107TH CONGRESS
2D SESSION

S. 2736

To amend title XVIII of the Social Security Act to provide medicare beneficiaries with a drug discount card that ensures access to affordable outpatient prescription drugs.

IN THE SENATE OF THE UNITED STATES

JULY 16, 2002

Mr. HAGEL (for himself, Mr. ENSIGN, Mr. LUGAR, Mr. GRAMM, and Mr. INHOFE) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend title XVIII of the Social Security Act to provide medicare beneficiaries with a drug discount card that ensures access to affordable outpatient prescription drugs.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Rx Drug Discount and Security Act of 2002''.

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

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

(a) ESTABLISHMENT OF PROGRAM.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended—

(1) by redesignating part D as part E; and

(2) by inserting after part C the following new part:

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

''DEFINITIONS

''SEC. 1860. In this part:

''(1) COVERED OUTPATIENT DRUG.—

''(A) IN GENERAL.—Except as provided in this paragraph, the term 'covered outpatient drug' means—

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

''(ii) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section or insulin described in subparagraph (C) of such section,

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered outpatient drug for a medically accepted indication (as defined in section 1927(k)(6)).

''(B) EXCLUSIONS.—

''(i) IN GENERAL.—Such term does not include drugs or classes of drugs, or

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

''(ii) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this part shall not be so considered if payment for such drug is available under part A or B for an individual entitled to benefits under part A and enrolled under part B.

''(C) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this part shall not be so considered under a plan if the plan excludes the drug under a formulary and such exclusion is not successfully appealed under section 1860D(a)(4)(B).

''(D) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A prescription drug discount card plan or Medicare+Choice plan may

exclude from qualified prescription drug coverage any covered outpatient drug—

"(i) for which payment would not be made if section 1862(a) applied to part D; or

"(ii) which are not prescribed in accordance with the plan or this part.

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860D(a)(4).

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

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

"(B) not eligible for prescription drug coverage under a State plan under the medicaid program under title XIX.

"(3) ELIGIBLE ENTITY.—The term 'eligible entity' means any—

"(A) pharmaceutical benefit management company;

"(B) wholesale pharmacy delivery system;

"(C) retail pharmacy delivery system;

''(D) insurer (including any issuer of a medicare supplemental policy under section 1882);

''(E) Medicare+Choice organization;

''(F) State (in conjunction with a pharmaceutical benefit management company);

''(G) employer-sponsored plan;

''(H) other entity that the Secretary determines to be appropriate to provide benefits under this part; or

''(I) combination of the entities described in subparagraphs (A) through (H).

''(4) OUT-OF-POCKET EXPENSES.—The term 'out-of-pocket expenses' means only those expenses for covered outpatient drugs that are incurred by the eligible beneficiary using a card approved by the Secretary under this part that are paid by that beneficiary and for which the beneficiary is not reimbursed (through insurance or otherwise) by another person.

''(5) POVERTY LINE.—The term 'poverty line' means the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the

Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

''(6) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services.

''ESTABLISHMENT OF PROGRAM

''SEC. 1860A. (a) PROVISION OF BENEFIT.—The Secretary shall establish a Medicare Outpatient Prescription Drug Discount and Security Program under which the Secretary endorses prescription drug card plans offered by eligible entities in which eligible beneficiaries may voluntarily enroll and receive benefits under this part.

''(b) ENDORSEMENT OF PRESCRIPTION DRUG DISCOUNT CARD PLANS.—

''(1) IN GENERAL.—The Secretary shall endorse a prescription drug card plan offered by an eligible entity with a contract under this part if the eligible entity meets the requirements of this part with respect to that plan.

''(2) NATIONAL PLANS.—In addition to other types of plans, the Secretary may endorse national prescription drug plans under paragraph (1).

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

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

''ENROLLMENT

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

''(1) ESTABLISHMENT OF PROCESS.—

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

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

''(2) ENROLLMENT PERIODS.—

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

ment period under part B (as determined under section 1837).

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

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

''(i) enroll under this part; or

''(ii) enroll or reenroll under this part after having previously declined or terminated such enrollment.

''(3) PERIOD OF COVERAGE.—

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

that section applied to the program under this part.

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

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

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

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

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

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

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

''(ii) the coverage under title XIX.

''(b) ENROLLMENT WITH ELIGIBLE ENTITY.—

''(1) PROCESS.—The Secretary shall establish a process through which an eligible beneficiary who is enrolled under this part shall make an annual election to enroll in a prescription drug card plan offered by an eligible entity that has been awarded a contract under this part and serves the geographic area in which the beneficiary resides.

''(2) ELECTION PERIODS.—

''(A) IN GENERAL.—Except as provided in this paragraph, the election periods under this subsection shall be the same as the coverage election periods under the Medicare+Choice program under section 1851(e), including—

''(i) annual coordinated election periods; and

''(ii) special election periods.

