I

108TH CONGRESS
1ST SESSION

H. R. 2578

To amend title XVIII of the Social Security Act to establish a voluntary Medicare outpatient prescription drug discount and security program.

IN THE HOUSE OF REPRESENTATIVES

JUNE 24, 2003

Mr. BURR (for himself, Mr. BARTON of Texas, Mr. BUYER, Mr. NORWOOD, Mr. SHADEGG, Mr. AKIN, Mr. BARTLETT of Maryland, Mr. BURGESS, Mrs. CUBIN, Mr. HOEKSTRA, Mr. KING of Iowa, Mr. KLINE, Mr. OTTER, Mr. PITTS, Mr. TOOMEY, Mr. WELDON of Florida, Mr. GARRETT of New Jersey, and Mr. JONES of North Carolina) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XVIII of the Social Security Act to establish a voluntary Medicare outpatient prescription drug discount and security program.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare for the 21st Century Act''.

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

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

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

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

"ESTABLISHMENT OF PROGRAM

"SEC. 1860D–1. (a) PROVISION OF BENEFIT.—The Secretary shall establish a Medicare Outpatient Prescription Drug Discount and Security Program under this part under which an eligible beneficiary who voluntarily enrolls under this part is provided—

''(1) access to negotiated prices through an eligible entity with a contract under this part that has been selected by the beneficiary;

''(2) catastrophic coverage under this part; and

''(3) a prescription drug account and a public contribution into such an account.

''(b) ELIGIBLE BENEFICIARY; ELIGIBLE ENTITY; PRESCRIPTION DRUG ACCOUNT.—For purposes of this part:

''(1) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual who is eligible for benefits under part A or enrolled under part B, regardless of whether or not the individual is enrolled with a plan under part C.

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

''(A) pharmaceutical benefit management companies and pharmacists;

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

''(C) insurers;

''(D) Medicare+Choice organizations;

''(E) other entities; or

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

''(3) PRESCRIPTION DRUG ACCOUNT.—The term 'prescription drug account' means, with respect to an eligible beneficiary, an account established for the benefit of that beneficiary under section 1860D–5.

''(c) IMPLEMENTATION OF PROGRAM.—The Secretary shall establish the program under this part in a manner so that—

''(1) eligible beneficiaries may first enroll with eligible entities and obtain prescription drug discounts not later than 90 days after the date of the enactment of this part; and

''(2) benefits with respect to contributions to a prescription drug account and catastrophic coverage shall begin with the month of September 2004, but there shall be no catastrophic coverage provided for any period before January 1, 2005.

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

''(e) FINANCING.—The costs of providing benefits under this part shall be payable from the Federal Supple-

mentary Medical Insurance Trust Fund established under section 1841.

''ENROLLMENT; SELECTION OF ELIGIBLE ENTITY

''SEC. 1860D–2. (a) ENROLLMENT UNDER PART D.—

''(1) ESTABLISHMENT OF PROCESS.—

''(A) IN GENERAL.—The Secretary shall establish a process through which an eligible beneficiary may make an election to enroll under this part.

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

''(C) LIMITATION ON ENROLLMENT.—

''(i) IN GENERAL.—Except as provided under this subparagraph and under such exceptional circumstances as the Secretary may provide, an eligible individual shall only have 1 opportunity to enroll under this part. The Secretary shall specify the form, manner, and timing of such election but shall permit the exercise of such election at the time the individual is eligible to so enroll.

"(ii) LATE ENROLLMENT.—The Secretary shall permit individuals to elect to enroll under this part at times other than as permitted under the previous provisions of this paragraph, except that in the case of such a late enrollment the amount of the premiums for catastrophic coverage otherwise established under section 1860D–4(b)(3) shall be increased by such percentage as the Secretary shall specify in order to deter adverse selection.

"(C) TERMINATION OF ENROLLMENT.—An enrollee under this part shall be disenrolled—

"(i) upon failure to pay the applicable enrollment fee under subsection (e) or the premium for catastrophic coverage under section 1860D–4(b);

"(ii) upon termination of coverage under part A or part B; or

"(iii) upon notice submitted to the Secretary in such form, manner, and time as the Secretary shall provide.

Terminations of enrollment under this subparagraph shall be effective as specified by the Secretary in regulations.

''(2) ENROLLMENT PERIODS.—

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

''(B) OPEN ENROLLMENT PERIOD 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 and shall end on November 30, 2003, during which any eligible beneficiary may enroll under this part.

''(C) SPECIAL ENROLLMENT PERIOD IN CASE OF TERMINATION OF COVERAGE UNDER A GROUP HEALTH PLAN.—The Secretary shall provide for a special enrollment period under this part in the same manner as is provided under section 1837(i) with respect to part B, except that for purposes of this subparagraph any reference to 'by reason of the individual's (or the individual's spouse's) current employment status' shall be treated as being deleted.

''(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.

''(b) SELECTION OF AN ELIGIBLE ENTITY FOR ACCESS TO NEGOTIATED PRICES.—

''(1) PROCESS.—

''(A) IN GENERAL.—The Secretary shall establish a process through which an eligible beneficiary who is enrolled under this part shall select any eligible entity, that has been awarded a contract under this part and serves the State in which the beneficiary resides, to provide ac-

cess to negotiated prices under section 1860D–4(a).

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

''(i) an individual may not select more than one eligible entity at any time; and

''(ii) an individual shall only be permitted (except for unusual circumstances) to change the selection of the entity once a year.

In carrying out clause (ii), the Secretary may consider a change in residential setting (such as placement in a nursing facility) to be an unusual circumstance.

''(C) DEFAULT SELECTION.—In establishing such process, the Secretary shall provide an equitable method for the selection of an eligible entity for individuals who enroll under this part and fail to make such a selection.

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

''(c) ENROLLMENT PERIOD FOR BENEFITS.—The processes developed under subsections (a) and (b) shall ensure that eligible beneficiaries are permitted to enroll under this part and to select an eligible entity prior to 90 days after the date of the enactment of this part, in order to ensure that prescription drug discount benefits are available under this part as of such date.

''(d) PROVIDING ENROLLMENT, SELECTION, AND COVERAGE INFORMATION TO BENEFICIARIES.—

''(1) 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, the selection of eligible entities, and the prescription drug coverage made available by eligible entities with a contract under this part.

