United States allies to accomplish the United States and North Atlantic Treaty Organization objectives in the Federal Republic of Yugoslavia, Serbia and Montenegro''. I thought the broad wording of that resolution constituted a blank check which was unwise. Instead, the President should seek specific congressional authority after specifying the objectives and the means for accomplishing those objectives.

There is an understandable reluctance on the part of Members of the House and Senate to challenge a President, especially a popular President, on his actions as Commander-in-Chief to protect U.S. national interests. The constitutional issues on separation of powers and the respective authority of the Congress vis-a-vis the President are obviously important. Of even greater importance, however, is the value of a united front with the President backed by congressional authorization and American public opinion on an issue where most, if not virtually all, of the international community is in opposition.

If the Congress sits back and does nothing and the President is right, then there is public approval. If the President turns out to be wrong, then it is his responsibility without blame being attached to the Congress. There is an added element that the President may, and probably does, know more than the Congress. Hearings, in closed session, could address that discrepancy in knowledge.

The current issue of Iraq is another chapter, albeit a very important chapter, in the ongoing effort to define congressional and Presidential authority on the critical constitutional doctrine of separation of powers. In the present case, there is ample time for Congress to deliberate and decide. With the stakes so high, Congress should assert its constitutional authority to make this critical decision.

AMENDMENTS SUBMITTED & PROPOSED

SA 4307. Mr. NELSON of Florida submitted an amendment intended to be proposed by him to the bill S. 812, to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table.

SA 4308. Mr. TORRICELLI (for himself, Mr. LEAHY, and Mr. JEFFORDS) submitted an amendment intended to be proposed by him to the bill S. 812, supra; which was ordered to lie on the table.

SA 4309. Mr. GRAHAM (for himself, Mr. MILLER, Mr. KENNEDY, and Mr. CORZINE) proposed an amendment to the bill S. 812, supra.

SA 4310. Mr. HATCH (for Mr. GRASSLEY (for himself, Ms. SNOWE, Mr. JEFFORDS, Mr. BREAUX, Mr. HATCH, Ms. COLLINS, Ms. LANDRIEU, Mr. HUTCHINSON, and Mr. DOMENICI)) proposed an amendment to the bill S. 812, supra.

SA 4311. Mr. REID (for Mr. WYDEN (for himself and Mr. ALLEN)) proposed an amendment to the bill S. 2037, to mobilize technology and science experts to respond quickly to the threats posed by terrorist attacks and other emergencies, by providing for the establishment of a national emergency technology guard, a technology reliability advisory board, and a center for evaluating antiterrorism and disaster response technology within the National Institute of Standards and Technology.

TEXT OF AMENDMENTS

SA 4304. Mr. SMITH of New Hampshire (for himself, Mr. ALLARD, Mr. GRASSLEY, Mr. HATCH, Mr. BURNS, Mr. CRAIG, Mr. CRAPO, and Mr. SANTORUM) submitted an amendment intended to be proposed by him to the bill S. 812, to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. MEDICARE PAYMENT FOR OUTPATIENT PRESCRIPTION DRUGS UNDER THE RX OPTION.

(a) IN GENERAL.—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 E—VOLUNTARY MEDICARE PRESCRIPTION DRUG COVERAGE

''MEDICARE PRESCRIPTION DRUG PLAN

''SEC. 1860AA. (a) IN GENERAL.—Each Medicare Prescription Drug Plan eligible individual may elect coverage (beginning on January 1, 2003) under this part in lieu of any other prescription drug coverage program under this title by enrolling in the Rx Option in order to receive coverage for outpatient prescription drugs as described in section 1860BB and to pay a combined deductible under section 1860CC.

''(b) MEDICARE PRESCRIPTION DRUG PLAN ELIGIBLE INDIVIDUAL DEFINED.—In this part, the term 'Medicare Prescription Drug Plan eligible individual' means an individual who is—

''(1) eligible for benefits under part A and enrolled under part B;

''(2) not enrolled in a Medicare+Choice plan under part C; and

''(3) not eligible for medical assistance for outpatient prescription drugs under title XIX.

''RX OPTION

''SEC. 1860BB. (a) ENROLLMENT IN THE RX OPTION.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall establish a process for the enrollment of Medicare Prescription Drug Plan eligible individuals under the Rx Option that is based upon the process for enrollment in Medicare+Choice plans under part C of this title.

''(2) EXCEPTIONS.—

''(A) 2-YEAR OBLIGATION.—Except as provided in subparagraph (B), a Medicare Prescription Drug Plan eligible individual who elects the Rx Option shall be subject to the provisions of this part for a minimum period of 2 years, beginning with the first full month during which the individual is eligible for benefits under the Rx Option.

''(B) FREE LOOK PERIOD.—An individual who elects the Rx Option may disenroll from such Option no later than the last day of the first full month following the month in which such election was made.

''(3) ENROLLMENT IN MEDICARE SUPPLEMENTAL POLICIES.—An individual enrolled in the Rx Option may be enrolled only in a medicare supplemental policy subject to the special rules described in section 1882(v).

''(b) OUTPATIENT PRESCRIPTION DRUG BENEFITS.—

''(1) IN GENERAL.—Beginning in 2002, under the Rx Option, after the enrollee has met the combined deductible under section 1860C, the Secretary shall provide a benefit for outpatient prescription drugs through private entities under section 1860D equal to 50 percent of the lesser of—

''(A) the cost of outpatient prescription drugs for such year; or

''(B) $5000.

''(2) COST-OF-LIVING ADJUSTMENT.—In the case of any calendar year beginning after 2002, the dollar amount in paragraph (1)(B) shall be increased by an amount equal to—

''(A) such dollar amount; multiplied by

''(B) the percentage (if any) by which—

''(i) the prescription drug component of the Consumer Price Index for all urban consumers (all items city average) for the 12-month period ending with August of the preceding year; exceeds

''(ii) such prescription drug component of the Consumer Price Index for the 12-month period ending with August 2001.

''(3) ROUNDING.—If any increase determined under paragraph (2) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

''COMBINED DEDUCTIBLE

''SEC. 1860CC. (a) IN GENERAL.—Notwithstanding any provision of this title and beginning in 2002, a beneficiary electing the Rx Option shall be subject to a combined deductible that shall apply in lieu of the deductibles applied under sections 1813(a)(1) and 1833(b).

''(b) AMOUNT.—

''(1) IN GENERAL.—For purposes of subsection (a), the combined deductible is equal to $675.

''(2) COST-OF-LIVING ADJUSTMENT.—In the case of any calendar year after 2002, the dollar amount in paragraph (1) shall be increased by an amount equal to—

''(A) such dollar amount; multiplied by

''(B) the percentage (if any) by which—

''(i) the medical component of the Consumer Price Index for all urban consumers (all items city average) for the 12-month period ending with August of the preceding year; exceeds

''(ii) such medical component of the Consumer Price Index for the 12-month period ending with August 2001.

''(3) ROUNDING.—If any increase determined under paragraph (2) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

''(c) APPLICATION.—In applying the combined deductible described in subsection (a) such deductible shall apply to each expense incurred on a calendar year basis for each item or service covered under this title, and each expense paid on a calendar year basis for such an item or service shall be credited against such deductible.

''PARTNERSHIPS WITH PRIVATE ENTITIES TO OFFER THE RX OPTION

''SEC. 1860DD. (a) PARTNERSHIPS.—

''(1) IN GENERAL.—The Secretary shall contract with private entities for the provision of outpatient prescription drug benefits under the Rx Option.

''(2) PRIVATE ENTITIES.—The private entities described in paragraph (1) shall include insurers (including issuers of medicare supplemental policies under section 1882), pharmaceutical benefit managers, chain pharmacies, groups of independent pharmacies, and other private entities that the Secretary determines are appropriate.

''(3) AREAS.—The Secretary may award a contract to a private entity under this section on a local, regional, or national basis.

''(4) DRUG BENEFITS ONLY THROUGH PRIVATE ENTITIES.—Outpatient prescription drug benefits under the Rx Option shall be offered only through a contract with a private entity under this section.

''(b) SECRETARY REQUIRED TO CONTRACT WITH ANY WILLING QUALIFIED PRIVATE ENTITY.—The Secretary may not exclude a private entity from receiving a contract to provide outpatient prescription drug benefits under the Rx Option if the private entity meets all of the requirements established by the Secretary for providing such benefits.

''ELIGIBILITY FOR CATASTROPHIC COVERAGE

''SEC. 1860EE. Noting in this part shall be construed to prohibit an individual who elects coverage under the Rx Option from obtaining catastrophic coverage under any other program under this title.''.

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

''(v) SPECIAL RULES FOR MEDICARE PRESCRIPTION DRUG PLAN ENROLLEES.—

''(1) REVISION OF BENEFIT PACKAGES.—

''(A) IN GENERAL.—Notwithstanding subsection (p), the benefit packages established under such subsection (including the 2 plans described in paragraph (11)(A) of such subsection) shall be revised (in the manner described in subsection (p)(1)(E)) so that each of the benefit packages classified as 'A' through 'J' remain exactly the same, except that each benefit package shall include special rules that apply only to individuals enrolled in the Rx Option under section 1860B as follows:

''(i) COMBINED DEDUCTIBLE.—Each benefit package shall require the beneficiary of the policy to pay annual out-of-pocket expenses (other than premiums) in an amount equal to the amount of the combined deductible under section 1860C(b) before the policy begins payment of any benefits.

''(ii) PRESCRIPTION DRUG COVERAGE.—In the case of a benefit package classified as 'H', 'I', and 'J', such policy may not provide coverage for outpatient prescription drugs that duplicates the coverage for outpatient prescription drugs provided under the Rx Option under section 1860B(b).

''(B) ADJUSTED PREMIUM.—In the case of an individual enrolled in the Rx Option, the premium for the policy in which the individual is enrolled may be appropriately adjusted to reflect the special rules applicable to such individual under subparagraph (A).

''(2) RENEWABILITY AND CONTINUITY OF COVERAGE.—The revisions of benefit packages under paragraph (1) shall not affect—

''(A) the renewal of medicare supplemental policies under this section that are in existence on the effective date of such revisions; or

''(B) the continuity of coverage under such policies.''.

SA 4307. Mr. NELSON of Florida submitted an amendment intended to be proposed by him to the bill S. 812, to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. LIMITATION ON PAYMENTS TO PROVIDERS UNDER A FEDERAL HEALTH CARE PROGRAM.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128F the following new section:

''SEC. 1128G. LIMITATION ON PAYMENTS TO PROVIDERS UNDER A FEDERAL HEALTH CARE PROGRAM.

''(a) IN GENERAL.—No Federal funds shall be used to provide payments under a Federal health care program to any physician (as defined in section 1861(r)), practitioner (as described in section 1842(b)(18)(C)), or other individual who charges a membership fee or any other extraneous or incidental fee to a patient, or requires a patient to purchase an item or service, as a prerequisite for the provision of an item or service to the patient.

''(b) FEDERAL HEALTH CARE PROGRAM DEFINED.—In this section, the term 'Federal health care program' has the meaning given that term under section 1128B(f) except that, for purposes of this section, such term includes the health insurance program under chapter 89 of title 5, United States Code.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to payments made on or after the date of enactment of this Act.

SA 4308. Mr. TORRICELLI (for himself, Mr. LEAHY, and Mr. JEFFORDS) submitted an amendment intended to be proposed by him to the bill S. 812. to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

TITLE ___—GIFT AND REBATE DISCLOSURE

SEC. ___01. SHORT TITLE.

This title may be cited as the ''Gift and Rebate Disclosure Act of 2002''.

SEC. ___02. DISCLOSURE BY PRESCRIPTION DRUG MANUFACTURERS, PACKERS, AND DISTRIBUTORS OF CERTAIN GIFTS.

Section 503 of the Federal Food, Drug, and Cosmetics Act (21 U.S.C. 353) is amended by adding at the end the following:

''(h)(1) Each manufacturer, packer, or distributor of a drug subject to subsection (b)(1) shall disclose to the Commissioner—

''(A) not later than June 30, 2004, and each June 30 thereafter, the value, nature, and purpose of any—

''(i) gift provided during the preceding calendar year to any covered health entity by the manufacturer, packer, or distributor, or a representative thereof, in connection with detailing, promotional, or other marketing activities; and

''(ii) cash rebate, discount, or any other financial consideration provided during the preceding calendar year to any pharmaceutical benefit manager by the manufacturer, packer, or distributor, or a representative thereof, in connection with detailing, promotional, or other marketing activities; and

''(B) not later than the date that is 6 months after the date of enactment of this subsection and each June 30 thereafter, the name and address of the individual responsible for the compliance of the manufacturer, packer, or distributor with the provisions of this subsection.