In applying the last sentence of section 1851(e)(4) (relating to discontinuance of a Medicare+Choice election during the first year of eligibility) under this subparagraph, in the case of an election described in such section in

which the individual had elected or is provided qualified prescription drug coverage at the time of such first enrollment, the individual shall be permitted to enroll in a prescription drug card plan under this part at the time of the election of coverage under the original fee-for-service plan.

''(B) INITIAL ELECTION PERIODS.—

''(i) INDIVIDUALS CURRENTLY COVERED.—In the case of an individual who is entitled to benefits under part A or enrolled under part B as of November 1, 2003, there shall be an initial election period of 6 months beginning on that date.

''(ii) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who is first entitled to benefits under part A or enrolled under part B after such date, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

''(C) ADDITIONAL SPECIAL ELECTION PERIODS.—The Administrator shall establish special election periods—

"(i) in cases of individuals who have and involuntarily lose prescription drug coverage described in paragraph (3);

"(ii) in cases described in section 1837(h) (relating to errors in enrollment), in the same manner as such section applies to part B; and

"(iii) in the case of an individual who meets such exceptional conditions (including conditions provided under section 1851(e)(4)(D)) as the Secretary may provide.

"(D) ENROLLMENT WITH ONE PLAN ONLY.—The rules established under subparagraph (B) shall ensure that an eligible beneficiary may only enroll in 1 prescription drug card plan offered by an eligible entity for a year.

"(3) MEDICARE+CHOICE ENROLLEES.—An eligible beneficiary who is enrolled under this part and enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization must enroll in a prescription drug discount card plan offered by an eligible entity in order to receive benefits under this part. The beneficiary may elect to receive such bene-

fits through the Medicare+Choice organization in which the beneficiary is enrolled if the organization has been awarded a contract under this part.

''(4) CONTINUOUS PRESCRIPTION DRUG COVERAGE.—An individual is considered for purposes of this part to be maintaining continuous prescription drug coverage on and after the date the individual first qualifies to elect prescription drug coverage under this part if the individual establishes that as of such date the individual is covered under any of the following prescription drug coverage and before the date that is the last day of the 63-day period that begins on the date of termination of the particular prescription drug coverage involved (regardless of whether the individual subsequently obtains any of the following prescription drug coverage):

''(A) COVERAGE UNDER PRESCRIPTION DRUG CARD PLAN OR MEDICARE+CHOICE PLAN.—Prescription drug coverage under a prescription drug card plan under this part or under a Medicare+Choice plan.

''(B) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care for

the Elderly (PACE) under section 1934, through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997), or through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

''(C) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any outpatient prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan (as defined by the Secretary), but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

''(D) PRESCRIPTION DRUG COVERAGE UNDER CERTAIN MEDIGAP POLICIES.—Coverage

under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)) and if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

''(E) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

''(F) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans under chapter 17 of title 38, United States Code, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a prescription drug card plan under this part.

For purposes of carrying out this paragraph, the certifications of the type described in sections 2701(e) of the Public Health Service Act and in sec-

tion 9801(e) of the Internal Revenue Code of 1986 shall also include a statement for the period of coverage of whether the individual involved had prescription drug coverage described in this paragraph.

''(5) COMPETITION.—Each eligible entity with a contract under this part shall compete for the enrollment of beneficiaries in a prescription drug card plan offered by the entity on the basis of discounts, formularies, pharmacy networks, and other services provided for under the contract.

''PROVIDING ENROLLMENT AND COVERAGE INFORMATION TO BENEFICIARIES

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

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

''ENROLLEE PROTECTIONS

''SEC. 1860D. (a) REQUIREMENTS FOR ALL ELIGIBLE ENTITIES.—Each eligible entity shall meet the following requirements:

''(1) GUARANTEED ISSUANCE AND NONDISCRIMINATION.—

''(A) GUARANTEED ISSUANCE.—

''(i) IN GENERAL.—An eligible beneficiary who is eligible to enroll in a prescription drug card plan offered by an eligible entity under section 1860B(b) for prescription drug coverage under this part at a time during which elections are accepted under this part with respect to the coverage shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

''(ii) MEDICARE+CHOICE LIMITATIONS PERMITTED.—The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i), relating to default enrollment) of section 1851(g) (relating to priority and limitation on termination of elec-

tion) shall apply to eligible entities under this subsection.

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

''(2) DISCLOSURE OF INFORMATION.—

''(A) INFORMATION.—

''(i) GENERAL INFORMATION.—Each eligible entity with a contract under this part to provide a prescription drug card plan shall disclose, in a clear, accurate, and standardized form to each eligible beneficiary enrolled in a prescription drug discount card program offered by such entity under this part at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such prescription drug coverage.

''(ii) SPECIFIC INFORMATION.—In addition to the information described in clause (i), each eligible entity with a contract under this part shall disclose the following:

"(I) How enrollees will have access to covered outpatient drugs, including access to such drugs through pharmacy networks.

"(II) How any formulary used by the eligible entity functions.