''(2) SPECIAL RULE FOR FIRST ENROLLMENT UNDER THE PROGRAM.—To the extent practicable, the activities described in paragraph (1) shall ensure that eligible beneficiaries are provided with such in-

formation at least 60 days prior to the first enrollment period described in section 1860D–2(c).

''(e) ENROLLMENT FEE.—

''(1) AMOUNT.—

''(A) IN GENERAL.—Except as provided in paragraph (3), enrollment under the program under this part is conditioned upon payment of an annual enrollment fee of $30 for 2004 (including any portion of 2003 in which the program is implemented under this section), plus the premium for catastrophic coverage provided under section 1860D–4(b)(3).

''(B) ANNUAL PERCENTAGE INCREASE IN ENROLLMENT FEE.—

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

''(I) such dollar amount; multiplied by

''(II) the annual percentage increase in the consumer price index for all urban consumers (all items; U.S.

city average) for the year ending in September of the previous year.

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

''(2) COLLECTION OF ENROLLMENT FEE.—The annual enrollment fee 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, except that it shall be collected only 1 time per year.

''(3) PAYMENT OF ENROLLMENT FEE BY STATE FOR CERTAIN BENEFICIARIES.—

''(A) IN GENERAL.—The Secretary shall establish an arrangement under which a State may provide for payment of some or all of the enrollment fee for some or all qualifying low income enrollees in the State, as specified by the State under the arrangement. Insofar as such a payment arrangement is made with respect to an enrollee, the amount of the enrollment fee shall be paid directly by the State and shall not

be collected under paragraph (2). In carrying out this paragraph, the Secretary may apply procedures similar to that applied under state agreements under section 1843.

''(B) NO FEDERAL MATCHING AVAILABLE UNDER MEDICAID OR SCHIP.—Expenditures made by a State described in subparagraph (A) shall not be treated as State expenditures for purposes of Federal matching payments under titles XIX and XXI insofar as such expenditures are for an enrollment fee under this subsection.

''(4) DISTRIBUTION OF PORTION OF ENROLLMENT FEE.—Of the enrollment fee collected by the Secretary under this paragraph with respect to a beneficiary, ⅔ of that fee shall be made available to the eligible entity selected by the eligible beneficiary.

''(f) ISSUANCE OF CARD AND COORDINATION.—Each eligible entity shall—

''(1) issue, in a uniform standard format specified by the Secretary, to each enrolled beneficiary a card and an enrollment number that establishes proof of enrollment and that can be used in a coordinated manner—

''(A) to identify the eligible entity selected to provide access to negotiated prices under section 1860D–4(a);

''(B) to identify the beneficiary for purposes of the catastrophic coverage under section 1860D–4(b) and, including tracking expenditures that count against the catastrophic coverage threshold; and

''(C) to make deposits to and withdrawals from a prescription drug account under section 1860D–5; and

''(2) provide for electronic methods to coordinate with such prescription drug accounts.

''ENROLLEE PROTECTIONS

''SEC. 1860D–3. (a) GUARANTEED ISSUE AND NONDISCRIMINATION.—

''(1) GUARANTEED ISSUE.—

''(A) IN GENERAL.—An eligible beneficiary who is eligible to select an eligible entity under section 1860D–2(b) for prescription drug coverage under this part at a time during which selections are accepted under this part with respect to the coverage shall not be denied selection based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor and

may not be charged any selection or other fee as a condition of such acceptance.

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

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

''(3) COVERAGE OF ALL PORTIONS OF A STATE.—If an eligible entity with a contract under this part serves any part of a State it shall serve the entire State.

''(b) DISSEMINATION OF INFORMATION.—

''(1) GENERAL INFORMATION.—An eligible entity with a contract under this part shall disclose, in a clear, accurate, and standardized form to each eligible beneficiary who has selected the entity to provide access to negotiated prices under this part at the time of selection and at least annually there-

after, the information described in section 1852(c)(1) relating to such prescription drug coverage. Such information includes the following (in a manner designed to permit and promote competition among eligible entities and to be understood by eligible beneficiaries with mental impairments):

"(A) Summary information regarding negotiated prices (including discounts) for covered outpatient drugs.

"(B) Access to such prices through pharmacy networks.

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

"(D) Any use of tiered copayments.

The eligible entity also shall notify enrolled beneficiaries when there is a change in the formulary during the year.

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

"(3) RESPONSE TO BENEFICIARY QUESTIONS.—Each eligible entity offering prescription drug cov-

erage under this part shall have a mechanism (including a toll-free telephone number) for providing upon request specific information (such as negotiated prices, including discounts) to individuals who have selected the entity. The entity shall make available, through an Internet website and in writing upon request, information on specific changes in its formulary.

''(4) COORDINATION WITH CATASTROPHIC COVERAGE AND PRESCRIPTION DRUG ACCOUNT BENEFITS.—Each such eligible entity shall provide for coordination of such information as the Secretary may specify to carry out sections 1860D–4(b) and 1860D–5.

''(5) DISCLOSURE.—Each such eligible entity shall disclose to the Secretary (in a manner specified by the Secretary) the extent to which discounts or rebates or other remuneration or price concessions made available to the entity by a manufacturer are passed through to enrollees through pharmacies and other dispensers or otherwise. The provisions of section 1927(b)(3)(D) shall apply to information disclosed to the Secretary under this paragraph in the same manner as such provisions apply to information disclosed under such section.

"(c) ACCESS TO COVERED BENEFITS.—

"(1) ENSURING PHARMACY ACCESS.—

"(A) PARTICIPATION OF ANY WILLING PHARMACY.—The eligible entity shall permit the participation of any pharmacy that meets terms and conditions that the entity has established.

"(B) DISCOUNTS ALLOWED FOR NETWORK PHARMACIES.—An eligible entity may, notwithstanding subparagraph (A), reduce coinsurance or copayments for its enrolled beneficiaries below the level otherwise provided for covered outpatient drugs dispensed through in-network pharmacies, but in no case shall such a reduction result in an increase in payments made by the Secretary under this part.

"(C) CONVENIENT ACCESS FOR NETWORK PHARMACIES.—The eligible entity 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, consistent with rules of the Secretary. The Secretary shall establish convenient access rules under this subparagraph that are no less favorable to enrollees

than the rules for convenient access to pharmacies of the Secretary of Defense established as of June 1, 2003, for purposes of the TRICARE Retail Pharmacy (TRRx) program. Such rules shall include adequate emergency access for enrolled beneficiaries.

