project shall be made from funds other-

- 1 wise appropriated to the Secretary of Health and Human
- 2 Services.