"(III) Information on grievance and appeals procedures.

"(IV) Information on enrollment fees and prices charged to the enrollee for covered outpatient drugs.

"(V) Any other information that the Secretary determines is necessary to promote informed choices by eligible beneficiaries among eligible entities.

"(B) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an eligible beneficiary, the eligible entity shall provide the information described in paragraph (3) to such beneficiary.

"(C) RESPONSE TO BENEFICIARY QUESTIONS.—Each eligible entity offering a prescription drug discount card plan under this part

shall have a mechanism for providing specific information to enrollees upon request. The entity shall make available, through an Internet website and, upon request, in writing, information on specific changes in its formulary.

''(3) GRIEVANCE MECHANISM, COVERAGE DETERMINATIONS, AND RECONSIDERATIONS.—

''(A) IN GENERAL.—With respect to the benefit under this part, each eligible entity offering a prescription drug discount card plan shall provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the eligible entity provides covered benefits) and enrollees with prescription drug card plans of the eligible entity under this part in accordance with section 1852(f).

''(B) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—Each eligible entity shall meet the requirements of paragraphs (1) through (3) of section 1852(g) with respect to covered benefits under the prescription drug card plan it offers under this part in the same manner as such requirements apply to a Medicare+Choice organi-

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

''(C) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a prescription drug card plan offered by an eligible entity that provides for tiered cost-sharing for drugs included within a formulary and provides lower cost-sharing for preferred drugs included within the formulary, an individual who is enrolled in the plan may request coverage of a nonpreferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

''(4) APPEALS.—

''(A) IN GENERAL.—Subject to subparagraph (B), each eligible entity offering a prescription drug card plan shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to drugs not included on any formulary in the same manner as such requirements apply to a Medicare+Choice organi-

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

''(B) FORMULARY DETERMINATIONS.—An individual who is enrolled in a prescription drug card plan offered by an eligible entity may appeal to obtain coverage under this part for a covered outpatient drug that is not on a formulary of the eligible entity if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

''(5) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Each eligible entity offering a prescription drug discount card plan shall meet the requirements of the Health Insurance Portability and Accountability Act of 1996.

(b) ELIGIBLE ENTITIES OFFERING A DISCOUNT CARD PROGRAM.—If an eligible entity offers a discount card program under this part, in addition to the requirements under subsection (a), the entity shall meet the following requirements:

''(1) ACCESS TO COVERED BENEFITS.—

''(A) ASSURING PHARMACY ACCESS.—

''(i) IN GENERAL.—The eligible entity offering the prescription drug discount card plan shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (as determined by the Secretary and including adequate emergency access) for enrolled beneficiaries, in accordance with standards established under section 1860D(a)(3) that ensure such convenient access.

''(ii) USE OF POINT-OF-SERVICE SYSTEM.—Each eligible entity offering a prescription drug discount card plan shall establish an optional point-of-service method of operation under which—

''(I) the plan provides access to any or all pharmacies that are not participating pharmacies in its network; and

''(II) discounts under the plan may not be available.

The additional copayments so charged shall not be counted as out-of-pocket expenses for purposes of section 1860F(b).

''(B) USE OF STANDARDIZED TECHNOLOGY.—

''(i) IN GENERAL.—Each eligible entity offering a prescription drug discount card plan shall issue (and reissue, as appropriate) such a card (or other technology) that may be used by an enrolled beneficiary to assure access to negotiated prices under section 1860F(a) for the purchase of prescription drugs for which coverage is not otherwise provided under the prescription drug discount card plan.

''(ii) STANDARDS.—The Secretary shall provide for the development of national standards relating to a standardized format for the card or other technology referred to in subparagraph (A). Such standards shall be compatible with standards established under part C of title XI.

''(C) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If an eligible entity that offers a prescription drug dis-

count card plan uses a formulary, the following requirements must be met:

''(i) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—The eligible entity must establish a pharmacy and therapeutic committee that develops and reviews the formulary. Such committee shall include at least 1 physician and at least 1 pharmacist both with expertise in the care of elderly or disabled persons and a majority of its members shall consist of individuals who are a physician or a practicing pharmacist (or both).

''(ii) FORMULARY DEVELOPMENT.—In developing and reviewing the formulary, the committee shall base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and such other information as the committee determines to be appropriate.

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

''(iv) PROVIDER EDUCATION.—The committee shall establish policies and procedures to educate and inform health care providers concerning the formulary.

''(v) NOTICE BEFORE REMOVING DRUGS FROM FORMULARY.—Any removal of a drug from a formulary shall take effect only after appropriate notice is made available to beneficiaries and physicians.

''(vi) GRIEVANCES AND APPEALS RELATING TO APPLICATION OF FORMULARIES.—For provisions relating to grievances and appeals of coverage, see subsections (e) and (f).