''(2) Subject to paragraph (3), the Commissioner shall make all information disclosed to the Commissioner under paragraph (1) publicly available, including by posting such information on the Internet.

''(3) The Commissioner shall keep confidential any information disclosed to or otherwise obtained by the Commissioner under this subsection that relates to a trade secret referred to in section 1905 of title 18, United States Code. The Commissioner shall provide an opportunity in the disclosure form required under paragraph (4) for a manufacturer, packer, or distributor to identify any such information.

''(4) Each disclosure under this subsection shall be made in such form and manner as the Commissioner may require.

''(5) Each manufacturer, packer, and distributor described in paragraph (1) shall be subject to a civil monetary penalty of not more than $10,000 for each violation of this subsection. Each unlawful failure to disclose shall constitute a separate violation. The provisions of paragraphs (3), (4), and (5) of section 303(g) shall apply to such a violation in the same manner as such provisions apply to a violation of a requirement of this Act that relates to devices.

''(6) For purposes of this subsection:

''(A) The term 'covered health entity' includes any physician, pharmaceutical benefit manager, hospital, nursing home, pharmacist, health benefit plan administrator, or any other entity authorized to prescribe or dispense drugs that are subject to subsection (b)(1), in the District of Columbia or any State, commonwealth, possession, or territory of the United States.

''(B) The term 'gift' includes any gift, fee, payment, subsidy, or other economic benefit with a value of $50 or more, except that such term excludes the following:

''(i) Free samples of drugs subject to subsection (b)(1) intended to be distributed to patients.

''(ii) The payment of reasonable compensation and reimbursement of expenses in connection with any clinical trial conducted in connection with a valid scientific study designed to answer specific questions about drugs, devices, new therapies, or new ways of using known treatments, or in connection with a clinical trial involving the compassionate use of an experimental drug or device as permitted under regulations promulgated by the Food and Drug Administration.

''(iii) Any scholarship or other support for medical students, residents, or fellows selected by a national, regional, or specialty medical or other professional association to attend a significant educational, scientific, or policy-making conference of the association.''.

SEC. ___03. DISALLOWANCE OF DEDUCTION FOR PHYSICIAN GIFT EXPENSES OF PRESCRIPTION DRUG MANUFACTURERS.

(a) GENERAL RULE.—Part IX of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items not deductible) is amended by adding at the end the following new section:

''SEC. 280I. PHYSICIAN GIFT EXPENSES OF PRESCRIPTION DRUG MANUFACTURERS.

''(a) GENERAL RULE.—No deduction shall be allowed under this chapter for any physician gift expense paid or incurred by any prescription drug manufacturer.

''(b) PHYSICIAN GIFT EXPENSE.—For purposes of this section, the term 'physician gift expense' means any gift provided directly or indirectly to or for the benefit of a physician, including gifts of meals, sponsored teachings, symposia, and travel, but not including product samples.

''(c) PRESCRIPTION DRUG MANUFACTURER.—For purposes of this section, the term 'prescription drug manufacturer' means—

''(1) any person engaged in the trade or business of manufacturing or producing any prescription drug, and

''(2) any person who is a member of an affiliated group which includes a person described in paragraph (1).

For purposes of the preceding sentence, the term 'affiliated group' means any affiliated group as defined in section 1504 (determined without regard to paragraphs (3) and (4) of 1504(b)).''

(b) CLERICAL AMENDMENT.—The table of sections for part IX of subchapter B of chapter 1 of such Code is amended by adding at the end thereof the following new item:

''Sec. 280I. Physician gift expenses of prescription drug manufacturers.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts paid or incurred after December 31, 2001.

SA 4309. Mr. GRAHAM (for himself, Mr. MILLER, Mr. KENNEDY and Mr. CORZINE) proposed an amendment to the bill S. 812. to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; as follows:

At the end, add the following:

TITLE II—MEDICARE OUTPATIENT PRESCRIPTION DRUG BENEFIT PROGRAM

SEC. 201. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This title may be cited as the ''Medicare Outpatient Prescription Drug Act of 2002''.

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

SEC. 202. MEDICARE OUTPATIENT PRESCRIPTION DRUG BENEFIT PROGRAM.

(a) ESTABLISHMENT.—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—OUTPATIENT PRESCRIPTION DRUG BENEFIT PROGRAM

''DEFINITIONS

''SEC. 1860. In this part:

''(1) COVERED OUTPATIENT DRUG.—

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

''(i) A drug which may be dispensed only upon prescription, and—

''(I) which is approved for safety and effectiveness as a prescription drug under section 505 of the Federal Food, Drug, and Cosmetic Act;

''(II)(aa) which was commercially used or sold in the United States before the date of enactment of the Drug Amendments of 1962 or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (bb) which has not been the subject of a final determination by the Secretary that it is a 'new drug' (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act) or an action brought by the Secretary under section 301, 302(a), or 304(a) of such Act to enforce section 502(f) or 505(a) of such Act; or

''(III)(aa) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (bb) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such drug under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling.

''(ii) A biological product which—

''(I) may only be dispensed upon prescription;

''(II) is licensed under section 351 of the Public Health Service Act; and

''(III) is produced at an establishment licensed under such section to produce such product.

''(iii) Insulin approved under appropriate Federal law, including needles and syringes for the administration of such insulin.

''(iv) A prescribed drug or biological product that would meet the requirements of clause (i) or (ii) except that it is available over-the-counter in addition to being available upon prescription.

''(B) EXCLUSION.—The term 'covered outpatient drug' does not include any product—

''(i) except as provided in subparagraph (A)(iv), which may be distributed to individuals without a prescription;

''(ii) for which payment is available under part A or B or would be available under part B but for the application of a deductible under such part (unless payment for such product is not available because benefits under part A or B have been exhausted), determined, except as provided in subparagraph (C), without regard to whether the beneficiary involved is entitled to benefits under part A or enrolled under part B; or

''(iii) except for agents used to promote smoking cessation and agents used for the treatment of obesity, for which coverage may be excluded or restricted under section 1927(d)(2).

''(C) CLARIFICATION REGARDING IMMUNOSUPPRESSIVE DRUGS.—In the case of a beneficiary who is not eligible for any coverage under part B of drugs described in section 1861(s)(2)(J) because of the requirements under such section (and would not be so eligible if the individual were enrolled under such part), the term 'covered outpatient drug' shall include such drugs if the drugs would otherwise be described in subparagraph (A).

''(2) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual that is entitled to benefits under part A or enrolled under part B.

''(3) ELIGIBLE ENTITY.—The term 'eligible entity' means any entity that the Secretary determines to be appropriate to provide eligible beneficiaries with covered outpatient drugs under a plan under this part, including—

''(A) a pharmacy benefit management company;

''(B) a retail pharmacy delivery system;

''(C) a health plan or insurer;

''(D) a State (through mechanisms established under a State plan under title XIX);

''(E) any other entity approved by the Secretary; or

''(F) any combination of the entities described in subparagraphs (A) through (E) if the Secretary determines that such combination—

''(i) increases the scope or efficiency of the provision of benefits under this part; and

''(ii) is not anticompetitive.

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

''(5) PRESCRIPTION DRUG ACCOUNT.—The term 'Prescription Drug Account' means the Prescription Drug Account (as established under section 1860K) in the Federal Supplementary Medical Insurance Trust Fund under section 1841.

''ESTABLISHMENT OF OUTPATIENT PRESCRIPTION DRUG BENEFIT PROGRAM

''SEC. 1860A. (a) PROVISION OF BENEFIT.—

''(1) IN GENERAL.—Beginning in 2005, the Secretary shall provide for and administer an outpatient prescription drug benefit program under which each eligible beneficiary enrolled under this part shall be provided with coverage of covered outpatient drugs as follows:

''(A) MEDICARE+CHOICE PLAN.—If the eligible beneficiary is eligible to enroll in a Medicare+Choice plan, the beneficiary—

''(i) may enroll in such a plan; and

''(ii) if so enrolled, shall obtain coverage of covered outpatient drugs through such plan.

''(B) MEDICARE PRESCRIPTION DRUG PLAN.—If the eligible beneficiary is not enrolled in a Medicare+Choice plan, the beneficiary shall obtain coverage of covered outpatient drugs through enrollment in a plan offered by an eligible entity with a contract under this part.

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

''(3) SCOPE OF BENEFITS.—The program established under this part shall provide for coverage of all therapeutic classes of covered outpatient drugs.

''(b) ACCESS TO ALTERNATIVE PRESCRIPTION DRUG COVERAGE.—In the case of an eligible beneficiary who has creditable prescription drug coverage (as defined in section 1860B(b)(1)(F)), such beneficiary—

''(1) may continue to receive such coverage and not enroll under this part; and

''(2) pursuant to section 1860B(b)(1)(C), is permitted to subsequently enroll under this part without any penalty and obtain coverage of covered outpatient drugs in the manner described in subsection (a) if the beneficiary involuntarily loses such coverage.

''(c) FINANCING.—The costs of providing benefits under this part shall be payable from the Prescription Drug Account.

''ENROLLMENT UNDER PROGRAM

''SEC. 1860B. (a) ESTABLISHMENT OF PROCESS.—

''(1) PROCESS SIMILAR TO ENROLLMENT UNDER PART B.—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. Such process shall be similar to the process for enrollment in part B under section 1837, including the deeming provisions of such section.

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

''(b) SPECIAL ENROLLMENT PROCEDURES.—

''(1) LATE ENROLLMENT PENALTY.—

''(A) INCREASE IN PREMIUM.—Subject to the succeeding provisions of this paragraph, in the case of an eligible beneficiary whose coverage period under this part began pursuant to an enrollment after the beneficiary's initial enrollment period under part B (determined pursuant to section 1837(d)) and not pursuant to the open enrollment period described in paragraph (2), the Secretary shall establish procedures for increasing the amount of the monthly part D premium under section 1860E(a) applicable to such beneficiary by an amount that the Secretary determines is actuarily sound for each full 12-month period (in the same continuous period of eligibility) in which the eligible beneficiary could have been enrolled under this part but was not so enrolled.

''(B) PERIODS TAKEN INTO ACCOUNT.—For purposes of calculating any 12-month period under subparagraph (A), there shall be taken into account—

''(i) the months which elapsed between the close of the eligible beneficiary's initial enrollment period and the close of the enrollment period in which the beneficiary enrolled; and

''(ii) in the case of an eligible beneficiary who reenrolls under this part, the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which the beneficiary reenrolled.

''(C) PERIODS NOT TAKEN INTO ACCOUNT.—

''(i) IN GENERAL.—For purposes of calculating any 12-month period under subparagraph (A), subject to clause (ii), there shall not be taken into account months for which the eligible beneficiary can demonstrate that the beneficiary had creditable prescription drug coverage (as defined in subparagraph (F)).

''(ii) APPLICATION.—This subparagraph shall only apply with respect to a coverage period the enrollment for which occurs before the end of the 60-day period that begins on the first day of the month which includes—

''(I) in the case of a beneficiary with coverage described in clause (ii) of subparagraph (F), the date on which the plan terminates, ceases to provide, or reduces the value of the prescription drug coverage under such plan to below the actuarial value of the coverage provided under the program under this part; or

''(II) in the case of a beneficiary with coverage described in clause (i), (iii), or (iv) of subparagraph (F), the date on which the beneficiary loses eligibility for such coverage.

''(D) PERIODS TREATED SEPARATELY.—Any increase in an eligible beneficiary's monthly part D premium under subparagraph (A) with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which the beneficiary may have.

''(E) CONTINUOUS PERIOD OF ELIGIBILITY.—

''(i) IN GENERAL.—Subject to clause (ii), for purposes of this paragraph, an eligible beneficiary's 'continuous period of eligibility' is the period that begins with the first day on which the beneficiary is eligible to enroll under section 1836 and ends with the beneficiary's death.

''(ii) SEPARATE PERIOD.—Any period during all of which an eligible beneficiary satisfied paragraph (1) of section 1836 and which terminated in or before the month preceding the month in which the beneficiary attained age 65 shall be a separate 'continuous period of eligibility' with respect to the beneficiary (and each such period which terminates shall be deemed not to have existed for purposes of subsequently applying this paragraph).

''(F) CREDITABLE PRESCRIPTION DRUG COVERAGE DEFINED.—For purposes of this part, the term 'creditable prescription drug coverage' means any of the following:

''(i) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care for the Elderly (PACE) under section 1934 and through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997), but only if the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Secretary) to the beneficiary equals or exceeds the actuarial value of the benefits provided to an individual enrolled in the outpatient prescription drug benefit program under this part.