''(D) LEVEL PLAYING FIELD.—An eligible entity shall permit enrollees to receive benefits (which may include a 90-day supply of drugs or biologicals) through a community pharmacy, rather than through mail order, with any differential in cost paid by such enrollees.

''(E) NOT REQUIRED TO ACCEPT INSURANCE RISK.—The terms and conditions under subparagraph (A) may not require participating pharmacies to accept insurance risk as a condition of participation.

''(2) ACCESS TO NEGOTIATED PRICES FOR PRESCRIPTION DRUGS.—For requirements relating to the access of an eligible beneficiary to negotiated prices (including applicable discounts), see section 1860D–4(a).

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

gible entity with a contract under this part uses a formulary, the following requirements must be met:

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

''(B) FORMULARY DEVELOPMENT.—In developing and reviewing the formulary, the committee shall—

''(i) 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; and

''(ii) shall take into account whether including in the formulary particular cov-

ered outpatient drugs has therapeutic advantages in terms of safety and efficacy.

"(C) 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). In establishing such classes, the committee shall take into account the standards published in the United States Pharmacopeia-Drug Information. The committee shall make available to the enrollees under the plan through the Internet or otherwise the clinical bases for the coverage of any drug on the formulary.

"(D) PROVIDER AND PATIENT EDUCATION.—The committee shall establish policies and procedures to educate and inform health care providers and enrollees concerning the formulary.

"(E) NOTICE BEFORE REMOVING DRUG FROM FORMULARY OR CHANGING PREFERRED OR TIER STATUS OF DRUG.—Any removal of a covered outpatient drug from a formulary and any change in the preferred or tier cost-sharing

status of such a drug shall take effect only after appropriate notice is made available to beneficiaries and physicians.

''(F) PERIODIC EVALUATION OF PROTOCOLS.—In connection with the formulary, an eligible entity shall provide for the periodic evaluation and analysis of treatment protocols and procedures.

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

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

''(1) IN GENERAL.—For purposes of providing access to negotiated benefits under section 1860D–4(a) and the catastrophic benefit described in section 1860D–4(b), the eligible entity shall have in place—

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

''(B) quality assurance measures and systems to reduce medical errors and adverse drug

interactions, including a medication therapy management program described in paragraph (2); and

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

''(2) MEDICATION THERAPY MANAGEMENT PROGRAM.—

''(A) IN GENERAL.—A medication therapy management program described in this paragraph is a program of drug therapy management and medication administration that may be furnished by a pharmacy provider and that is designed to assure, with respect to beneficiaries at risk for potential medication problems, such as beneficiaries with complex or chronic diseases (such as diabetes, asthma, hypertension, and congestive heart failure) or multiple prescriptions, that covered outpatient drugs under the plans under this part are appropriately used to optimize therapeutic outcomes through improved medication use and reduce the risk of adverse events, including adverse drug interactions. Such programs may distinguish between services in ambulatory and institutional settings.

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

''(i) enhanced beneficiary understanding to promote the appropriate use of medications by beneficiaries and to reduce the risk of potential adverse events associated with medications, through beneficiary education, counseling, case management, disease state management programs, and other appropriate means;

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

''(iii) detection of patterns of overuse and underuse of prescription drugs.

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

''(D) CONSIDERATIONS IN PHARMACY FEES.—Each eligible entity 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. Each such entity shall disclose to the Secretary upon request the amount of any such management or dispensing fees.

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

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

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

''(4) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—Each eligible entity 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 available generic drug covered under the plan that is therapeutically equivalent and bioequivalent.

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

''(1) IN GENERAL.—Each eligible entity shall provide meaningful procedures for hearing and resolving grievances between the entity (including any entity or individual through which the entity provides covered benefits) and enrollees in accordance with section 1852(f).

''(2) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—An eligible entity shall meet the requirements of paragraphs (1) through (3) of section 1852(g) with respect to covered benefits under the plan it offers under this part in the same manner as such requirements apply to an organization with respect to benefits it offers under a plan under part C.

''(3) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a 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 non-preferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual or both.

''(f) APPEALS.—

''(1) IN GENERAL.—Subject to paragraph (2), an eligible entity shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to drugs (including a determination related to the application of tiered cost-sharing described in subsection (e)(3)) in the same manner as such requirements apply to an organization with respect to benefits it offers under a plan under part C.

''(2) FORMULARY DETERMINATIONS.—An individual who is enrolled in a plan offered by an eligible entity may appeal to obtain coverage for a covered outpatient drug that is not on a formulary of the entity offering the plan if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual or both.

''(g) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—An eligible entity shall meet the requirements of section 1852(h) with respect to enrollees under this section in the same manner as such requirements apply to a Medicare Advantage organization with respect to enrollees under part C. The eligible entity shall implement policies and procedures to safeguard the use and disclosure of enrollees' 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. The eligible entity shall be treated as a covered entity for purposes of the provisions of subpart E of part 164 of title 45, Code of Federal Regulations, adopted pursuant to the authority of the Secretary under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S. C. 1320d–2 note).

''(h) OVERSIGHT.—The Secretary shall provide appropriate oversight to ensure compliance of eligible entities with the requirements of this section, including verification of the discounts and services provided.

''BENEFITS UNDER THE PROGRAM

''SEC. 1860D–4. (a) SAVINGS TO ENROLLEES THROUGH NEGOTIATED PRICES.—

''(1) IN GENERAL.—Subject to paragraph (2), each eligible entity with a contract under this part shall provide each eligible beneficiary enrolled with the entity with access to negotiated prices (including applicable discounts). For purposes of this paragraph, 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. The prices negotiated by an eligible entity under this paragraph 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).

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

''(3) PROHIBITION ON APPLICATION ONLY TO MAIL ORDER.—The negotiated prices under this subsection shall apply to prescription drugs that are available other than solely through mail order.

''(4) PROHIBITION ON CHARGES FOR REQUIRED SERVICES.—An eligible entity (and any pharmacy

contracting with such entity for the provision of a discount under this part) may not charge a beneficiary any amount for any services required to be provided by the entity under this part.