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

"(A) IN GENERAL.—Each eligible entity offering a prescription drug discount card plan may have in place with respect to covered outpatient drugs—

"(i) an effective cost and drug utilization management program, including medically appropriate incentives to use generic drugs and therapeutic interchange, when appropriate;

"(ii) quality assurance measures and systems to reduce medical errors and adverse drug interactions, including a medication therapy management program described in subparagraph (B) and an electronic prescription program described in subparagraph (C); and

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

Nothing in this section shall be construed as impairing an eligible entity from applying cost management tools (including differential payments) under all methods of operation.

"(B) MEDICATION THERAPY MANAGEMENT PROGRAM.—

''(i) IN GENERAL.—A medication therapy management program described in this paragraph is a program of drug therapy management and medication administration that is designed to ensure, with respect to beneficiaries with chronic diseases (such as diabetes, asthma, hypertension, and congestive heart failure) or multiple prescriptions, that covered outpatient drugs under the prescription drug discount card plan are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

''(ii) ELEMENTS.—Such program may include—

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

''(II) increased beneficiary adherence with prescription medication regimens through medication refill reminders, special packaging, and other appropriate means; and

"(III) detection of patterns of overuse and underuse of prescription drugs.

"(iii) DEVELOPMENT OF PROGRAM IN COOPERATION WITH LICENSED PHARMACISTS.—The program shall be developed in cooperation with licensed pharmacists and physicians.

"(iv) CONSIDERATIONS IN PHARMACY FEES.—Each eligible entity offering a prescription drug discount card plan shall take into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program.

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

"(i) Paragraph (1) (including quality assurance), including any medication therapy management program under paragraph (2).

"(ii) Subsection (c)(1) (relating to access to covered benefits).

"(iii) Subsection (g) (relating to confidentiality and accuracy of enrollee records).

"(D) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—Each eligible entity offering a prescription drug discount card plan shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered outpatient drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost generic drug covered under the plan that is therapeutically equivalent and bioequivalent.

"ANNUAL ENROLLMENT FEE

"SEC. 1860E. (a) AMOUNT.—

"(1) IN GENERAL.—Except as provided in subsection (c), enrollment under the program under this

part is conditioned upon payment of an annual enrollment fee of $25.

''(2) ANNUAL PERCENTAGE INCREASE.—

''(A) IN GENERAL.—In the case of any calendar year beginning after 2004, the dollar amount in paragraph (1) shall be increased by an amount equal to—

''(i) such dollar amount; multiplied by

''(ii) the inflation adjustment.

''(B) INFLATION ADJUSTMENT.—For purposes of subparagraph (A)(ii), the inflation adjustment for any calendar year is the percentage (if any) by which—

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

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

''(C) ROUNDING.—If any increase determined under clause (ii) is not a multiple of $1,

such increase shall be rounded to the nearest multiple of $1.

''(b) COLLECTION OF ANNUAL ENROLLMENT FEE.—

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

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

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

''BENEFITS UNDER THE PROGRAM

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

''(1) NEGOTIATED PRICES.—

''(A) IN GENERAL.—Subject to subparagraph (B), each prescription drug card plan of-

fering a discount card program by an eligible entity with a contract under this part shall provide each eligible beneficiary enrolled in such plan with access to negotiated prices (including applicable discounts) for such prescription drugs as the eligible entity determines appropriate. Such discounts may include discounts for nonformulary drugs. If such a beneficiary becomes eligible for the catastrophic benefit under subsection (b), the negotiated prices (including applicable discounts) shall continue to be available to the beneficiary for those prescription drugs for which payment may not be made under section 1860H(b). For purposes of this subparagraph, the term 'prescription drugs' is not limited to covered outpatient drugs, but does not include any over-the-counter drug that is not a covered outpatient drug.

''(B) LIMITATIONS.—

''(i) FORMULARY RESTRICTIONS.—Insofar as an eligible entity with a contract under this part uses a formulary, the negotiated prices (including applicable discounts) for nonformulary drugs may differ.

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

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

''(3) ENSURING DISCOUNTS IN ALL AREAS.—The Secretary shall develop procedures that ensure that each eligible beneficiary that resides in an area where no prescription drug discount card plans are available is provided with access to negotiated prices for prescription drugs (including applicable discounts).

''(b) CATASTROPHIC BENEFIT.—

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

''(A) BENEFICIARIES WITH ANNUAL INCOMES BELOW 200 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose modified adjusted gross income (as defined in paragraph (4)(E)) is below 200 percent of the poverty line, the beneficiary shall not be responsible for making a payment for a covered outpatient drug provided under this part to the beneficiary in a year to the extent that the out-of-pocket expenses of the beneficiary for such drug exceed $1,500, unless the Secretary implements cost-sharing (as authorized under this part).

''(B) BENEFICIARIES WITH ANNUAL INCOMES BETWEEN 200 AND 400 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose modified adjusted gross income (as so defined) equals or exceeds 200 percent, but does not exceed 400 percent, of the poverty

line, the beneficiary shall not be responsible for making a payment for a covered outpatient drug provided under this part to the beneficiary in a year to the extent that the out-of-pocket expenses of the beneficiary for such drug exceed $3,500, unless the Secretary implements cost-sharing (as authorized under this part).