''(ii) PRESCRIPTION DRUG COVERAGE UNDER A GROUP HEALTH PLAN.—Prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan (as defined in section 1860J(e)(3)), but only if the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Secretary) to the beneficiary equals or exceeds the actuarial value of the benefits provided to an individual enrolled in the outpatient prescription drug benefit program under this part.

''(iii) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program, but only if the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Secretary) to the beneficiary equals or exceeds the actuarial value of the benefits provided to an individual enrolled in the outpatient prescription drug benefit program under this part.

''(iv) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans, and survivors and dependents of veterans, under chapter 17 of title 38, United States Code, but only if the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Secretary) to the beneficiary equals or exceeds the actuarial value of the benefits provided to an individual enrolled in the outpatient prescription drug benefit program under this part.

''(2) OPEN ENROLLMENT PERIOD FOR CURRENT BENEFICIARIES IN WHICH LATE ENROLLMENT PROCEDURES DO NOT APPLY.—

''(A) IN GENERAL.—The Secretary shall establish an applicable 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 enroll under this part without the application of the late enrollment procedures established under paragraph (1)(A).

''(B) OPEN ENROLLMENT PERIOD TO BEGIN PRIOR TO JANUARY 1, 2005.—The Secretary shall ensure that eligible beneficiaries are permitted to enroll under this part prior to January 1, 2005, in order to ensure that coverage under this part is effective as of such date.

''(3) SPECIAL ENROLLMENT PERIOD FOR BENEFICIARIES WHO INVOLUNTARILY LOSE CREDITABLE PRESCRIPTION DRUG COVERAGE.—The Secretary shall establish a special open enrollment period for an eligible beneficiary that loses creditable prescription drug coverage.

''(c) PERIOD OF COVERAGE.—

''(1) IN GENERAL.—Except as provided in paragraph (2) and subject to paragraph (3), an eligible beneficiary's coverage under the program under this part shall be effective for the period provided in section 1838, as if that section applied to the program under this part.

''(2) OPEN AND SPECIAL ENROLLMENT.—Subject to paragraph (3), an eligible beneficiary who enrolls under the program under this part pursuant to paragraph (2) or (3) of subsection (b) shall be entitled to the benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

''(3) LIMITATION.—Coverage under this part shall not begin prior to January 1, 2005.

''(d) TERMINATION.—

''(1) IN GENERAL.—The causes of termination specified in section 1838 shall apply to this part in the same manner as such causes apply to part B.

''(2) COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PARTS A AND B.—

''(A) IN GENERAL.—In addition to the causes of termination specified in paragraph (1), the Secretary shall terminate an individual's coverage under this part if the individual is no longer enrolled in either part A or B.

''(B) EFFECTIVE DATE.—The termination described in subparagraph (A) shall be effective on the effective date of termination of coverage under part A or (if later) under part B.

''(3) PROCEDURES REGARDING TERMINATION OF A BENEFICIARY UNDER A PLAN.—The Secretary shall establish procedures for determining the status of an eligible beneficiary's enrollment under this part if the beneficiary's enrollment in a plan offered by an eligible entity under this part is terminated by the entity for cause (pursuant to procedures established by the Secretary under section 1860C(a)(1)).

''ENROLLMENT IN A PLAN

''SEC. 1860C. (a) PROCESS.—

''(1) ESTABLISHMENT.—

''(A) ELECTION.—

''(i) IN GENERAL.—The Secretary shall establish a process through which an eligible beneficiary who is enrolled under this part but not enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization—

''(I) shall make an annual election to enroll in any 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; and

''(II) may make an annual election to change the election under this clause.

''(ii) DEFAULT ENROLLMENT.—Such process shall include for the default enrollment in such a plan in the case of an eligible beneficiary who is enrolled under this part but who has failed to make an election of such a plan.

''(B) RULES.—In establishing the process under subparagraph (A), the Secretary shall—

''(i) use rules similar to the rules for enrollment, disenrollment, and termination of enrollment with a Medicare+Choice plan under section 1851, including—

''(I) the establishment of special election periods under subsection (e)(4) of such section; and

''(II) the application of the guaranteed issue and renewal provisions of subsection (g) of such section (other than paragraph (3)(C)(i), relating to default enrollment); and

''(ii) coordinate enrollments, disenrollments, and terminations of enrollment under part C with enrollments, disenrollments, and terminations of enrollment under this part.

''(2) FIRST ENROLLMENT PERIOD FOR PLAN ENROLLMENT.—The process developed under paragraph (1) shall—

''(A) ensure that eligible beneficiaries who choose to enroll under this part are permitted to enroll with an eligible entity prior to January 1, 2005, in order to ensure that coverage under this part is effective as of such date; and

''(B) be coordinated with the open enrollment period under section 1860B(b)(2)(A).

''(b) MEDICARE+CHOICE ENROLLEES.—

''(1) IN GENERAL.—An eligible beneficiary who is enrolled under this part and enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization shall receive coverage of covered outpatient drugs under this part through such plan.

''(2) RULES.—Enrollment in a Medicare+Choice plan is subject to the rules for enrollment in such a plan under section 1851.

''PROVIDING INFORMATION TO BENEFICIARIES

''SEC. 1860D. (a) ACTIVITIES.—

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

''(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 information at least 30 days prior to the open enrollment period described in section 1860B(b)(2)(A).

''(b) REQUIREMENTS.—

''(1) IN GENERAL.—The activities described in subsection (a) shall—

''(A) be similar to the activities performed by the Secretary under section 1851(d);

''(B) be coordinated with the activities performed by the Secretary under such section and under section 1804; and

''(C) provide for the dissemination of information comparing the plans offered by eligible entities under this part that are available to eligible beneficiaries residing in an area.

''(2) COMPARATIVE INFORMATION.—The comparative information described in paragraph (1)(C) shall include a comparison of the following:

''(A) BENEFITS.—The benefits provided under the plan, including the prices beneficiaries will be charged for covered outpatient drugs, any preferred pharmacy networks used by the eligible entity under the plan, and the formularies and appeals processes under the plan.

''(B) QUALITY AND PERFORMANCE.—To the extent available, the quality and performance of the eligible entity offering the plan.

''(C) BENEFICIARY COST-SHARING.—The cost-sharing required of eligible beneficiaries under the plan.

''(D) CONSUMER SATISFACTION SURVEYS.—To the extent available, the results of consumer satisfaction surveys regarding the plan and the eligible entity offering such plan.

''(E) ADDITIONAL INFORMATION.—Such additional information as the Secretary may prescribe.

''(3) INFORMATION STANDARDS.—The Secretary shall develop standards to ensure that the information provided to eligible beneficiaries under this part is complete, accurate, and uniform.

''(c) USE OF MEDICARE CONSUMER COALITIONS TO PROVIDE INFORMATION.—

''(1) IN GENERAL.—The Secretary may contract with Medicare Consumer Coalitions to conduct the informational activities under—

''(A) this section;

''(B) section 1851(d); and

''(C) section 1804.

''(2) SELECTION OF COALITIONS.—If the Secretary determines the use of Medicare Consumer Coalitions to be appropriate, the Secretary shall—

''(A) develop and disseminate, in such areas as the Secretary determines appropriate, a request for proposals for Medicare Consumer Coalitions to contract with the Secretary in order to conduct any of the informational activities described in paragraph (1); and

''(B) select a proposal of a Medicare Consumer Coalition to conduct the informational activities in each such area, with a preference for broad participation by organizations with experience in providing information to beneficiaries under this title.

''(3) PAYMENT TO MEDICARE CONSUMER COALITIONS.—The Secretary shall make payments to Medicare Consumer Coalitions contracting under this subsection in such amounts and in such manner as the Secretary determines appropriate.

''(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary such sums as may be necessary to contract with Medicare Consumer Coalitions under this section.

''(5) MEDICARE CONSUMER COALITION DEFINED.—In this subsection, the term 'Medicare Consumer Coalition' means an entity that is a nonprofit organization operated under the direction of a board of directors that is primarily composed of beneficiaries under this title.

''PREMIUMS

''SEC. 1860E. (a) ANNUAL ESTABLISHMENT OF MONTHLY PART D PREMIUM RATES.—

''(1) IN GENERAL.—The Secretary shall, during September of each year (beginning in 2004), determine and promulgate a monthly part D premium rate for the succeeding year.

''(2) AMOUNT.—The Secretary shall determine the monthly part D premium rate for the succeeding year as follows:

''(A) PREMIUM FOR 2005.—The monthly part D premium rate for 2005 shall be $25.

''(B) INFLATION ADJUSTMENT OF PREMIUM FOR 2006 AND SUBSEQUENT YEARS.—

''(i) IN GENERAL.—Subject to clause (ii), in the case of any calendar year beginning after 2005, the monthly part D premium rate for the year shall be the amount described in subparagraph (A) increased by an amount equal to—

''(I) such dollar amount, multiplied by

''(II) the percentage (if any) by which the amount of the average annual per capita aggregate expenditures payable from the Prescription Drug Account for the year (as estimated under section 1860J(c)(2)(C)) exceeds the amount of such expenditures in 2005.

''(ii) ROUNDING.—If the monthly part D premium rate determined under clause (i) is not a multiple of $1, such rate shall be rounded to the nearest multiple of $1.

''(b) COLLECTION OF PART D PREMIUM.—The monthly part D premium applicable to an eligible beneficiary under this part (after application of any increase under section 1860B(b)(1)) shall be collected and credited to the Prescription Drug Account in the same manner as the monthly premium determined under section 1839 is collected and credited to the Federal Supplementary Medical Insurance Trust Fund under section 1840.

''OUTPATIENT PRESCRIPTION DRUG BENEFITS

''SEC. 1860F. (a) REQUIREMENT.—A plan offered by an eligible entity under this part shall provide eligible beneficiaries enrolled in such plan with—

''(1) coverage of covered outpatient drugs—

''(A) without the application of any deductible; and

''(B) with the cost-sharing described in subsection (b); and

''(2) access to negotiated prices for such drugs under subsection (c).

''(b) COST-SHARING.—

''(1) COPAYMENT STRUCTURE FOR DRUGS INCLUDED IN THE FORMULARY.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, in the case of a covered outpatient drug that is dispensed in a year to an eligible beneficiary and that is included in the formulary established by the eligible entity (pursuant to section 1860H(c)) for the plan, the beneficiary shall be responsible for a copayment for the drug in an amount equal to the following:

''(i) GENERIC DRUGS.—In the case of a generic covered outpatient drug, $10 for each prescription (as defined in subparagraph (D)) of such drug.

''(ii) PREFERRED BRAND NAME DRUGS.—In the case of a preferred brand name covered outpatient drug (including a drug treated as a preferred brand name drug under subparagraph (C)), $40 for each prescription (as so defined) of such drug.

''(B) REDUCTION BY ELIGIBLE ENTITY.—An eligible entity offering a plan under this part may reduce the applicable copayment amount that an eligible beneficiary enrolled in the plan is subject to under subparagraph (A) if the Secretary determines that such reduction—

''(i) is tied to the performance requirements described in section 1860I(b)(1)(C); and

''(ii) will not result in an increase in the expenditures made from the Prescription Drug Account.

''(C) TREATMENT OF MEDICALLY NECESSARY NONFORMULARY DRUGS.—The eligible entity shall treat a nonformulary drug as a preferred brand name drug under subparagraph (A)(ii) if such nonformulary drug is determined (pursuant to subparagraph (D) or (E) of section 1860H(a)(4)) to be medically necessary.

''(D) PRESCRIPTION DEFINED.—

''(i) IN GENERAL.—Subject to clause (ii), for purposes of subparagraph (A), the term 'prescription' means—

''(I) a 30-day supply for a maintenance drug; and

''(II) a supply necessary for the length of the course that is typical of current practice for a nonmaintenance drug.

''(ii) SPECIAL RULE FOR MAIL ORDER DRUGS.—In the case of drugs obtained by mail order, the term 'prescription' may be for a supply that is longer than the period specified in clause (i) or (ii) (as the case may be) if the Secretary determines that the longer supply will not result in an increase in the expenditures made from the Prescription Drug Account.