"(b) CATASTROPHIC COVERAGE.—

"(1) THROUGH COMPETITION AMONG PRIVATE PLANS.—

"(A) IN GENERAL.—Each enrollee under this part shall be entitled to catastrophic coverage through a contract with a qualified private entity under this subsection.

"(B) CONTRACT REQUIREMENTS TO PROMOTE COMPETITION.—The Secretary shall enter into contracts with qualified private entities to offer the catastrophic coverage under this subsection. To the maximum extent practicable, the Secretary shall enter into such contracts in a manner so that enrollees in all areas have a choice among at least 3 such entities to obtain the catastrophic coverage. Such an entity may be an eligible entity with a contract under subsection (a). Each such entity shall meet such financial solvency and other requirements as the Secretary determines to be necessary to carry out the program under this subsection.

Such a contract shall provide for the prospective assumption of the maximum amount of risk under the contract as the Secretary may negotiate. In providing catastrophic coverage under this subsection, the qualified private entities (and not the Secretary) shall establish the payment rates for drugs so covered.

''(C) CONTINGENCY.—If the Secretary is otherwise unable to enter into a contract with any qualified private entity under this paragraph for the offering of catastrophic coverage for enrollees in an area, the Secretary shall otherwise provide directly for the offering of the catastrophic coverage under this subsection to such enrollees. In such contingency, the payment rates for drugs so covered shall be the rates established by entities offering price discounts under this part.

''(2) SCOPE OF COVERAGE.—

''(A) SCOPE.—

''(i) IN GENERAL.—Subject to paragraph (4), the catastrophic coverage under this section shall consist of payment under this part for incurred expenses for covered outpatient drugs for an enrollee, less the

applicable copayment amount under paragraph (4), after the enrollee has incurred in a year expenses that equal the catastrophic coverage threshold specified in subparagraph (C) or (D) for the enrollee and year involved.

''(ii) PAYMENT RATE.—The rate of payment negotiated (or agreed to) by the eligible entity with the manufacturer for a covered outpatient drug shall be the amount paid under this part on behalf of the individual for the drug except as may otherwise be provided under the contract under paragraph (1).

''(B) COUNTING ALL INCURRED EXPENSES.—

''(i) IN GENERAL.—In applying subparagraph (A), expenses shall be treated as incurred if they are paid directly from the prescription drug account of the individual or, subject to clause (ii), if they are paid by the individual or by any other person, including a family member, on behalf of the individual or otherwise, whether or not such expenses may otherwise be reim-

bursed through insurance or otherwise, a group health plan, or other third-party payment arrangement, but shall not include expenses insofar as payment is made for such expenses under part A or part B of this title.

''(ii) REQUIREMENT FOR ACCOUNT NUMBER ON ALL COUNTABLE TRANSACTIONS.—Expenses that are not paid directly from a prescription drug account shall be counted under clause (i) only if, under such process as the Secretary shall recognize, the account number of the individual's prescription drug account is part of the transaction involved.

''(C) CATASTROPHIC COVERAGE THRESHOLDS.—

''(i) INITIAL CATASTROPHIC COVERAGE THRESHOLD.—Subject to clause (ii), the catastrophic coverage threshold is $10,000.

''(ii) INFLATION ADJUSTMENT.—The provisions of subsection (c)(2)(B) shall apply with respect to the catastrophic coverage threshold under clause (i) for a year

after 2004 in the same manner as it applied to the annual Federal contribution amount for that year, except that, for purposes of this subparagraph, any reference in subsection (c)(2)(B)(ii) to '$1' is deemed a reference to '$100'.

''(3) PREMIUMS.—

''(A) IN GENERAL.—The premium for catastrophic coverage under this subsection through a qualified private entity shall be the rate negotiated by the Secretary with the entity reduced by the premium subsidy under this paragraph. Such rate shall be consistent with rules similar to the rules applied under section 1860D–3(a) for eligible entities offering prescription drug coverage (including guaranteed issue, community-rated premiums, and nondiscrimination). In the case described in paragraph (1)(C), such premium shall be based on an actuarial basis specified by the Secretary.

''(B) SUBSIDIZED PREMIUMS.—

''(i) FULL PREMIUM SUBSIDY FOR QUALIFYING LOW INCOME ENROLLEES.—In the case of an enrollee who is a qualifying low income enrollee (as defined in

section 1860D–6(5)) for a month, there shall be a premium subsidy equal to the average of the premiums under subparagraph (A) for catastrophic coverage under this subsection in the area in which the enrollee resides.

''(ii) SLIDING SCALE PREMIUM SUBSIDIES FOR OTHER ENROLLEES.—In the case of an enrollee who is not a qualifying low income enrollee (as so defined) but would be a qualifying low income enrollee (as defined in section 1860D–6(5)) for a month if 250 percent were substituted for 175 percent in such section, there shall be a premium subsidy equal to a percentage of the average referred to in clause (i), with such percentage determined on a sliding scale from—

''(I) 75 percent for enrollees with income equal to 175 percent of the poverty line; to

''(II) 0 percent for enrollees with income equal to 250 percent of such poverty line.

''(C) COLLECTION.—Premiums under this paragraph shall be collected in the manner specified in section 1860D–2(e)(2) but shall be paid over, in a manner specified by the Secretary, to the entity that offers the catastrophic coverage. Premium subsidies under subparagraph (B) shall also be paid over in such a manner to such an entity.

''(4) APPLICABLE COPAYMENT AMOUNTS.—

''(A) IN GENERAL.—For purposes of this subsection, subject to subparagraphs (D) and (E), the term 'applicable copayment amount', with respect to an enrollee that has selected an eligible entity under this part and for a covered outpatient drug that is—

''(i) a multiple source or generic drug (as described in section 1927(k)(7)(A)(i)), means $3;

''(ii) a single source or brand-name drug (as described in section 1927(k)(7)(A)(iv))) that is included in formulary of that eligible entity, means $5; or

''(iii) any other drug, means $10.

In the case of a private contract entered into under paragraph (1), the Secretary may provide

for the substitution of the qualifying private entity offering such contract for the eligible entity under this subparagraph.

''(B) COLLECTION.—Nothing in this paragraph shall be construed as preventing a pharmacy from requiring, as a condition of supplying covered outpatient drugs to any enrollee, that payment is made of the applicable copayment amount under subparagraph (A).