''(C) BENEFICIARIES WITH ANNUAL INCOMES BETWEEN 400 AND 600 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose modified adjusted gross income (as so defined) equals or exceeds 400 percent, but does not exceed 600 percent, of the poverty line, the beneficiary shall not be responsible for making a payment for a covered outpatient drug provided under this part to the beneficiary in a year to the extent that the out-of-pocket expenses of the beneficiary for such drug exceed $5,500, unless the Secretary implements cost-sharing (as authorized under this part).

''(D) BENEFICIARIES WITH ANNUAL INCOMES THAT EXCEED 600 PERCENT OF THE POVERTY LINE.—In the case of an eligible beneficiary whose modified adjusted gross income (as so defined) equals or exceeds 600 percent of

the poverty line, the beneficiary shall not be responsible for making a payment for a covered outpatient drug provided under this part to the beneficiary in a year to the extent that the out-of-pocket expenses of the beneficiary for such drug exceeds 20 percent of that beneficiary's income, unless the Secretary implements cost-sharing (as authorized under this part).

''(2) ANNUAL PERCENTAGE INCREASE.—

''(A) IN GENERAL.—In the case of any calendar year after 2004, the dollar amounts in paragraph (1) shall be increased by an amount equal to—

''(i) such dollar amount; multiplied by

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

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

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

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

provision of the catastrophic benefit under this subsection.

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

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

''(i) IN GENERAL.—The Secretary shall establish procedures for determining the modified adjusted gross income of eligible beneficiaries enrolled under this part.

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

''(iii) DISCLOSURE OF INFORMATION.—Notwithstanding section 6103(a) of the Internal Revenue Code of 1986, the Secretary of the Treasury may, upon written request from the Secretary, disclose to officers and employees of the Centers for Medicare & Medicaid Services such return information as is necessary to make the

determinations described in clause (i). Return information disclosed under the preceding sentence may be used by officers and employees of the Centers for Medicare & Medicaid Services only for the purposes of, and to the extent necessary, in making such determinations.

''(D) DEFINITION OF MODIFIED ADJUSTED GROSS INCOME.—In this paragraph, the term 'modified adjusted gross income' means adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

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

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

''(iii) increased by any amount received under title II.

''(5) ENSURING CATASTROPHIC BENEFIT IN ALL AREAS.—The Secretary shall develop procedures for the provision of the catastrophic benefit under this subsection to each eligible beneficiary that re-

sides in an area where there are no prescription drug discount card plans offered that have been awarded a contract under this part.

''REQUIREMENTS FOR ENTITIES TO PROVIDE PRESCRIPTION DRUG COVERAGE

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

''(b) SUBMISSION OF BIDS.—Each eligible entity desiring to enter into a contract under this part shall submit a bid to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may require.

''(c) ADMINISTRATIVE FEE BID.—

''(1) SUBMISSION.—For the bid described in subsection (b), each entity shall submit to the Secretary information regarding administration of the discount card and catastrophic benefit under this part.

''(2) BID SUBMISSION REQUIREMENTS.—

''(A) ADMINISTRATIVE FEE BID SUBMISSION.—In submitting bids, the entities shall include separate costs for administering the discount card component, if applicable, and the

catastrophic benefit. The entity shall submit the administrative fee bid in a form and manner specified by the Secretary, and shall include a statement of projected enrollment and a separate statement of the projected administrative costs for at least the following functions:

''(i) Enrollment, including income eligibility determination.

''(ii) Claims processing.

''(iii) Quality assurance, including drug utilization review.

''(iv) Beneficiary and pharmacy customer service.

''(v) Coordination of benefits.

''(vi) Fraud and abuse prevention.

''(B) NEGOTIATED ADMINISTRATIVE FEE BID AMOUNTS.—The Secretary has the authority to negotiate regarding the bid amounts submitted. The Secretary may reject a bid if the Secretary determines it is not supported by the administrative cost information provided in the bid as specified in subparagraph (A).

''(C) PAYMENT TO PLANS BASED ON ADMINISTRATIVE FEE BID AMOUNTS.—The Secretary shall use the bid amounts to calculate a

benchmark amount consisting of the enrollment-weighted average of all bids for each function and each class of entity. The class of entity is either a regional or national entity, or such other classes as the Secretary may determine to be appropriate. The functions are the discount card and catastrophic components. If an eligible entity's combined bid for both functions is above the combined benchmark within the entity's class for the functions, the eligible entity shall collect additional necessary revenue through one or both of the following:

"(i) Additional fees charged to the beneficiary, not to exceed $25 annually.

"(ii) Use of rebate amounts from drug manufacturers to defray administrative costs.