''(2) BENEFICIARY RESPONSIBLE FOR NEGOTIATED PRICE OF NONFORMULARY DRUGS.—In the case of a covered outpatient drug that is dispensed to an eligible beneficiary and that is not included in the formulary established by the eligible entity (pursuant to section 1860H(c)) for the plan (and not treated a preferred brand name drug under paragraph (1)(C)), the beneficiary shall be responsible for the negotiated price for the drug (as reported to the Secretary pursuant to section 1860H(a)(6)(A)).

''(3) COST-SHARING MAY NOT EXCEED NEGOTIATED PRICE.—

''(A) IN GENERAL.—If the amount of cost-sharing for a covered outpatient drug that

would otherwise be required under this subsection (but for this paragraph) is greater than the applicable amount, then the amount of such cost-sharing shall be reduced to an amount equal to such applicable amount.

''(B) APPLICABLE AMOUNT DEFINED.—For purposes of subparagraph (A), the term 'applicable amount' means an amount equal to—

''(i) in the case of a drug included in the formulary (generic drugs and preferred brand name drugs, including a drug treated as a preferred brand name drug under paragraph (1)(C)), the negotiated price for the drug (as reported to the Secretary pursuant to section 1860H(a)(6)(A)) less $5; and

''(ii) in the case of a nonformulary drug, the negotiated price for the drug (as so reported).

''(4) NO COST-SHARING ONCE EXPENSES EQUAL ANNUAL OUT-OF-POCKET LIMIT.—

''(A) IN GENERAL.—An eligible entity offering a plan under this part shall provide coverage of covered outpatient drugs without any cost-sharing if the individual has incurred costs (as described in subparagraph (C)) for covered outpatient drugs in a year equal to the annual out-of-pocket limit specified in subparagraph (B).

''(B) ANNUAL OUT-OF-POCKET LIMIT.—Subject to paragraph (5), for purposes of this part, the 'annual out-of-pocket limit' specified in this subparagraph is equal to $4,000.

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

''(i) incurred costs shall only include costs incurred for the cost-sharing described in this subsection; but

''(ii) such costs shall be treated as incurred without regard to whether the individual or another person, including a State program or other third-party coverage, has paid for such costs.

''(5) INFLATION ADJUSTMENT FOR COPAYMENT AMOUNTS AND ANNUAL OUT-OF-POCKET LIMIT FOR 2006 AND SUBSEQUENT YEARS.—

''(A) IN GENERAL.—For any year after 2005—

''(i) the copayment amounts described in clauses (i) and (ii) of paragraph (1)(A) are equal to the copayment amounts determined under such paragraph (or this paragraph) for the previous year—

''(I) increased by the annual percentage increase described in subparagraph (B); and

''(II) further adjusted to reflect relative changes in the composition of drug spending among the copayment structure under paragraph (1) to ensure that the percentage of drug spending that beneficiaries enrolled under this part are required to pay in the year is the same (as estimated by the Secretary) as the percentage required in the previous year; and

''(ii) the annual out-of-pocket limit specified in paragraph (4)(B) is equal to the annual out-of-pocket limit determined under such paragraph (or this paragraph) for the previous year increased by the annual percentage increase described in subparagraph (C).

''(B) ANNUAL PERCENTAGE INCREASE SPECIFIED IN SUBPARAGRAPH (B).—The annual percentage increase specified in this subparagraph for a year is equal to the annual percentage increase in the prices of covered outpatient drugs (including both price inflation and price changes due to changes in therapeutic mix), as determined by the Secretary for the 12-month period ending in July of the previous year.

''(C) ANNUAL PERCENTAGE INCREASE SPECIFIED IN SUBPARAGRAPH (C).—The annual percentage increase specified in this subparagraph for a year is equal to the annual percentage increase in average per capita aggregate expenditures for covered outpatient drugs in the United States for medicare beneficiaries, as determined by the Secretary for the 12-month period ending in July of the previous year.

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

''(c) ACCESS TO NEGOTIATED PRICES.—

''(1) ACCESS.—Under a plan offered by an eligible entity with a contract under this part, the eligible entity offering such plan shall provide eligible beneficiaries enrolled in such plan with access to negotiated prices (including applicable discounts) used for payment for covered outpatient drugs, regardless of the fact that only partial benefits may be payable under the coverage with respect to such drugs because of the application of the cost-sharing under subsection (b).

''(2) MEDICAID RELATED PROVISIONS.—Insofar as a State elects to provide medical assistance under title XIX for a drug based on the prices negotiated under a plan under this part, the requirements of section 1927 shall not apply to such drugs. The prices negotiated under a plan under this part with respect to covered outpatient drugs, under a Medicare+Choice plan with respect to such drugs, or under a qualified retiree prescription drug plan (as defined in section 1860J(e)(3)) with respect to such drugs, on behalf of eligible beneficiaries, 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).

''ENTITIES ELIGIBLE TO PROVIDE OUTPATIENT DRUG BENEFIT

''SEC. 1860G. (a) ESTABLISHMENT OF PANELS OF PLANS AVAILABLE IN AN AREA.—

''(1) IN GENERAL.—The Secretary shall establish procedures under which the Secretary—

''(A) accepts bids submitted by eligible entities for the plans which such entities intend to offer in an area established under subsection (b); and

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

''(2) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5))) shall be used to enter into contracts under this part.

''(b) AREA FOR CONTRACTS.—

''(1) REGIONAL BASIS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B) and subject to paragraph (2), the contract entered into between the Secretary and an eligible entity with respect to a plan shall require the eligible entity to provide coverage of covered outpatient drugs under the plan in a region determined by the Secretary under paragraph (2).

''(B) PARTIAL REGIONAL BASIS.—

''(i) IN GENERAL.—If determined appropriate by the Secretary, the Secretary may permit the coverage described in subparagraph (A) to be provided in a partial region determined appropriate by the Secretary.

''(ii) REQUIREMENTS.—If the Secretary permits coverage pursuant to clause (i), the Secretary shall ensure that the partial region in which coverage is provided is—

''(I) at least the size of the commercial service area of the eligible entity for that area; and

''(II) not smaller than a State.

''(2) DETERMINATION.—

''(A) IN GENERAL.—In determining regions for contracts under this part, the Secretary shall—

''(i) take into account the number of eligible beneficiaries in an area in order to encourage participation by eligible entities; and

''(ii) ensure that there are at least 10 different regions in the United States.

''(B) NO ADMINISTRATIVE OR JUDICIAL REVIEW.—The determination of coverage areas under this part shall not be subject to administrative or judicial review.

''(c) SUBMISSION OF BIDS.—

''(1) SUBMISSION.—

''(A) IN GENERAL.—Subject to subparagraph (B), each eligible entity desiring to offer a plan under this part in an area shall submit a bid with respect to such plan to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may reasonably require.

''(B) BID THAT COVERS MULTIPLE AREAS.—The Secretary shall permit an eligible entity to submit a single bid for multiple areas if the bid is applicable to all such areas.

''(2) REQUIRED INFORMATION.—The bids described in paragraph (1) shall include—

''(A) a proposal for the estimated prices of covered outpatient drugs and the projected annual increases in such prices, including differentials between formulary and nonformulary prices, if applicable;

''(B) a statement regarding the amount that the entity will charge the Secretary for managing, administering, and delivering the benefits under the contract;

''(C) a statement regarding whether the entity will reduce the applicable cost-sharing amount pursuant to section 1860F(b)(1)(B) and if so, the amount of such reduction and how such reduction is tied to the performance requirements described in section 1860I(b)(1)(C);

''(D) a detailed description of the performance requirements for which the payments to the entity will be subject to risk pursuant to section 1860I(b)(1)(C);

''(E) a detailed description of access to pharmacy services provided under the plan;

''(F) with respect to the formulary used by the entity, a detailed description of the procedures and standards the entity will use for—

''(i) adding new drugs to a therapeutic class within the formulary; and

''(ii) determining when and how often the formulary should be modified;

''(G) a detailed description of any ownership or shared financial interests with other entities involved in the delivery of the benefit as proposed under the plan;

''(H) a detailed description of the entity's estimated marketing and advertising expenditures related to enrolling eligible beneficiaries under the plan and retaining such enrollment; and

''(I) such other information that the Secretary determines is necessary in order to carry out this part, including information relating to the bidding process under this part.

''(d) ACCESS TO BENEFITS IN CERTAIN AREAS.—

''(1) AREAS NOT COVERED BY CONTRACTS.—The Secretary shall develop procedures for the provision of covered outpatient drugs under this part to each eligible beneficiary enrolled under this part that resides in an area that is not covered by any contract under this part.

''(2) BENEFICIARIES RESIDING IN DIFFERENT LOCATIONS.—The Secretary shall develop procedures to ensure that each eligible beneficiary enrolled under this part that resides in different areas in a year is provided the benefits under this part throughout the entire year.

''(e) AWARDING OF CONTRACTS.—

''(1) NUMBER OF CONTRACTS.—The Secretary shall, consistent with the requirements of this part and the goal of containing costs under this title, award in a competitive manner at least 2 contracts to offer a plan in an area, unless only 1 bidding entity (and the

plan offered by the entity) meets the minimum standards specified under this part and by the Secretary.

''(2) DETERMINATION.—In determining which of the eligible entities that submitted bids that meet the minimum standards specified under this part and by the Secretary to award a contract, the Secretary shall consider the comparative merits of each bid, as determined on the basis of the past performance of the entity and other relevant factors, with respect to—

''(A) how well the entity (and the plan offered by the entity) meet such minimum standards;

''(B) the amount that the entity will charge the Secretary for managing, administering, and delivering the benefits under the contract;

''(C) the performance requirements for which the payments to the entity will be subject to risk pursuant to section 1860I(b)(1)(C);

''(D) the proposed negotiated prices of covered outpatient drugs and annual increases in such prices;

''(E) the factors described in section 1860D(b)(2);

''(F) prior experience of the entity in managing, administering, and delivering a prescription drug benefit program;

''(G) effectiveness of the entity and plan in containing costs through pricing incentives and utilization management; and

''(H) such other factors as the Secretary deems necessary to evaluate the merits of each bid.

''(3) EXCEPTION TO CONFLICT OF INTEREST RULES.—In awarding contracts under this part, the Secretary may waive conflict of interest laws generally applicable to Federal acquisitions (subject to such safeguards as the Secretary may find necessary to impose) in circumstances where the Secretary finds that such waiver—

''(A) is not inconsistent with the—

''(i) purposes of the programs under this title; or

''(ii) best interests of beneficiaries enrolled under this part; and

''(B) permits a sufficient level of competition for such contracts, promotes efficiency of benefits administration, or otherwise serves the objectives of the program under this part.

''(4) NO ADMINISTRATIVE OR JUDICIAL REVIEW.—The determination of the Secretary to award or not award a contract to an eligible entity with respect to a plan under this part shall not be subject to administrative or judicial review.

''(f) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—The provisions of section 1851(h) shall apply to marketing material and application forms under this part in the same manner as such provisions apply to marketing material and application forms under part C.

''(g) DURATION OF CONTRACTS.—Each contract awarded under this part shall be for a term of at least 2 years but not more than 5 years, as determined by the Secretary.

''MINIMUM STANDARDS FOR ELIGIBLE ENTITIES

''SEC. 1860H. (a) IN GENERAL.—The Secretary shall not award a contract to an eligible entity under this part unless the Secretary finds that the eligible entity agrees to comply with such terms and conditions as the Secretary shall specify, including the following:

''(1) QUALITY AND FINANCIAL STANDARDS.—The eligible entity meets the quality and financial standards specified by the Secretary.

''(2) PROCEDURES TO ENSURE PROPER UTILIZATION, COMPLIANCE, AND AVOIDANCE OF ADVERSE DRUG REACTIONS.—

''(A) IN GENERAL.—The eligible entity has in place drug utilization review procedures to ensure—

''(i) the appropriate utilization by eligible beneficiaries enrolled in the plan covered by the contract of the benefits to be provided under the plan;

''(ii) the avoidance of adverse drug reactions among such beneficiaries, including problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions (including serious interactions with nonprescription or over-the-counter drugs), incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse and misuse; and

''(iii) the reasonable application of peer-reviewed medical literature pertaining to improvements in pharmaceutical safety and appropriate use of drugs.

''(B) AUTHORITY TO USE CERTAIN COMPENDIA AND LITERATURE.—The eligible entity may use the compendia and literature referred to in clauses (i) and (ii), respectively, of section 1927(g)(1)(B) as a source for the utilization review under subparagraph (A).

''(3) ELECTRONIC PRESCRIPTION PROGRAM.—

''(A) IN GENERAL.—The eligible entity has in place, for years beginning with 2006, an electronic prescription drug program that includes at least the following components, consistent with national standards established under subparagraph (B):

''(i) ELECTRONIC TRANSMITTAL OF PRESCRIPTIONS.—Prescriptions are only received electronically, except in emergency cases and other exceptional circumstances recognized by the Secretary.