''(C) NO FEDERAL MATCHING AVAILABLE UNDER MEDICAID OR SCHIP TO COVER COPAYMENT AMOUNTS.—No expenditure of a State that reimburses for, or otherwise covers, any copayment amounts established under this paragraph may be treated as State expenditures for purposes of Federal matching payments under titles XIX and XXI.

''(D) ALTERNATIVE TIERS PERMITTED FOR CATASTROPHIC COVERAGE.—With respect to catastrophic coverage, an eligible entity may provide for tiered copayments that are different from the copayments specified in subparagraph (A) so long as copayment amounts resulting from such application approximate the copayment amounts that would re-

sult from the application of the copayments under such subparagraph.

''(E) APPLICATION OF FORMULARY AT CATASTROPHIC COVERAGE LIMIT.—Once an eligible beneficiary reaches the catastrophic coverage limit on prescription drug expenses, such beneficiary is subject to the formulary of the eligible entity and rules regarding catastrophic coverage.

''(5) ADMINISTRATION.—Insofar as the Secretary does not provide for the catastrophic coverage under this subsection through a contract with a qualifying private entity, the Secretary is authorized to enter into such agreements with entities as may be required to provide for the benefits under this subsection. Such entities may be eligible entities, carriers under part B, fiscal intermediaries under part A, or other qualified entities.

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

''(c) CONTRIBUTION INTO PRESCRIPTION DRUG ACCOUNT.—

''(1) IN GENERAL.—In the case of an individual enrolled under this part—

"(A) the Secretary shall establish a prescription drug account for the individual under section 1860D–5; and

"(B) shall deposit into such account on a monthly or other periodic basis an amount that, on an annual basis, is equivalent to the annual Federal contribution amount specified in paragraph (2) for the enrollee involved.

Amounts so deposited shall not be treated as income to the accountholder for purposes of the Internal Revenue Code of 1986.

"(2) ANNUAL FEDERAL CONTRIBUTION AMOUNT.—

"(A) INITIAL AMOUNT.—Subject to subparagraph (B) and subsection (d), in the case of an accountholder whose modified adjusted gross income is—

"(i) not more than 100 percent of the poverty line, the annual Federal contribution amount is $2,500;

"(ii) more than 100 percent, but less than 125 percent, of the poverty line, the annual Federal contribution amount is $1,500;

"(iii) more than 125 percent, but less than 175 percent, of the poverty line, the annual Federal contribution amount is $1,100;

"(iv) at least 175 percent, but less than 250 percent, of the poverty line, the annual Federal contribution amount is $600;

"(v) at least 250 percent, but less than 350 percent, of the poverty line the annual Federal contribution amount is $300.

"(vi) at least 350 percent of the poverty line (or who has not authorized income verification under subsection (d)) the annual Federal contribution amount is $100.

"(B) INFLATION ADJUSTMENT.—

"(i) IN GENERAL.—For a year after 2004, the annual Federal contribution amount shall be the amount specified in subparagraph (A) increased by the percentage (if any) by which—

"(I) the average per capita aggregate expenditures for covered out-

patient 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 2004.

"(ii) ROUNDING.—If an annual Federal contribution amount determined under clause (i) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

"(C) AVAILABILITY OF ADDITIONAL AMOUNTS FOR VERY LOW INCOME INDIVIDUALS.—

"(i) IN GENERAL.—The Secretary shall make available an additional amount for accounts of individuals in subparagraph (A)(i) up to $7,500 in any year insofar as the accountholder incurs expenses in the year for which the balance in the account may be applied.

"(ii) CONDITION.—In the case of an individual described in clause (i) who is re-

siding in a State, upon the request of the State, the Secretary may condition the availability of an additional amount under such clause upon the individual's enrollment under this part with an eligible entity that is recognized or approved by that State.

''(iii) TREATMENT AS MEDICAL ASSISTANCE.—For provisions providing for State participation with respect to additional amounts made available under clause (i), see section 1935(c)(1)(A)(ii).

''(d) REQUIREMENT FOR INCOME VERIFICATION TO OBTAIN INCREASED CONTRIBUTION AMOUNT OR FOR REDUCED PREMIUM.—

''(1) IN GENERAL.—The provisions of subsections (b)(2)(C)(iii), (b)(3)(B), and clauses (i) through (iii) of subsection (c)(2)(A) shall apply to an individual only if the individual—

''(A) provides such information as the Secretary may require in order to determine the appropriate category of benefits or subsidies under the respective provisions; and

''(B) authorizes in a form and manner specified by the Secretary the verification of the

individual's modified adjusted gross income by the Secretary through arrangements with States.

An arrangement with a State under subparagraph (B) shall provide for the payment by the Secretary under this part of the State's reasonable costs of conducting income verifications under such arrangement.

''(2) PENALTIES FOR UNDERSTATEMENT OF INCOME.—The provision of false information under paragraph (1)(A) is subject to criminal penalties under section 1128B.

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

''(A) IN GENERAL.—The Secretary shall establish procedures for determining the modified adjusted gross income of enrollees. The Secretary shall consult with the Secretary of the Treasury in making such determinations. Income determinations under this subsection shall be valid for a period (of not less than 1 year) specified by the Secretary.

''(B) 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 the Secretary such return information as is necessary to make the determinations described in subparagraph (A). Return information disclosed under the preceding sentence may be used by the Secretary only for the purposes of, and to the extent necessary in, making such determinations.

''(e) APPROPRIATION TO COVER NET PROGRAM EXPENDITURES.—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 sum of the portion of the enrollment fees retained by the Secretary and premiums collected under subsection (b)(3).

''PRESCRIPTION DRUG ACCOUNTS

''SEC. 1860D–5. ''(a) ESTABLISHMENT OF ACCOUNTS.—

''(1) IN GENERAL.—The Secretary shall establish and maintain for each eligible beneficiary who is enrolled under this part at the time of enrollment a prescription drug account (in this section referred to as an 'account').

''(2) RESERVE ACCOUNTS.—In cases described in subsections (b)(3)(A), (b)(3)(B)(i), and (b)(3)(B)(ii)(I), the Secretary shall establish and maintain for each surviving spouse who is not enrolled under this part a reserve prescription drug account (in this section referred to as a 'reserve account').