"(d) AWARDING OF CONTRACTS.—

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

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

''(3) REQUIREMENTS FOR ELIGIBLE ENTITIES PROVIDING DISCOUNT CARD PROGRAM.—Except as provided in subsection (e), in determining which of the eligible entities that submitted bids that meet the terms and conditions specified by the Secretary under paragraph (2) to award a contract, the Secretary shall consider whether the bid submitted by the entity meets at least the following requirements:

''(A) LEVEL OF SAVINGS TO MEDICARE BENEFICIARIES.—The program passes on to medicare beneficiaries who enroll in the program discounts on prescription drugs, including discounts negotiated with manufacturers.

''(B) PROHIBITION ON APPLICATION ONLY TO MAIL ORDER.—The program applies to drugs that are available other than solely through mail order and provides convenient access to retail pharmacies.

''(C) LEVEL OF BENEFICIARY SERVICES.—The program provides pharmaceutical support

services, such as education and services to prevent adverse drug interactions.

''(D) ADEQUACY OF INFORMATION.—The program makes available to medicare beneficiaries through the Internet and otherwise information, including information on enrollment fees, prices charged to beneficiaries, and services offered under the program, that the Secretary identifies as being necessary to provide for informed choice by beneficiaries among endorsed programs.

''(E) EXTENT OF DEMONSTRATED EXPERIENCE.—The entity operating the program has demonstrated experience and expertise in operating such a program or a similar program.

''(F) EXTENT OF QUALITY ASSURANCE.—The entity has in place adequate procedures for assuring quality service under the program.

''(G) OPERATION OF ASSISTANCE PROGRAM.—The entity meets such requirements relating to solvency, compliance with financial reporting requirements, audit compliance, and contractual guarantees as specified by the Secretary.

"(H) PRIVACY COMPLIANCE.—The entity implements policies and procedures to safeguard the use and disclosure of program beneficiaries' individually identifiable health information in a manner consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

"(I) ADDITIONAL BENEFICIARY PROTECTIONS.—The program meets such additional requirements as the Secretary identifies to protect and promote the interest of medicare beneficiaries, including requirements that ensure that beneficiaries are not charged more than the lower of the negotiated retail price or the usual and customary price.

The prices negotiated by a prescription drug discount card program endorsed under this section shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

"(4) BENEFICIARY ACCESS TO SAVINGS AND REBATES.—The Secretary shall require eligible enti-

ties offering a discount card program to pass on savings and rebates negotiated with manufacturers to eligible beneficiaries enrolled with the entity.

''(5) NEGOTIATED AGREEMENTS WITH EMPLOYER-SPONSORED PLANS.—Notwithstanding any other provision of this part, the Secretary may negotiate agreements with employer-sponsored plans under which eligible beneficiaries are provided with a benefit for prescription drug coverage that is more generous than the benefit that would otherwise have been available under this part if such an agreement results in cost savings to the Federal Government.

''(e) REQUIREMENTS FOR OTHER ELIGIBLE ENTITIES.—If an eligible entity is licensed under State law to provide the benefit under this section, such entity shall not be required to meet the requirements of subsection (d)(3). If an eligible entity offers a national plan, such entity shall not be required to meet the requirements of subsection (d)(3), but shall meet the requirements of Employee Retirement Income Security Act of 1974 that apply with respect to such plan.

''PAYMENTS TO ELIGIBLE ENTITIES FOR ADMINISTERING THE CATASTROPHIC BENEFIT

''SEC. 1860H. (a) IN GENERAL.—The Secretary may establish procedures for making payments to an eligible entity under a contract entered into under this part for—

''(1) no less than 90 percent of the costs of providing covered outpatient prescription drugs to beneficiaries eligible for the benefit under this part in accordance with subsection (b); and

''(2) costs incurred by the entity in administering the catastrophic benefit in accordance with section 1860G.

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

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

''(2) LIMITATIONS.—

''(A) FORMULARY RESTRICTIONS.—Insofar as an eligible entity with a contract under this part uses a formulary, the Secretary may not make any payment for a covered outpatient drug that is not included in such formulary, except to the extent provided under section 1860D(a)(4)(B).

''(B) NEGOTIATED PRICES.—The Secretary may not pay an amount for a covered outpatient drug furnished to an eligible beneficiary that exceeds the negotiated price (including applicable discounts) that the beneficiary would have been responsible for under section 1860F(a) or the price negotiated for insurance coverage under the Medicare+Choice program under part C, a medicare supplemental policy, employer-sponsored coverage, or a State plan.

''(C) COST-SHARING LIMITATIONS.—An eligible entity may not charge an individual enrolled with such entity who is eligible for the catastrophic benefit under this part any copayment, tiered copayment, coinsurance, or other cost-sharing that exceeds 10 percent of the cost of the drug that is dispensed to the individual.

''(3) PAYMENT IN COMPETITIVE AREAS.—In a geographic area in which 2 or more eligible entities offer a plan under this part, the Secretary may negotiate an agreement with the entity to reimburse the entity for costs incurred in providing the benefit under this part on a capitated basis.