''(ii) PROVISION OF INFORMATION TO PRESCRIBING HEALTH CARE PROFESSIONAL.—The program provides, upon transmittal of a prescription by a prescribing health care professional, for transmittal by the pharmacist to the professional of information that includes—

''(I) information (to the extent available and feasible) on the drugs being prescribed for that patient and other information relating to the medical history or condition of the patient that may be relevant to the appropriate prescription for that patient;

''(II) cost-effective alternatives (if any) for the use of the drug prescribed; and

''(III) information on the drugs included in the applicable formulary.

To the extent feasible, such program shall permit the prescribing health care professional to provide (and be provided) related information on an interactive, real-time basis.

''(B) STANDARDS.—

''(i) DEVELOPMENT.—The Secretary shall provide for the development of national standards relating to the electronic prescription drug program described in subparagraph (A). Such standards shall be compatible with standards established under part C of title XI.

''(ii) ADVISORY TASK FORCE.—In developing such standards, the Secretary shall establish a task force that includes representatives of physicians, hospitals, pharmacists, and technology experts and representatives of the Departments of Veterans Affairs and Defense and other appropriate Federal agencies to provide recommendations to the Secretary on such standards, including recommendations relating to the following:

''(I) The range of available computerized prescribing software and hardware and their costs to develop and implement.

''(II) The extent to which such systems reduce medication errors and can be readily implemented by physicians and hospitals.

''(III) Efforts to develop a common software platform for computerized prescribing.

''(IV) The cost of implementing such systems in the range of hospital and physician office settings, including hardware, software, and training costs.

''(V) Implementation issues as they relate to part C of title XI, and current Federal and State prescribing laws and regulations and their impact on implementation of computerized prescribing.

''(iii) DEADLINES.—

''(I) The Secretary shall constitute the task force under clause (ii) by not later than April 1, 2003.

''(II) Such task force shall submit recommendations to Secretary by not later than January 1, 2004.

''(III) The Secretary shall develop and promulgate the national standards referred to in clause (ii) by not later than January 1, 2005.

''(C) WAIVER OF APPLICATION FOR CERTAIN RURAL PROVIDERS.—If the Secretary determines that it is unduly burdensome on providers in rural areas to comply with the requirements under this paragraph, the Secretary may waive such requirements for such providers.

''(D) REFERENCE TO AVAILABILITY OF GRANT FUNDS.—Grant funds are authorized under section 399O of the Public Health Service Act to provide assistance to health care providers in implementing electronic prescription drug programs.

''(4) PATIENT PROTECTIONS.—

''(A) ACCESS.—

''(i) IN GENERAL.—The eligible entity ensures that the covered outpatient drugs are accessible and convenient to eligible beneficiaries enrolled in the plan covered by the contract, including by offering the services 24 hours a day and 7 days a week for emergencies.

''(ii) AGREEMENTS WITH PHARMACIES.—The eligible entity shall enter into a participation agreement with any pharmacy that meets the requirements of subsection (d) to dispense covered prescription drugs to eligible beneficiaries under this part. Such agreements shall include the payment of a reasonable dispensing fee for covered outpatient drugs dispensed to a beneficiary under the agreement.

''(iii) PREFERRED PHARMACY NETWORKS.—If the eligible entity utilizes a preferred pharmacy network, the network complies with the standards under subsection (e).

''(B) ENSURING THAT BENEFICIARIES ARE NOT OVERCHARGED.—The eligible entity has procedures in place to ensure that each pharmacy with a participation agreement under this part with the entity complies with the requirements under subsection (d)(1)(C) (relating to adherence to negotiated prices).

''(C) CONTINUITY OF CARE.—

''(i) IN GENERAL.—The eligible entity ensures that, in the case of an eligible beneficiary who loses coverage under this part with such entity under circumstances that would permit a special election period (as established by the Secretary under section 1860C(a)(1)), the entity will continue to provide coverage under this part to such beneficiary until the beneficiary enrolls and receives such coverage with another eligible entity under this part or, if eligible, with a Medicare+Choice organization.

''(ii) LIMITED PERIOD.—In no event shall an eligible entity be required to provide the extended coverage required under clause (i) beyond the date which is 30 days after the coverage with such entity would have terminated but for this subparagraph.

''(D) PROCEDURES REGARDING THE DETERMINATION OF DRUGS THAT ARE MEDICALLY NECESSARY.—

''(i) IN GENERAL.—The eligible entity has in place procedures on a case-by-case basis to treat a nonformulary drug as a preferred brand name drug under this part if the nonformulary drug is determined—

''(I) to be not as effective for the enrollee in preventing or slowing the deterioration of, or improving or maintaining, the health of the enrollee; or

''(II) to have a significant adverse effect on the enrollee.

''(ii) REQUIREMENT.—The procedures under clause (i) shall require that determinations under such clause are based on professional medical judgment, the medical condition of the enrollee, and other medical evidence.

''(E) PROCEDURES REGARDING APPEAL RIGHTS WITH RESPECT TO DENIALS OF CARE.—The eligible entity has in place procedures to ensure—

''(i) a timely internal review for resolution of denials of coverage (in whole or in part and including those regarding the coverage of nonformulary drugs as preferred brand name drugs) in accordance with the medical exigencies of the case and a timely resolution of complaints, by enrollees in the plan, or by providers, pharmacists, and other individuals acting on behalf of each such enrollee (with the enrollee's consent) in accordance with requirements (as established by the Secretary) that are comparable to such requirements for Medicare+Choice organizations under part C (and are not less favorable to the enrollee than such requirements under such part as in effect on the date of enactment of the Medicare Outpatient Prescription Drug Act of 2002);

''(ii) that the entity complies in a timely manner with requirements established by the Secretary that (I) provide for an external review by an independent entity selected by the Secretary of denials of coverage described in clause (i) not resolved in the favor of the beneficiary (or other complainant) under the process described in such clause, and (II) are comparable to the external review requirements established for Medicare+Choice organizations under part C (and are not less favorable to the enrollee than such requirements under such part as in effect on the date of enactment of the Medicare Outpatient Prescription Drug Act of 2002); and

''(iii) that enrollees are provided with information regarding the appeals procedures under this part at the time of enrollment with the entity and upon request thereafter.

''(F) PROCEDURES REGARDING PATIENT CONFIDENTIALITY.—Insofar as an eligible entity maintains individually identifiable medical records or other health information regarding eligible beneficiaries enrolled in the plan that is covered by the contract, the entity has in place procedures to—

''(i) safeguard the privacy of any individually identifiable beneficiary 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 (Public Law 104–191; 110 Stat. 2033);

''(ii) maintain such records and information in a manner that is accurate and timely;

''(iii) ensure timely access by such beneficiaries to such records and information; and

''(iv) otherwise comply with applicable laws relating to patient confidentiality.

''(G) PROCEDURES REGARDING TRANSFER OF MEDICAL RECORDS.—

''(i) IN GENERAL.—The eligible entity has in place procedures for the timely transfer of records and information described in subparagraph (F) (with respect to a beneficiary who loses coverage under this part with the entity and enrolls with another entity (including a Medicare+Choice organization) under this part) to such other entity.

''(ii) PATIENT CONFIDENTIALITY.—The procedures described in clause (i) shall comply with the patient confidentiality procedures described in subparagraph (F).

''(H) PROCEDURES REGARDING MEDICAL ERRORS.—The eligible entity has in place procedures for—

''(i) working with the Secretary to deter medical errors related to the provision of covered outpatient drugs; and

''(ii) ensuring that pharmacies with a contract with the entity have in place procedures to deter medical errors related to the provision of covered outpatient drugs.

''(5) PROCEDURES TO CONTROL FRAUD, ABUSE, AND WASTE.—

''(A) IN GENERAL.—The eligible entity has in place procedures to control fraud, abuse, and waste.

''(B) APPLICABILITY OF FRAUD AND ABUSE PROVISIONS.—The provisions of section 1128 through 1128C (relating to fraud and abuse) apply to eligible entities with contracts under this part.

''(6) REPORTING REQUIREMENTS.—

''(A) IN GENERAL.—The eligible entity provides the Secretary with reports containing information regarding the following:

''(i) The negotiated prices that the eligible entity is paying for covered outpatient drugs.

''(ii) The prices that eligible beneficiaries enrolled in the plan that is covered by the contract will be charged for covered outpatient drugs.

''(iii) The management costs of providing such benefits.

''(iv) Utilization of such benefits.

''(v) Marketing and advertising expenditures related to enrolling and retaining eligible beneficiaries.

''(B) TIMEFRAME FOR SUBMITTING REPORTS.—

''(i) IN GENERAL.—The eligible entity shall submit a report described in subparagraph (A) to the Secretary within 3 months after the end of each 12-month period in which the eligible entity has a contract under this part. Such report shall contain information concerning the benefits provided during such 12-month period.

''(ii) LAST YEAR OF CONTRACT.—In the case of the last year of a contract under this part, the Secretary may require that a report described in subparagraph (A) be submitted 3 months prior to the end of the contract. Such report shall contain information concerning the benefits provided between the period covered by the most recent report under this subparagraph and the date that a report is submitted under this clause.

''(C) CONFIDENTIALITY OF INFORMATION.—

''(i) IN GENERAL.—Notwithstanding any other provision of law and subject to clause (ii), information disclosed by an eligible entity pursuant to subparagraph (A) (except for information described in clause (ii) of such subparagraph) is confidential and shall only be used by the Secretary for the purposes of, and to the extent necessary, to carry out this part.

''(ii) UTILIZATION DATA.—Subject to patient confidentiality laws, the Secretary shall make information disclosed by an eligible entity pursuant to subparagraph (A)(iv) (regarding utilization data) available for research purposes. The Secretary may charge a reasonable fee for making such information available.

''(7) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—The eligible entity complies with the requirements described in section 1860G(f).

''(8) RECORDS AND AUDITS.—The eligible entity maintains adequate records related to the administration of the benefits under this part and affords the Secretary access to such records for auditing purposes.

''(b) SPECIAL RULES REGARDING COST-EFFECTIVE PROVISION OF BENEFITS.—

''(1) IN GENERAL.—In providing the benefits under a contract under this part, an eligible entity shall—

''(A) employ mechanisms to provide the benefits economically, such as through the use of—

''(i) alternative methods of distribution;

''(ii) preferred pharmacy networks (pursuant to subsection (e)); and

''(iii) generic drug substitution;

''(B) use mechanisms to encourage eligible beneficiaries to select cost-effective drugs or less costly means of receiving drugs, such as through the use of—

''(i) pharmacy incentive programs;

''(ii) therapeutic interchange programs; and

''(iii) disease management programs;

''(C) encourage pharmacy providers to—

''(i) inform beneficiaries of the differentials in price between generic and brand name drug equivalents; and

''(ii) provide medication therapy management programs in order to enhance beneficiaries' understanding of the appropriate use of medications and to reduce the risk of potential adverse events associated with medications; and

''(D) develop and implement a formulary in accordance with subsection (c).

''(2) RESTRICTION.—If an eligible entity uses alternative methods of distribution pursuant to paragraph (1)(A)(i), the entity may not require that a beneficiary use such methods in order to obtain covered outpatient drugs.

''(c) REQUIREMENTS FOR FORMULARIES.—

''(1) STANDARDS.—

''(A) IN GENERAL.—The formulary developed and implemented by the eligible entity shall comply with standards established by the Secretary in consultation with the Medicare Prescription Drug Advisory Committee established under section 1860L.

''(B) NO NATIONAL FORMULARY OR REQUIREMENT TO EXCLUDE SPECIFIC DRUGS.—

''(i) SECRETARY MAY NOT ESTABLISH A NATIONAL FORMULARY.—The Secretary may not establish a national formulary.

''(ii) NO REQUIREMENT TO EXCLUDE SPECIFIC DRUGS.—The standards established by the Secretary pursuant to subparagraph (A) may not require that an eligible entity exclude a specific covered outpatient drug from the formulary developed and implemented by the entity.