''(3) ACCOUNTHOLDER DEFINED.—In this section, the term 'accountholder' means an individual for whom an account or reserve account has been established under this section.

''(4) EXPENDITURES FROM ACCOUNT.—Nothing in this section shall be construed as requiring the Federal Government to obligate funds for amounts in any account until such time as a withdrawal from such account is authorized under this section.

''(b) USE OF ACCOUNTS.—

''(1) IN GENERAL.—Except as provided in this subsection, amounts credited to an account shall only be used for the purchase of covered outpatient drugs for the accountholder. Any amounts remaining at the end of a year remain available for expenditures in succeeding years.

''(2) ACCOUNT RULES FOR PUBLIC AND PRIVATE CONTRIBUTIONS.—The Secretary shall establish an ongoing process for the determination of the amount in each account that is attributable to public and private contributions (including spousal rollover contributions) based on the following rules:

''(A) TREATMENT OF EXPENDITURES.—Expenditures from the account shall—

''(i) first be counted against any public contribution; and

''(ii) next be counted against private contributions.

''(B) TREATMENT OF SPOUSAL ROLLOVER CONTRIBUTIONS.—With respect to any spousal rollover contribution, the portions of such contribution that were attributable to public and private contributions at the time of its distribution under subsection (b)(3) shall be treated under this paragraph as if it were a direct public or private contribution, respectively, into the account of the spouse.

''(3) DEATH OF ACCOUNTHOLDER.—In the case of the death of an accountholder, the balance in any account (taking into account liabilities accrued be-

fore the time of death) shall be distributed as follows:

"(A) TREATMENT OF PUBLIC CONTRIBUTIONS.—If the accountholder is married at the time of death, the amount in the account that is attributable to public contributions shall be credited to the account (if any) of the surviving spouse of the accountholder (or, if the surviving spouse is not an eligible beneficiary, into a reserve account to be held for when that spouse becomes an eligible beneficiary).

"(B) TREATMENT OF PRIVATE CONTRIBUTIONS.—The amount in the account that is attributable to private contributions shall be distributed as follows:

"(i) DESIGNATION OF DISTRIBUTEE.—If the accountholder has made a designation, in a form and manner specified by the Secretary, for the distribution of some or all of such amount, such amount shall be distributed in accordance with the designation. Such designation may provide for the distribution into an account (including a reserve account) of a surviving spouse.

''(ii) ABSENCE OF DESIGNATION.—Insofar as the accountholder has not made such a designation—

''(I) SURVIVING SPOUSE.—If the accountholder was married at the time of death, the remainder shall be credited to an account (including a reserve account) of the accountholder's surviving spouse.

''(II) NO SURVIVING SPOUSE.—If the accountholder was not so married, the remainder shall be distributed to the estate of the accountholder and distributed as provided by law.

''(4) USE OF ACCOUNT FOR PREMIUMS.—

''(A) FOR ENROLLMENT IN A MEDICARE PLAN.—During any period in which an accountholder is enrolled in a plan under part C, the balance in the account may be used and applied only to reimburse the amount of the premium (if any) established for enrollment under the plan.

''(B) FOR CATASTROPHIC COVERAGE.—Amounts in an account of an accountholder may be used and applied to reimburse the

amount of the premium imposed for catastrophic coverage under section 1860D–4(b)(3).

''(5) APPLICATION TO MEDICAID EXPENSES IN CERTAIN CASES.—

''(A) IN GENERAL.—Except as provided in this paragraph, an account shall be treated as an asset for purposes of establishing eligibility for medical assistance under title XIX.

''(B) APPLICATION TOWARDS SPENDDOWN.—In the case of an accountholder who is applying for such medical assistance and who would, but for the application of subparagraph (A), be eligible for such assistance—

''(i) subparagraph (A) shall not apply; and

''(ii) the account shall be available (in accordance with a procedure established by the Secretary) to the State to reimburse the State for any expenditures made under the plan for such medical assistance.

''(6) TREATMENT OF WITHDRAWALS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the withdrawal of any amounts from an account in accordance with

this section shall not be subject to income or other tax.

''(B) DISTRIBUTION OF PRIVATE CONTRIBUTIONS AT TIME OF DEATH.—Amounts in the account of an accountholder at the time of death of the accountholder that are not transferred to an account (including a reserve account) of a surviving spouse shall be includable in the estate of the accountholder and may be subject to taxation as part of such estate.

''(c) AMOUNTS CREDITED IN ACCOUNT.—The Secretary shall credit to a prescription drug account of an eligible beneficiary the following amounts:

''(1) PUBLIC CONTRIBUTIONS.—The following contributions (each referred to in this section as a 'public contribution'):

''(A) FEDERAL CONTRIBUTIONS.—Federal contributions provided under subsection (d).

''(B) STATE CONTRIBUTIONS.—Contributions made by a State under subsection (f).

''(2) SPOUSAL ROLLOVER CONTRIBUTION.—A distribution from a deceased spouse under subsection (b)(3) (referred to in this section as a 'spousal rollover contribution').

''(3) PRIVATE CONTRIBUTIONS.—The following contributions (each referred to in this section as a 'private contribution'):

''(A) TAX-FAVORED EMPLOYER AND INDIVIDUAL CONTRIBUTIONS.—Contributions made under subsection (e).

''(B) OTHER INDIVIDUAL CONTRIBUTIONS.—Contributions made by accountholder other than under subsection (e).

''(C) CONTRIBUTIONS BY NONPROFIT ORGANIZATIONS.—Contributions made by a charitable, not-for-profit organization (that may be a religious organization).

Except as provided in this subsection, no amounts may be contributed to, or credited to, a prescription drug account.

''(d) FEDERAL CONTRIBUTION.—For Federal contributions in the case of accountholders, see section 1860D–4(c). Such contributions shall not be treated as income for purposes of chapter 1 of the Internal Revenue Code of 1986.

''(e) EMPLOYER AND INDIVIDUAL CONTRIBUTIONS.—

''(1) EMPLOYMENT-RELATED CONTRIBUTION.—

"(A) IN GENERAL.—In the case of any accountholder who is a beneficiary or participant in a group health plan (including a multiemployer plan), whether as an employee, former employee or otherwise, including as a dependent of an employee or former employee, the plan may make a contribution into the accountholder's account (but not into a reserve account of the accountholder). Amounts so contributed shall be treated under the Internal Revenue Code of 1986 as employer-provided coverage under an accident or health plan (described in section 106 of such Code).