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

''DETERMINATION OF INCOME LEVELS

''SEC. 1860I. (a) DETERMINATION OF INCOME LEVELS.—

''(1) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, shall establish procedures under which each eligible entity awarded a contract under this part determines the income levels of eligible beneficiaries enrolled in a prescription drug card plan offered by that entity at least annually for purposes of sections 1860E(c) and 1860F(b).

''(2) PROCEDURES.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the procedures established under paragraph (1) shall—

''(i) require each eligible beneficiary who is enrolled in a prescription drug card plan to present the Federal income tax return for the preceding taxable year to the eligible entity offering the plan as proof of income for that year;

''(ii) require, upon the request of an eligible entity, the Secretary of the Treas-

ury to confirm the amount of income reported on such a Federal income tax return; and

"(iii) attribute, in the case of a joint return, ½ of the income reported on the return to each eligible beneficiary filing such a return.

"(B) OTHER PROOF OF INCOME.—If an eligible beneficiary did not file a Federal income tax return for the preceding year, if such beneficiary experiences a significant decrease in income during a year, or if such other circumstances exist as the Secretary may specify, an eligible beneficiary may submit an affidavit and such supporting documents as the Secretary may require as proof of the income of that beneficiary instead of a Federal income tax return.

"(b) ENFORCEMENT OF INCOME DETERMINATIONS.—The Secretary, in consultation with the Secretary of the Treasury, shall—

"(1) establish procedures that ensure that eligible beneficiaries comply with sections 1860E(c) and 1860F(b); and

"(2) require, if the Secretary determines that payments were made under this part to which an eli-

gible beneficiary was not entitled, the repayment of any excess payments with interest and a penalty.

''(c) QUALITY CONTROL SYSTEM.—

''(1) ESTABLISHMENT.—The Secretary shall establish a quality control system to monitor income determinations made by eligible entities under this section and to produce appropriate and comprehensive measures of error rates.

''(2) PERIODIC AUDITS.—The Inspector General of the Department of Health and Human Services shall conduct periodic audits to ensure that the system established under paragraph (1) is functioning appropriately.

''APPROPRIATIONS

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

''MEDICARE COMPETITION AND PRESCRIPTION DRUG ADVISORY BOARD

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

''(b) ADVICE ON POLICIES; REPORTS.—

''(1) ADVICE ON POLICIES.—The Board shall advise the Secretary on policies relating to the Medicare Outpatient Prescription Drug Discount and Security Program under this part.

''(2) REPORTS.—

''(A) IN GENERAL.—With respect to matters of the administration of the program under this part, the Board shall submit to Congress and to the Secretary such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of the program under this part. Each such report shall be published in the Federal Register.

''(B) MAINTAINING INDEPENDENCE OF BOARD.—The Board shall directly submit to Congress reports required under subparagraph (A). No officer or agency of the United States

may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to the submission to Congress of such reports.

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

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

''(A) PRESIDENTIAL APPOINTMENTS.—

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

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

''(B) SENATORIAL APPOINTMENTS.—Two members (each member from a different political party) shall be appointed by the President pro tempore of the Senate with the advice of the Chairman and the Ranking Minority Member of the Committee on Finance of the Senate.

''(C) CONGRESSIONAL APPOINTMENTS.—Two members (each member from a different political party) shall be appointed by the Speak-

er of the House of Representatives, with the advice of the Chairman and the Ranking Minority Member of the Committee on Ways and Means of the House of Representatives.

''(2) QUALIFICATIONS.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education, experience, and attainments, exceptionally qualified to perform the duties of members of the Board.

''(3) COMPOSITION.—Of the members appointed under paragraph (1)—

''(A) at least one shall represent the pharmaceutical industry;

''(B) at least one shall represent physicians;

''(C) at least one shall represent medicare beneficiaries;

''(D) at least one shall represent practicing pharmacists; and

''(E) at least one shall represent eligible entities.

''(d) TERMS OF APPOINTMENT.—

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

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

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

''(B) STAGGERED TERMS.—The terms of service of the members initially appointed under this section shall begin on January 1, 2004, and expire as follows:

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

''(I) 2 years;

''(II) 4 years; and

''(III) 6 years.

''(ii) SENATORIAL APPOINTMENTS.—The terms of service of members initially appointed by the President pro tempore of

the Senate shall expire as designated by the President pro tempore of the Senate at the time of nomination, 1 each at the end of—

"(I) 3 years; and

"(II) 6 years.

"(iii) CONGRESSIONAL APPOINTMENTS.—The terms of service of members initially appointed by the Speaker of the House of Representatives shall expire as designated by the Speaker of the House of Representatives at the time of nomination, 1 each at the end of—

"(I) 4 years; and

"(II) 5 years.

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

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

Board shall be filled in the manner in which the original appointment was made.

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

''(f) EXPENSES AND PER DIEM.—Members of the Board shall serve without compensation, except that, while serving on business of the Board away from their homes or regular places of business, members may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government employed intermittently.