''(2) REQUIREMENTS FOR STANDARDS.—The standards established under paragraph (1) shall require that the eligible entity—

''(A) use a pharmacy and therapeutic committee (that meets the standards for a pharmacy and therapeutic committee established by the Secretary in consultation with such Medicare Prescription Drug Advisory Committee) to develop and implement the formulary;

''(B) include—

''(i) all generic covered outpatient drugs in the formulary; and

''(ii) at least 1 but no more than 2 (unless the Secretary determines that such limitation is determined to be clinically inappropriate for a given therapeutic class) brand name covered outpatient drugs from each therapeutic class (as defined by the Secretary in consultation with such Medicare Prescription Drug Advisory Committee) as a preferred brand name drug in the formulary;

''(C) develop procedures for the modification of the formulary, including for the addition of new drugs to an existing therapeutic class;

''(D) pursuant to section 1860F(b)(1)(C), provide for coverage of nonformulary drugs at the preferred brand name drug rate when determined under subparagraph (D) or (E) of subsection (a)(3) to be medically necessary;

''(E) disclose to current and prospective beneficiaries and to providers in the service area the nature of the formulary restrictions, including information regarding the drugs included in the formulary and any difference in the cost-sharing for—

''(i) drugs included in the formulary; and

''(ii) for drugs not included in the formulary; and

''(F) provide a reasonable amount of notice to beneficiaries enrolled in the plan that is covered by the contract under this part of any change in the formulary.

''(3) CONSTRUCTION.—Nothing in this part shall be construed as precluding an eligible entity from—

''(A) educating prescribing providers, pharmacists, and beneficiaries about the medical and cost benefits of drugs included in the formulary (including generic drugs); or

''(B) requesting prescribing providers to consider a drug included in the formulary prior to dispensing of a drug not so included, as long as such a request does not unduly delay the provision of the drug.

''(d) TERMS OF PARTICIPATION AGREEMENT WITH PHARMACIES.—

''(1) IN GENERAL.—A participation agreement between an eligible entity and a pharmacy under this part (pursuant to subsection (a)(3)(A)(ii)) shall include the following terms and conditions:

''(A) APPLICABLE REQUIREMENTS.—The pharmacy shall meet (and throughout the contract period continue to meet) all applicable Federal requirements and State and local licensing requirements.

''(B) ACCESS AND QUALITY STANDARDS.—The pharmacy shall comply with such standards as the Secretary (and the eligible entity) shall establish concerning the quality of, and enrolled beneficiaries' access to, pharmacy services under this part. Such standards shall require the pharmacy—

''(i) not to refuse to dispense covered outpatient drugs to any eligible beneficiary enrolled under this part;

''(ii) to keep patient records (including records on expenses) for all covered outpatient drugs dispensed to such enrolled beneficiaries;

''(iii) to submit information (in a manner specified by the Secretary to be necessary to administer this part) on all purchases of such drugs dispensed to such enrolled beneficiaries; and

''(iv) to comply with periodic audits to assure compliance with the requirements of this part and the accuracy of information submitted.

''(C) ENSURING THAT BENEFICIARIES ARE NOT OVERCHARGED.—

''(i) ADHERENCE TO NEGOTIATED PRICES.—The total charge for each covered outpatient drug dispensed by the pharmacy to a beneficiary enrolled in the plan, without regard to whether the individual is financially responsible for any or all of such charge, shall not exceed the negotiated price for the drug (as reported to the Secretary pursuant to subsection (a)(5)(A)).

''(ii) ADHERENCE TO BENEFICIARY OBLIGATION.—The pharmacy may not charge (or collect from) such beneficiary an amount that exceed's the cost-sharing that the beneficiary is responsible for under this part (as determined under section 1860F(b) using the negotiated price of the drug).

''(D) ADDITIONAL REQUIREMENTS.—The pharmacy shall meet such additional contract requirements as the eligible entity specifies under this section.

''(2) APPLICABILITY OF FRAUD AND ABUSE PROVISIONS.—The provisions of section 1128 through 1128C (relating to fraud and abuse) apply to pharmacies participating in the program under this part.

''(e) PREFERRED PHARMACY NETWORKS.—

''(1) IN GENERAL.—If an eligible entity uses a preferred pharmacy network to deliver benefits under this part, such network shall meet minimum access standards established by the Secretary.

''(2) STANDARDS.—In establishing standards under paragraph (1), the Secretary shall take into account reasonable distances to pharmacy services in both urban and rural areas.

''PAYMENTS

''SEC. 1860I. (a) PROCEDURES FOR PAYMENTS TO ELIGIBLE ENTITIES.—The Secretary shall establish procedures for making payments to each eligible entity with a contract under this part for the management, administration, and delivery of the benefits under this part.

''(b) REQUIREMENTS FOR PROCEDURES.—

''(1) IN GENERAL.—The procedures established under subsection (a) shall provide for the following:

''(A) MANAGEMENT PAYMENT.—Payment for the management, administration, and delivery of the benefits under this part.

''(B) REIMBURSEMENT FOR NEGOTIATED COSTS OF DRUGS PROVIDED.—Payments for the negotiated costs of covered outpatient drugs provided to eligible beneficiaries enrolled under this part and in a plan offered by the eligible entity, reduced by any applicable cost-sharing under section 1860F(b).

''(C) RISK REQUIREMENT TO ENSURE PURSUIT OF PERFORMANCE REQUIREMENTS.—An adjustment of a percentage (as determined under paragraph (2)) of the payments made to an entity under subparagraph (A) to ensure that the entity, in managing, administering, and delivering the benefits under this part, pursues performance requirements established by the Secretary, including the following:

''(i) CONTROL OF MEDICARE AND BENEFICIARY COSTS.—The entity contains costs to the Prescription Drug Account and to eligible beneficiaries enrolled under this part and in the plan offered by the entity, as measured by generic substitution rates, price discounts, and other factors determined appropriate by the Secretary that do not reduce the access of such beneficiaries to medically necessary covered outpatient drugs.

''(ii) QUALITY CLINICAL CARE.—The entity provides such beneficiaries with quality clinical care, as measured by such factors as—

''(I) the level of adverse drug reactions and medical errors among such beneficiaries; and

''(II) providing specific clinical suggestions to improve health and patient and prescriber education as appropriate.

''(iii) QUALITY SERVICE.—The entity provides such beneficiaries with quality services, as measured by such factors as sustained pharmacy network access, timeliness and accuracy of service delivery in claims processing and card production, pharmacy and member service support access, response time in mail delivery service, and timely action with regard to appeals and current beneficiary service surveys.

''(2) PERCENTAGE OF PAYMENT TIED TO RISK.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall determine the percentage (which may be up to 100 percent) of the payments made to an entity under subparagraph (A) that will be tied to the performance requirements described in paragraph (1)(C).

''(B) LIMITATION ON RISK TO ENSURE PROGRAM STABILITY.—In order to provide for program stability, the Secretary may not establish a percentage to be adjusted under this subsection at a level that jeopardizes the ability of an eligible entity to administer and deliver the benefits under this part or administer and deliver such benefits in a quality manner.

''(3) RISK ADJUSTMENT OF PAYMENTS BASED ON ENROLLEES IN PLAN.—To the extent that an eligible entity is at risk under this subsection, the procedures established under subsection (a) may include a methodology for risk adjusting the payments made to such entity based on the differences in actuarial risk of different enrollees being served if the Secretary determines such adjustments to be necessary and appropriate.

''(4) PASS-THROUGH OF REBATES, DISCOUNTS, AND PRICE CONCESSIONS OBTAINED BY THE ELIGIBLE ENTITY.—The Secretary shall establish procedures for reducing the amount of payments to an eligible entity under subsection (a) to take into account any rebates, discounts, or price concessions obtained by the entity from manufacturers of covered outpatient drugs, unless the Secretary determines that such procedures are not in the best interests of the medicare program or eligible beneficiaries.

''(c) PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS.—For provisions related to payments to Medicare+Choice organizations for the administration and delivery of benefits under this part to eligible beneficiaries enrolled in a Medicare+Choice plan offered by the organization, see section 1853(c)(8).

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

''EMPLOYER INCENTIVE PROGRAM FOR EMPLOYMENT-BASED RETIREE DRUG COVERAGE

''SEC. 1860J. (a) PROGRAM AUTHORITY.—The Secretary is authorized to develop and implement a program under this section to be known as the 'Employer Incentive Program' that encourages employers and other sponsors of employment-based health care coverage to provide adequate prescription drug benefits to retired individuals by subsidizing, in part, the sponsor's cost of providing coverage under qualifying plans.

''(b) SPONSOR REQUIREMENTS.—In order to be eligible to receive an incentive payment under this section with respect to coverage of an individual under a qualified retiree prescription drug plan (as defined in subsection (e)(3)), a sponsor shall meet the following requirements:

''(1) ASSURANCES.—The sponsor shall—

''(A) annually attest, and provide such assurances as the Secretary may require, that the coverage offered by the sponsor is a qualified retiree prescription drug plan, and will remain such a plan for the duration of the sponsor's participation in the program under this section; and

''(B) guarantee that it will give notice to the Secretary and covered retirees—

''(i) at least 120 days before terminating its plan; and

''(ii) immediately upon determining that the actuarial value of the prescription drug benefit under the plan falls below the actuarial value of the outpatient prescription drug benefit under this part.

''(2) BENEFICIARY INFORMATION.—The sponsor shall report to the Secretary, for each calendar quarter for which it seeks an incentive payment under this section, the names and social security numbers of all retirees (and their spouses and dependents) covered under such plan during such quarter and the dates (if less than the full quarter) during which each such individual was covered.

''(3) AUDITS.—The sponsor and the employment-based retiree health coverage plan seeking incentive payments under this section shall agree to maintain, and to afford the Secretary access to, such records as the Secretary may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage, the accuracy of incentive payments made, and such other matters as may be appropriate.

''(4) OTHER REQUIREMENTS.—The sponsor shall provide such other information, and

comply with such other requirements, as the Secretary may find necessary to administer the program under this section.

''(c) INCENTIVE PAYMENTS.—

''(1) IN GENERAL.—A sponsor that meets the requirements of subsection (b) with respect to a quarter in a calendar year shall be entitled to have payment made by the Secretary on a quarterly basis (to the sponsor or, at the sponsor's direction, to the appropriate employment-based health plan) of an incentive payment, in the amount determined in paragraph (2), for each retired individual (or spouse or dependent) who—

''(A) was covered under the sponsor's qualified retiree prescription drug plan during such quarter; and

''(B) was eligible for, but was not enrolled in, the outpatient prescription drug benefit program under this part.

''(2) AMOUNT OF PAYMENT.—

''(A) IN GENERAL.—The amount of the payment for a quarter shall be, for each individual described in paragraph (1), ⅔ of the sum of the monthly Government contribution amounts (computed under subparagraph (B)) for each of the 3 months in the quarter.

''(B) COMPUTATION OF MONTHLY GOVERNMENT CONTRIBUTION AMOUNT.—For purposes of subparagraph (A), the monthly Government contribution amount for a month in a year is equal to the amount by which—

''(i) 1/12 of the amount estimated under subparagraph (C) for the year involved; exceeds

''(ii) the monthly Part D premium under section 1860E(a) (determined without regard to any increase under section 1860B(b)(1)) for the month involved.

''(C) ESTIMATE OF AVERAGE ANNUAL PER CAPITA AGGREGATE EXPENDITURES.—

''(i) IN GENERAL.—The Secretary shall for each year after 2004 estimate for that year an amount equal to average annual per capita aggregate expenditures payable from the Prescription Drug Account for that year.

''(ii) TIMEFRAME FOR ESTIMATION.—The Secretary shall make the estimate described in clause (i) for a year before the beginning of that year.

''(3) PAYMENT DATE.—The payment under this section with respect to a calendar quarter shall be payable as of the end of the next succeeding calendar quarter.

''(d) CIVIL MONEY PENALTIES.—A sponsor, health plan, or other entity that the Secretary determines has, directly or through its agent, provided information in connection with a request for an incentive payment under this section that the entity knew or should have known to be false shall be subject to a civil monetary penalty in an amount up to 3 times the total incentive amounts under subsection (c) that were paid (or would have been payable) on the basis of such information.

''(e) DEFINITIONS.—In this section:

''(1) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage, whether provided by voluntary insurance coverage or pursuant to statutory or contractual obligation, of health care costs for retired individuals (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

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

''(3) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN.—The term 'qualified retiree prescription drug plan' means health insurance coverage included in employment-based retiree health coverage that—

''(A) provides coverage of the cost of prescription drugs with an actuarial value (as defined by the Secretary) to each retired beneficiary that equals or exceeds the actuarial value of the benefits provided to an individual enrolled in the outpatient prescription drug benefit program under this part; and

''(B) does not deny, limit, or condition the coverage or provision of prescription drug benefits for retired individuals based on age or any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

''(4) SPONSOR.—The term 'sponsor' has the meaning given the term 'plan sponsor' in section 3(16)(B) of the Employer Retirement Income Security Act of 1974.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, such sums as may be necessary to carry out the program under this section.