"(B) LIMITATION.—The total amount that may be contributed under subparagraph (A) under a plan to an account during any year may not exceed $5,000.

"(C) CONDITION.—A group health plan may condition a contribution with respect to an accountholder under this paragraph on the accountholder's enrollment under this part with an eligible entity that is recognized or approved by that plan.

"(2) OTHER INDIVIDUALS.—

"(A) IN GENERAL.—Any individual may also contribute to the account of that individual or the account of any other individual under this subsection. Notwithstanding any other provision of law, subject to subparagraph (B), the amount of income of an individual in a taxable year for purposes of subchapter A of chapter 1 of the Internal Revenue Code of 1986 shall be treated as being reduced by the amount contributed in the taxable year under the previous sentence by that individual.

"(B) LIMITATION.—The total amount that may be contributed to an account under subparagraph (A) and treated as a reduction in income under the second sentence of such subparagraph during any year may not exceed $5,000, regardless of who makes such contribution. Nothing in the previous sentence shall be treated as limiting the amount of non-tax-favored contributions that may be made to such an account.

"(3) NO CONTRIBUTION PERMITTED TO RESERVE ACCOUNT.—No contribution may be made under this subsection to a reserve account.

''(4) FORM AND MANNER OF CONTRIBUTION.—The Secretary shall specify the form and manner of contributions under this subsection.

''(5) INDEXING OF DOLLAR AMOUNTS.—The provisions of section 1860D–4(c)(2)(B) shall apply with respect to the limitation amounts specified in paragraphs (1)(B) and (2)(B) for a year after 2004 in the same manner as it applied to the annual Federal contribution amount for that year, except that, for purposes of this paragraph, any reference in clause (ii) of such section to '$1' is deemed a reference to '$100'.

''(f) STATE CONTRIBUTIONS.—

''(1) IN GENERAL.—A State may enter into arrangements with the Secretary for the crediting of amounts for accountholders.

''(2) FORM AND MANNER OF CONTRIBUTION.—The Secretary shall specify the form and manner of contributions under this subsection.

''(3) TAX AND MEDICAID TREATMENT.—Amounts credited under this subsection—

''(A) shall not be treated as income to the accountholder for purposes of the Internal Revenue Code of 1986; and

''(B) shall not be treated as medical assistance for purposes of title XIX or child health assistance for purposes of title XXI for individuals who are not qualifying low income enrollees.

''DEFINITIONS

''SEC. 1860D–6. In this part:

''(1) COVERED OUTPATIENT DRUG.—

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

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

''(ii) a biological product or insulin described in subparagraph (B) or (C) of such section.

''(B) EXCLUSIONS.—

''(i) IN GENERAL.—The term 'covered outpatient drug' does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than those restricted

under subparagraph (E) of such section (relating to smoking cessation agents).

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

''(2) INCOME.—

''(A) IN GENERAL.—The term 'income' means, with respect to benefits under this part in a year, the modified adjusted gross income of the individual for the taxable year ending in the previous year.

''(B) TREATMENT OF JOINT RETURNS.—In the case of a individual who files a joint return (as defined for purposes of the Internal Revenue Code of 1986), the income of the modified

adjusted gross income of both individuals shall be treated as the income of each individual.

"(C) TREATMENT OF SEPARATE RETURNS.—In the case of an individual who is married and who does not file a joint return and who is not living separate and apart from the individual's spouse during at least 6 months of the taxable year shall be treated for purposes of this title as having income that exceeds 350 percent of the poverty line.

"(3) DEFINITION OF MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

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

"(B) increased by—

"(i) the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax under such Code, and

"(ii) the amount of social security benefits not includible in gross income under section 86 of such Code.

''(4) 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.

''(5) QUALIFYING LOW INCOME; VERY LOW INCOME.—

''(A) The term 'qualifying low income' means, with respect to an enrollee or accountholder, that the income of the enrollee or accountholder is under 175 percent of the poverty line, but only if the enrollee or accountholder has authorized income verification under section 1860D–4(d).

''(B) The term 'very low income' means, with respect to an enrollee or accountholder, that the income of the enrollee or accountholder is under 100 percent of the poverty line, but only if the enrollee or accountholder has authorized income verification under section 1860D–4(d).''.

(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 F 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.

SEC. 3. 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. 4. MEDICAID AMENDMENTS.

(a) VERIFICATION OF ELIGIBILITY FOR IMPROVED PART D BENEFITS.—

(1) REQUIREMENT.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(A) by striking ''and'' at the end of paragraph (64);

(B) by striking the period at the end of paragraph (65) and inserting ''; and''; and

(C) by inserting after paragraph (65) the following new paragraph:

''(66) provide for verification of income under section 1860D–4(d)(1)(B).''.

(2) NEW SECTION.—Title XIX is further amended—

(A) by redesignating section 1935 as section 1936; and

(B) by inserting after section 1934 the following new section:

''SPECIAL PROVISIONS RELATING TO MEDICARE PART D BENEFITS

''SEC. 1935. (a) REQUIREMENT FOR VERIFICATION OF ELIGIBILITY DETERMINATIONS FOR IMPROVED PART

D BENEFITS.—As a condition of its State plan under this title under section 1902(a)(66) and receipt of any Federal financial assistance under section 1903(a), a State shall provide for verification of income statements in accordance with arrangements under section 1860D–4(d)(1).

''(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE COSTS.—

''(1) IN GENERAL.—The amounts expended by a State in carrying out subsection (a) are, subject to paragraph (2), expenditures reimbursable under the appropriate paragraph of section 1903(a); except that, notwithstanding any other provision of such section, the applicable Federal matching rates with respect to such expenditures under such section shall be increased as follows (but in no case shall the rate as so increased exceed 100 percent):

''(A) For expenditures attributable to costs incurred during 2004, the otherwise applicable Federal matching rate shall be increased by 10 percent of the percentage otherwise payable (but for this subsection) by the State.

''(B)(i) For expenditures attributable to costs incurred during 2005 and each subsequent year through 2011, the otherwise applicable Federal matching rate shall be increased by

the applicable percent (as defined in clause (ii)) of the percentage otherwise payable (but for this subsection) by the State.