''(g) MEETING.—

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

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

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

''(i) PERSONNEL.—

''(1) STAFF DIRECTOR.—The Board shall, without regard to the provisions of title 5, United States Code, relating to the competitive service, appoint a Staff Director who shall be paid at a rate equivalent to a rate established for the Senior Executive Service under section 5382 of title 5, United States Code.

''(2) STAFF.—

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

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

''(i) IN GENERAL.—The staff of the Board shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and, subject to clause (ii), shall be paid without regard to the provi-

sions of chapters 51 and 53 of such title (relating to classification and schedule pay rates).

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

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

(b) CONFORMING REFERENCES TO PREVIOUS PART D.—

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

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

and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this section.

(c) EFFECTIVE DATE.—

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

(2) IMPLEMENTATION.—Notwithstanding any provision of part D of title XVIII of the Social Security Act (as added by subsection (a)), the Secretary of Health and Human Services shall implement the Voluntary Medicare Outpatient Prescription Drug Discount and Security Program established under such part in a manner such that—

(A) benefits under such part for eligible beneficiaries (as defined in section 1860 of such Act, as added by such subsection) with annual incomes below 200 percent of the poverty line (as defined in such section) are available to such beneficiaries not later than the date that is 6 months after the date of enactment of this Act; and

(B) benefits under such part for other eligible beneficiaries are available to such beneficiaries not later than the date that is 1 year after the date of enactment of this Act.

SEC. 3. ADMINISTRATION OF VOLUNTARY MEDICARE OUTPATIENT PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM.

(a) ESTABLISHMENT OF CENTER FOR MEDICARE PRESCRIPTION DRUGS.—There is established, within the Centers for Medicare & Medicaid Services of the Department of Health and Human Services, a Center for Medicare Prescription Drugs. Such Center shall be separate from the Center for Beneficiary Choices, the Center for Medicare Management, and the Center for Medicaid and State Operations.

(b) DUTIES.—It shall be the duty of the Center for Medicare Prescription Drugs to administer the Voluntary Medicare Outpatient Prescription Drug Discount and Security Program established under part D of title XVIII of the Social Security Act (as added by section 2).

(c) DIRECTOR.—

(1) APPOINTMENT.—There shall be in the Center for Medicare Prescription Drugs a Director of Medicare Prescription Drugs, who shall be appointed

by the President, by and with the advice and consent of the Senate.

(2) RESPONSIBILITIES.—The Director shall be responsible for the exercise of all powers and the discharge of all duties of the Center for Medicare Prescription Drugs and shall have authority and control over all personnel and activities thereof.

(d) PERSONNEL.—The Director of the Center for Medicare Prescription Drugs may appoint and terminate such personnel as may be necessary to enable the Center for Medicare Prescription Drugs to perform its duties.

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

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

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

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

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

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

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

SEC. 5. MEDIGAP REVISIONS.

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

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

''(1) PROMULGATION OF MODEL REGULATION.—

''(A) NAIC MODEL REGULATION.—If, within 9 months after the date of enactment of the Medicare Rx Drug Discount and Security Act of 2002, the National Association of Insurance Commissioners (in this subsection referred to as the 'NAIC') changes the 1991 NAIC Model Regulation (described in subsection (p)) to revise the benefit package classified as 'J' under the standards established by subsection (p)(2) (including the benefit package classified as 'J' with a high deductible feature, as described in subsection (p)(11)) so that—

''(i) the coverage for outpatient prescription drugs available under such benefit package is replaced with coverage for outpatient prescription drugs that complements but does not duplicate the benefits for outpatient prescription drugs that

beneficiaries are otherwise entitled to under this title;

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

"(iii) such revised standards meet any additional requirements imposed by the Medicare Rx Drug Discount and Security Act of 2002;

subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy holders on and after January 1, 2004, as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the '2004 NAIC Model Regulation').

"(B) REGULATION BY THE SECRETARY.—If the NAIC does not make the changes in the 1991 NAIC Model Regulation within the 9-month period specified in subparagraph (A), the Secretary shall promulgate, not later than 9 months after the end of such period, a regulation and subsection (g)(2)(A) shall be applied in

each State, effective for policies issued to policy holders on and after January 1, 2004, as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation as changed by the Secretary under this subparagraph (such changed regulation referred to in this section as the '2004 Federal Regulation').

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

''(D) MODIFICATION OF STANDARDS IF MEDICARE BENEFITS CHANGE.—If benefits under part D of this title are changed and the Secretary determines, in consultation with the NAIC, that changes in the 2004 NAIC Model Regulation or 2004 Federal Regulation are needed to reflect such changes, the preceding provisions of this paragraph shall apply to the modification of standards previously established in the same manner as they applied to the original establishment of such standards.

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

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

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

''(i) any reference to the model regulation applicable under that subsection shall be deemed to be a reference to the applicable 2004 NAIC Model Regulation or 2004 Federal Regulation; and

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

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

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