''PRESCRIPTION DRUG ACCOUNT IN THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

''SEC. 1860K. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1841 an account to be known as the 'Prescription Drug Account' (in this section referred to as the 'Account').

''(2) FUNDS.—The Account shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, the account as provided in this part.

''(3) SEPARATE FROM REST OF TRUST FUND.—Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund.

''(b) PAYMENTS FROM ACCOUNT.—

''(1) IN GENERAL.—The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary certifies are necessary to make payments to operate the program under this part, including payments to eligible entities under section 1860I, payments to Medicare+Choice organizations under section 1853(c)(8), and payments with respect to administrative expenses under this part in accordance with section 201(g).

''(2) TREATMENT IN RELATION TO PART B PREMIUM.—Amounts payable from the Account shall not be taken into account in computing actuarial rates or premium amounts under section 1839.

''(c) APPROPRIATIONS TO COVER BENEFITS AND ADMINISTRATIVE COSTS.—

''(1) IN GENERAL.—Subject to paragraph (2), there are appropriated to the Account in a fiscal year, out of any moneys in the Treasury not otherwise appropriated, an amount equal to the amount by which the benefits and administrative costs of providing the benefits under this part in the year exceed the premiums collected under section 1860E(b) for the year.

''(2) LIMITATION.—

''(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), no obligations shall be incurred, no amounts shall be appropriated, and no amounts expended, for expenses incurred for providing coverage of covered outpatient drugs after December 31, 2010.

''(B) EXPENSES FOR COVERAGE PRIOR TO 2011.—The Secretary shall make payments on or after January 1, 2011, for expenses incurred to the extent such expenses were incurred for providing coverage of covered outpatient drugs prior to such date.

''(C) LEGISLATION ENACTED THAT PROVIDES SAVINGS.—Amounts shall continue to be appropriated, and the Secretary shall continue to incur obligations and expend amounts, for expenses incurred for providing coverage of covered outpatient drugs after December 31, 2010, if legislation is enacted prior to January 1, 2011, which states that savings have been achieved equal to or greater than the difference between the full cost of the Medicare Outpatient Prescription Drug Act of 2002 over the period beginning October 1, 2004, and ending September 30, 2012, and the full cost of such Act over such period if this paragraph had not been included in such Act.

''MEDICARE PRESCRIPTION DRUG ADVISORY COMMITTEE

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

''(b) FUNCTIONS OF COMMITTEE.—On and after January 1, 2004, the Committee shall advise the Secretary on policies related to—

''(1) the development of guidelines for the implementation and administration of the outpatient prescription drug benefit program under this part; and

''(2) the development of—

''(A) standards for a pharmacy and therapeutics committee required of eligible entities under section 1860H(c)(2)(A);

''(B) standards required under subparagraphs (D) and (E) of section 1860H(a)(4) for determining if a drug is medically necessary;

''(C) standards for—

''(i) establishing therapeutic classes;

''(ii) adding new therapeutic classes to a formulary; and

''(iii) defining maintenance and non-maintenance drugs and determining the length of the course that is typical of current practice for nonmaintenance drugs for purposes of applying section 1860F(b)(1);

''(D) procedures to evaluate the bids submitted by eligible entities under this part; and

''(E) procedures to ensure that eligible entities with a contract under this part are in compliance with the requirements under this part.

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

''(1) STRUCTURE.—The Committee shall be composed of 19 members who shall be appointed by the Secretary.

''(2) MEMBERSHIP.—

''(A) IN GENERAL.—The members of the Committee 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, attainments, and understanding of pharmaceutical cost control and quality enhancement, exceptionally qualified to perform the duties of members of the Committee.

''(B) SPECIFIC MEMBERS.—Of the members appointed under paragraph (1)—

''(i) five shall be chosen to represent physicians, 2 of whom shall be geriatricians;

''(ii) two shall be chosen to represent nurse practitioners;

''(iii) four shall be chosen to represent pharmacists;

''(iv) one shall be chosen to represent the Centers for Medicare & Medicaid Services;

''(v) four shall be chosen to represent actuaries, pharmacoeconomists, researchers, and other appropriate experts;

''(vi) one shall be chosen to represent emerging drug technologies;

''(vii) one shall be closed to represent the Food and Drug Administration; and

''(viii) one shall be chosen to represent individuals enrolled under this part.

''(d) TERMS OF APPOINTMENT.—Each member of the Committee shall serve for a term

determined appropriate by the Secretary. The terms of service of the members initially appointed shall begin on March 1, 2003.

''(e) CHAIRPERSON.—The Secretary shall designate a member of the Committee as Chairperson. The term as Chairperson shall be for a 1-year period.

''(f) COMMITTEE PERSONNEL MATTERS.—

''(1) MEMBERS.—

''(A) COMPENSATION.—Each member of the Committee who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Committee. All members of the Committee who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

''(B) TRAVEL EXPENSES.—The members of the Committee shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Committee.

''(2) STAFF.—The Committee may appoint such personnel as the Committee considers appropriate.

''(g) OPERATION OF THE COMMITTEE.—

''(1) MEETINGS.—The Committee shall meet at the call of the Chairperson (after consultation with the other members of the Committee) not less often than quarterly to consider a specific agenda of issues, as determined by the Chairperson after such consultation.

''(2) QUORUM.—Ten members of the Committee shall constitute a quorum for purposes of conducting business.

''(h) FEDERAL ADVISORY COMMITTEE ACT.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Committee.

''(i) TRANSFER OF PERSONNEL, RESOURCES, AND ASSETS.—For purposes of carrying out its duties, the Secretary and the Committee may provide for the transfer to the Committee of such civil service personnel in the employ of the Department of Health and Human Services (including the Centers for Medicare & Medicaid Services), and such resources and assets of the Department used in carrying out this title, as the Committee requires.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.''.

(b) EXCLUSIONS FROM COVERAGE.—

(1) APPLICATION TO PART D.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended in the matter preceding paragraph (1) by striking ''part A or part B'' and inserting ''part A, B, or D''.

(2) PRESCRIPTION DRUGS NOT EXCLUDED FROM COVERAGE IF REASONABLE AND NECESSARY.—Section 1862(a)(1) of the Social Security Act (42 U.S.C. 1395y(a)(1)) is amended—

(A) in subparagraph (H), by striking ''and'' at the end;

(B) in subparagraph (I), by striking the semicolon at the end and inserting '', and''; and

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

''(J) in the case of prescription drugs covered under part D, which are not reasonable and necessary to prevent or slow the deterioration of, or improve or maintain, the health of eligible beneficiaries;''.

(c) CONFORMING AMENDMENTS TO FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—Section 1841 of the Social Security Act (42 U.S.C. 1395t) is amended—

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

(A) by striking ''and'' before ''such amounts''; and

(B) by inserting before the period the following: '', and such amounts as may be deposited in, or appropriated to, the Prescription Drug Account established by section 1860K'';

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

(3) in subsection (h), by inserting after ''1840(d)'' the following: ''and section 1860E(b) (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund)''; and

(4) in subsection (i), by inserting after ''section 1840(b)(1)'' the following: '', section 1860E(b) (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund),''.

(d) 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 Act, the Secretary of Health and Human Services shall submit to Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this title.

SEC. 203. PART D BENEFITS UNDER MEDICARE+CHOICE PLANS.

(a) ELIGIBILITY, ELECTION, AND ENROLLMENT.—Section 1851 of the Social Security Act (42 U.S.C. 1395w–21) is amended—

(1) in subsection (a)(1)(A), by striking ''parts A and B'' and inserting ''parts A, B, and D''; and

(2) in subsection (i)(1), by striking ''parts A and B'' and inserting ''parts A, B, and D''.

(b) VOLUNTARY BENEFICIARY ENROLLMENT FOR DRUG COVERAGE.—Section 1852(a)(1)(A) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)(A)) is amended by inserting ''(and under part D to individuals also enrolled under that part)'' after ''parts A and B''.

(c) ACCESS TO SERVICES.—Section 1852(d)(1) of the Social Security Act (42 U.S.C. 1395w–22(d)(1)) is amended—

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

(2) in subparagraph (E), by striking the period at the end and inserting ''; and''; and

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

''(F) in the case of covered outpatient drugs (as defined in section 1860(1)) provided to individuals enrolled under part D, the organization complies with the access requirements applicable under part D.''.

(d) PAYMENTS TO ORGANIZATIONS FOR PART D BENEFITS.—

(1) IN GENERAL.—Section 1853(a)(1)(A) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(A)) is amended—

(A) by inserting ''determined separately for the benefits under parts A and B and under part D (for individuals enrolled under that part)'' after ''as calculated under subsection (c)'';

(B) by striking ''that area, adjusted for such risk factors'' and inserting ''that area. In the case of payment for the benefits under parts A and B, such payment shall be adjusted for such risk factors as''; and

(C) by inserting before the last sentence the following: ''In the case of the payments under subsection (c)(8) for the provision of coverage of covered outpatient drugs to individuals enrolled under part D, such payment shall be adjusted for the risk factors of each enrollee as the Secretary determines to be feasible and appropriate to ensure actuarial equivalence.''.

(2) AMOUNT.—Section 1853(c) of the Social Security Act (42 U.S.C. 1395w–23(c)) is amended—

(A) in paragraph (1), in the matter preceding subparagraph (A), by inserting ''for benefits under parts A and B'' after ''capitation rate''; and

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

''(8) CAPITATION RATE FOR PART D BENEFITS.—

''(A) IN GENERAL.—In the case of a Medicare+Choice plan that provides coverage of covered outpatient drugs to an individual enrolled under part D, the capitation rate for such coverage shall be the amount described in subparagraph (B). Such payments shall be made in the same manner and at the same time as the payments to the Medicare+Choice organization offering the plan for benefits under parts A and B are otherwise made, but such payments shall be payable from the Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund under section 1841.

''(B) AMOUNT.—The amount described in this paragraph is an amount equal to 1/12 of the average annual per capita aggregate expenditures payable from the Prescription Drug Account for the year (as estimated under section 1860J(c)(2)(C)).''.

(e) LIMITATION ON ENROLLEE LIABILITY.—Section 1854(e) of the Social Security Act (42 U.S.C. 1395w–24(e)) is amended by adding at the end the following new paragraph:

''(5) SPECIAL RULE FOR PART D BENEFITS.—With respect to outpatient prescription drug benefits under part D, a Medicare+Choice organization may not require that an enrollee pay any deductible or pay a cost-sharing amount that exceeds the amount of cost-sharing applicable for such benefits for an eligible beneficiary under part D.''.

(f) REQUIREMENT FOR ADDITIONAL BENEFITS.—Section 1854(f)(1) of the Social Security Act (42 U.S.C. 1395w–24(f)(1)) is amended by adding at the end the following new sentence: ''Such determination shall be made separately for the benefits under parts A and B and for prescription drug benefits under part D.''.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services provided under a Medicare+Choice plan on or after January 1, 2005.

SEC. 204. ADDITIONAL ASSISTANCE FOR LOW-INCOME BENEFICIARIES.

(a) INCLUSION IN MEDICARE COST-SHARING.—Section 1905(p)(3) of the Social Security Act (42 U.S.C. 1396d(p)(3)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by striking ''and'' at the end;

(B) in clause (ii), by inserting ''and'' at the end; and

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

''(iii) premiums under section 1860E(a).''; and

(2) in subparagraph (B), by inserting ''and cost-sharing described in section 1860F(b)'' after ''section 1813''.

(b) EXPANSION OF MEDICAL ASSISTANCE.—Section 1902(a)(10)(E) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)) is amended—

(1) in clause (iii)—

(A) by striking ''section 1905(p)(3)(A)(ii)'' and inserting ''clauses (ii) and (iii) of section

1905(p)(3)(A) and for medicare cost-sharing described in section 1905(p)(3)(B) (but only insofar as it relates to benefits provided under part D of title XVIII),''; and

(B) by striking ''and'' at the end;

(2) by redesignating clause (iv) as clause (vi); and

(3) by inserting after clause (iii) the following new clauses:

''(iv) for making medical assistance available for medicare cost-sharing described in section 1905(p)(3)(A)(iii) and for medicare cost-sharing described in section 1905(p)(3)(B) (but only insofar as it relates to benefits provided under part D of title XVIII) for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds 120 percent but does not exceed 135 percent of such official poverty line for a family of the size involved;

''(v) for making medical assistance available for medicare cost-sharing described in section 1905(p)(3)(A)(iii) on a linear sliding scale based on the income of such individuals for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds 135 percent but does not exceed 150 percent of such official poverty line for a family of the size involved; and''.