"(ii) For purposes of clause (i), the 'applicable percent' for—

"(I) 2005 is 20 percent; or

"(II) a subsequent year is the applicable percent under this clause for the previous year increased by 10 percentage points.

"(C) For expenditures attributable to costs incurred after 2011, the otherwise applicable Federal matching rate shall be increased to 100 percent.

"(2) COORDINATION.—The State shall provide the Secretary with such information as may be necessary to properly allocate administrative expenditures described in paragraph (1) that may otherwise be made for eligibility determinations.".

(b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID RESPONSIBILITY FOR PRESCRIPTION DRUG BENEFITS FOR DUALLY ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—Section 1903(a)(1) (42 U.S.C. 1396b(a)(1)) is amended by inserting before the semicolon the following: ", reduced by the

amount computed under section 1935(c)(1) for the State and the quarter''.

(2) AMOUNT DESCRIBED.—Section 1935, as inserted by subsection (a)(2), is amended by adding at the end the following new subsection:

''(c) FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION DRUG COSTS FOR DUALLY-ELIGIBLE BENEFICIARIES.—

''(1) IN GENERAL.—For purposes of section 1903(a)(1), for a State that is one of the 50 States or the District of Columbia for a calendar quarter in a year (beginning with 2004) the amount computed under this subsection is equal to the product of the following:

''(A) IMPROVED MEDICARE BENEFITS.—The sum of—

''(i) the total amount of reductions in catastrophic coverage premiums in the quarter under part D of title XVIII that are the result of applying a zero premium under section 1860D–4(b)(3)(D) for individuals who are residents of the State and are entitled to benefits with respect to prescribed drugs under the State plan under this title (including such a plan operating

under a waiver under section 1115), multiplied by the phase-out proportion (as defined in paragraph (2)) for the quarter; and

"(ii) the total amount of additional payments made to prescription drug accounts in the quarter under such part D that are attributable to the application of section 1860D–4(c)(2)(C) to individuals residing in the State.

"(B) STATE MATCHING RATE.—A proportion computed by subtracting from 100 percent the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State and the quarter.

"(2) PHASE-OUT PROPORTION.—For purposes of paragraph (1)(A)(i), the 'phase-out proportion' for a calendar quarter in—

"(A) 2004 is 90 percent;

"(B) a subsequent year before 2012, is the phase-out proportion for calendar quarters in the previous year decreased by 10 percentage points; or

"(C) a year after 2011 is 0 percent.".

(c) MEDICAID PROVIDING WRAP-AROUND BENEFITS.—Section 1935, as so inserted and amended, is further amended by adding at the end the following new subsection:

''(d) ADDITIONAL PROVISIONS.—

''(1) MEDICAID AS SECONDARY PAYOR.—In the case of an individual who is eligible to be enrolled under part D of title XVIII and is eligible for medical assistance for prescribed drugs under this title—

''(A) Federal financial participation is not available—

''(i) for such medical assistance for very low income individuals (as defined in section 1860D–6(5)); or

''(ii) for other individuals to the extent payment may be made under such part for such assistance; and

''(B) subject to paragraph (2), Federal financial participation shall continue to be available for prescribed drugs for such other individuals described in subparagraph (A)(ii) to the extent payment may not be made under such part (including under a prescription drug account under such part).

''(2) LIMITATION.—Federal financial participation shall not be available under paragraph (1)(B) for the following medical assistance:

''(A) For any applicable copayment amount under section 1860D–4(b)(4).

''(B) For the amount of any enrollment fee under section 1860D–2(e).

''(C) For any assistance for any individual who is not a qualifying low income individual (as defined in section 1860D–6(5)).''.

(d) TREATMENT OF TERRITORIES.—

(1) IN GENERAL.—Section 1935, as so inserted and amended, is further amended—

(A) in subsection (a) in the matter preceding paragraph (1), by inserting ''subject to subsection (e)'' after ''section 1903(a)'';

(B) in subsection (c)(1), by inserting ''subject to subsection (e)'' after ''1903(a)(1)''; and

(C) by adding at the end the following new subsection:

''(e) TREATMENT OF TERRITORIES.—

''(1) IN GENERAL.—In the case of a State, other than the 50 States and the District of Columbia—

''(A) the previous provisions of this section shall not apply to residents of such State; and

''(B) if the State establishes a plan described in paragraph (2) (for providing medical assistance with respect to the provision of prescription drugs to medicare beneficiaries), the amount otherwise determined under section 1108(f) (as increased under section 1108(g)) for the State shall be increased by the amount specified in paragraph (3).

''(2) PLAN.—The plan described in this paragraph is a plan that—

''(A) provides medical assistance with respect to the provision of covered outpatient drugs to low-income medicare beneficiaries; and

''(B) assures that additional amounts received by the State that are attributable to the operation of this subsection are used only for such assistance.

''(3) INCREASED AMOUNT.—

''(A) IN GENERAL.—The amount specified in this paragraph for a State for a year is equal to the product of—

''(i) the aggregate amount specified in subparagraph (B); and

''(ii) the amount specified in section 1108(g)(1) for that State, divided by the sum of the amounts specified in such section for all such States.

''(B) AGGREGATE AMOUNT.—The aggregate amount specified in this subparagraph for—

''(i) 2004, is equal to $20,000,000; or

''(ii) a subsequent year, is equal to the amount specified in clause (i) increased by applicable percentage increase specified in section 1860D–2(e)(1)(B) for the year involved.

''(4) REPORT.—The Secretary shall submit to Congress a report on the application of this subsection and may include in the report such recommendations as the Secretary deems appropriate.''.

(2) CONFORMING AMENDMENT.—Section 1108(g)(2) (42 U.S.C. 1308(g)(2)) is amended by inserting ''but subject to section 1935(e)(1)(B)'' after ''Notwithstanding subsection (f)''.

(e) AMENDMENT TO BEST PRICE.—Section 1927(c)(1)(C)(i) (42 U.S.C. 1396r–8(c)(1)(C)(i)) is amended—

(1) by striking ''and'' at the end of subclause (III);

(2) by striking the period at the end of subclause (IV) and inserting ''; and''; and

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

''(V) any prices charged which are negotiated under an eligible entity under part D of title XVIII on behalf of individuals enrolled under such part.''.

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