(c) NONAPPLICABILITY OF RESOURCE REQUIREMENTS TO MEDICARE PART D COST-SHARING.—Section 1905(p)(1) of the Social Security Act (42 U.S.C. 1396d(p)(1)) is amended by adding at the end the following flush sentence:

''In determining if an individual is a qualified medicare beneficiary under this paragraph, subparagraph (C) shall not be applied for purposes of providing the individual with medicare cost-sharing described in section 1905(p)(3)(A)(iii) or for medicare cost-sharing described in section 1905(p)(3)(B) (but only insofar as it relates to benefits provided under part D of title XVIII).''.

(d) NONAPPLICABILITY OF PAYMENT DIFFERENTIAL REQUIREMENTS TO MEDICARE PART D COST-SHARING.—Section 1902(n)(2) of the Social Security Act (42 U.S.C. 1396a(n)(2)) is amended by adding at the end the following new sentence: ''The preceding sentence shall not apply to the cost-sharing described in section 1860F(b).''.

(e) 100 PERCENT FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended—

(1) by striking ''and'' before ''(4)''; and

(2) by inserting before the period at the end the following: '', and (5) the Federal medical assistance percentage shall be 100 percent with respect to medical assistance provided under clauses (iv) and (v) of section 1902(a)(10)(E)''.

(f) TREATMENT OF TERRITORIES.—Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)) is amended by adding at the end the following new paragraph:

''(3) Notwithstanding the preceding provisions of this subsection, with respect to fiscal year 2005 and any fiscal year thereafter, the amount otherwise determined under this subsection (and subsection (f)) for the fiscal year for a Commonwealth or territory shall be increased by the ratio (as estimated by the Secretary) of—

''(A) the aggregate amount of payments made to the 50 States and the District of Columbia for the fiscal year under title XIX that are attributable to making medical assistance available for individuals described in clauses (i), (iii), (iv), and (v) of section 1902(a)(10)(E) for payment of medicare cost-sharing described in section 1905(p)(3)(A)(iii) and for medicare cost-sharing described in section 1905(p)(3)(B) (but only insofar as it relates to benefits provided under part D of title XVIII); to

''(B) the aggregate amount of total payments made to such States and District for the fiscal year under such title.''.

(g) AMENDMENT TO BEST PRICE.—Section 1927(c)(1)(C)(i) of the Social Security Act (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 a plan under part D of title XVIII with respect to covered outpatient drugs, under a Medicare+Choice plan under part C of such title with respect to such drugs, or by a qualified retiree prescription drug plan (as defined in section 1860J(e)(3)) with respect to such drugs, on behalf of eligible beneficiaries (as defined in section 1860(2).''.

(h) CONFORMING AMENDMENTS.—Section 1933 of the Social Security Act (42 U.S.C. 1396u–3) is amended—

(1) in subsection (a), by striking ''section 1902(a)(10)(E)(iv)'' and inserting ''section 1902(a)(10)(E)(vi)'';

(2) in subsection (c)(2)(A)—

(A) in clause (i), by striking ''section 1902(a)(10)(E)(iv)(I)'' and inserting ''section 1902(a)(10)(E)(vi)(I)''; and

(B) in clause (ii), by striking ''section 1902(a)(10)(E)(iv)(II)'' and inserting ''section 1902(a)(10)(E)(vi)(II)'';

(3) in subsection (d), by striking ''section 1902(a)(10)(E)(iv)'' and inserting ''section 1902(a)(10)(E)(vi)''; and

(4) in subsection (e), by striking ''section 1902(a)(10)(E)(iv)'' and inserting ''section 1902(a)(10)(E)(vi)''.

(i) EFFECTIVE DATE.—The amendments made by this section shall apply for medical assistance provided under section 1902(a)(10)(E) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)) on and after January 1, 2005.

SEC. 205. 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) MODERNIZED BENEFIT PACKAGES FOR MEDICARE SUPPLEMENTAL POLICIES.—

''(1) REVISION OF BENEFIT PACKAGES.—

''(A) IN GENERAL.—Notwithstanding subsection (p), the benefit packages classified as 'H', 'I', and '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)) shall be revised so that—

''(i) the coverage of outpatient prescription drugs available under such benefit packages is replaced with coverage of outpatient prescription drugs that complements but does not duplicate the coverage of outpatient prescription drugs that is otherwise available under this title;

''(ii) the revised benefit packages provide a range of coverage options for outpatient prescription drugs for beneficiaries, but do not provide coverage for more than 90 percent of the cost-sharing amount applicable to an individual under section 1860F(b);

''(iii) uniform language and definitions are used with respect to such revised benefits;

''(iv) uniform format is used in the policy with respect to such revised benefits;

''(v) such revised standards meet any additional requirements imposed by the amendments made by the Medicare Outpatient Prescription Drug Act of 2002; and

''(vi) except as revised under the preceding clauses or as provided under subsection (p)(1)(E), the benefit packages are identical to the benefit packages that were available on the date of enactment of the Medicare Outpatient Prescription Drug Act of 2002.

''(B) MANNER OF REVISION.—The benefit packages revised under this section shall be revised in the manner described in subparagraph (E) of subsection (p)(1), except that for purposes of subparagraph (C) of such subsection, the standards established under this subsection shall take effect not later than January 1, 2005.

''(2) CONSTRUCTION OF BENEFITS IN OTHER MEDICARE SUPPLEMENTAL POLICIES.—Nothing in the benefit packages classified as 'A' through 'G' 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) GUARANTEED ISSUANCE AND RENEWAL OF REVISED POLICIES.—The provisions of subsections (q) and (s), including provisions of subsection (s)(3) (relating to special enrollment periods in cases of termination or disenrollment), shall apply to medicare supplemental policies revised under this subsection in the same manner as such provisions apply to medicare supplemental policies issued under the standards established under subsection (p).

''(4) OPPORTUNITY OF CURRENT POLICYHOLDERS TO PURCHASE REVISED POLICIES.—

''(A) IN GENERAL.—No medicare supplemental policy of an issuer with a benefit package that is revised under paragraph (1) shall be deemed to meet the standards in subsection (c) unless the issuer—

''(i) provides written notice during the 60-day period immediately preceding the period established for the open enrollment period established under section 1860B(b)(2)(A), to each individual who is a policyholder or certificate holder of a medicare supplemental policy issued by that issuer (at the most recent available address of that individual) of the offer described in clause (ii) and of the fact that such individual will no longer be covered under such policy as of January 1, 2005; and

''(ii) offers the policyholder or certificate holder under the terms described in subparagraph (B), during at least the period established under section 1860B(b)(2)(A), a medicare supplemental policy with the benefit package that the Secretary determines is most comparable to the policy in which the individual is enrolled with coverage effective as of the date on which the individual is first entitled to benefits under part D.

''(B) TERMS OF OFFER DESCRIBED.—The terms described in this subparagraph are terms which do not—

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

''(ii) discriminate in the pricing of such policy because of health status, claims experience, receipt of health care, or medical condition; or

''(iii) impose an exclusion of benefits based on a preexisting condition under such policy.

''(5) ELIMINATION OF OBSOLETE POLICIES WITH NO GRANDFATHERING.—No person may sell, issue, or renew a medicare supplemental policy with a benefit package that is classified as 'H', 'I', or 'J' (or with a benefit package classified as 'J' with a high deductible feature) that has not been revised under this subsection on or after January 1, 2005.

''(6) PENALTIES.—Each penalty under this section shall apply with respect to policies revised under this subsection as if such policies were issued under the standards established under subsection (p), including the

penalties under subsections (a), (d), (p)(8), (p)(9), (q)(5), (r)(6)(A), (s)(4), and (t)(2)(D).''.

SEC. 206. COMPREHENSIVE IMMUNOSUPPRESSIVE DRUG COVERAGE FOR TRANSPLANT PATIENTS UNDER PART B.

(a) IN GENERAL.—Section 1861(s)(2)(J) of the Social Security Act (42 U.S.C. 1395x(s)(2)(J)), as amended by section 113(a) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–473), as enacted into law by section 1(a)(6) of Public Law 106–554, is amended by striking '', to an individual who receives'' and all that follows before the semicolon at the end and inserting ''to an individual who has received an organ transplant''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to drugs furnished on or after the date of enactment of this Act.

SEC. 207. HHS STUDY AND REPORT ON UNIFORM PHARMACY BENEFIT CARDS.

(a) STUDIES.—The Secretary of Health and Human Services shall conduct a study to determine the feasibility and advisability of establishing a uniform format for pharmacy benefit cards provided to beneficiaries by eligible entities under the outpatient prescription drug benefit program under part D of title XVIII of the Social Security Act (as added by section 202).

(b) REPORT.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the results of the study conducted under subsection (a) together with any recommendations for legislation that the Secretary determines to be appropriate as a result of such study.

SEC. 208. GAO STUDY AND BIENNIAL REPORTS ON COMPETITION AND SAVINGS.

(a) ONGOING STUDY.—The Comptroller General of the United States shall conduct an ongoing study and analysis of the outpatient prescription drug benefit program under part D of title XVIII of the Social Security Act (as added by section 202), including an analysis of—

(1) the extent to which the competitive bidding process under such program fosters maximum competition and efficiency; and

(2) the savings to the medicare program resulting from such outpatient prescription drug benefit program, including the reduction in the number or length of hospital visits.

(b) INITIAL REPORT ON COMPETITIVE BIDDING PROCESS.—Not later than 9 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the results of the portion of the study conducted pursuant to subsection (a)(1).

(c) BIENNIAL REPORTS.—Not later than January 1, 2006, and biennially thereafter, the Comptroller General of the United States shall submit to Congress a report on the results of the study conducted under subsection (a) together with such recommendations for legislation and administrative action as the Comptroller General determines appropriate.

SEC. 209. EXPANSION OF MEMBERSHIP AND DUTIES OF MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC).

(a) EXPANSION OF MEMBERSHIP.—

(1) IN GENERAL.—Section 1805(c) of the Social Security Act (42 U.S.C. 1395b–6(c)) is amended—

(A) in paragraph (1), by striking ''17'' and inserting ''19''; and

(B) in paragraph (2)(B), by inserting ''experts in the area of pharmacology and prescription drug benefit programs,'' after ''other health professionals,''.

(2) INITIAL TERMS OF ADDITIONAL MEMBERS.—

(A) IN GENERAL.—For purposes of staggering the initial terms of members of the Medicare Payment Advisory Commission under section 1805(c)(3) of the Social Security Act (42 U.S.C. 1395b–6(c)(3)), the initial terms of the 2 additional members of the Commission provided for by the amendment under paragraph (1)(A) are as follows:

(i) One member shall be appointed for 1 year.

(ii) One member shall be appointed for 2 years.

(B) COMMENCEMENT OF TERMS.—Such terms shall begin on January 1, 2004.

(b) EXPANSION OF DUTIES.—Section 1805(b)(2) of the Social Security Act (42 U.S.C. 1395b–6(b)(2)) is amended by adding at the end the following new subparagraph:

''(D) PRESCRIPTION MEDICINE BENEFIT PROGRAM.—Specifically, the Commission shall review, with respect to the outpatient prescription drug benefit program under part D, the impact of such program on—

''(i) the pharmaceutical market, including costs and pricing of pharmaceuticals, beneficiary access to such pharmaceuticals, and trends in research and development;

''(ii) franchise, independent, and rural pharmacies; and

''(iii) beneficiary access to outpatient prescription drugs, including an assessment of out-of-pocket spending, generic and brand name drug utilization, and pharmacists' services.''.

SA 4310. Mr. HATCH (for Mr. GRASSLEY (for himself, Ms. SNOWE, Mr. JEFFORDS, Mr. BREAUX, Mr. HATCH, Ms. COLLINS, Ms. LANDRIEU, Mr. HUTCHINSON, and Mr. DOMENICI)) proposed an amendment to the bill S. 812, to amend the Federal Food, Drug, and Cosmetic Act to provide greater access to affordable pharmaceuticals; as follows:

At the end, add the following:

DIVISION ___—21ST CENTURY MEDICARE ACT

SEC. 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO BIPA; TABLE OF CONTENTS.

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

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) BIPA; SECRETARY.—In this Act:

(1) BIPA.—The term ''BIPA'' means the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 1(a)(6) of Public Law 106–554.

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

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

(a) ESTABLISHMENT.—Title XVIII (42 U.S.C. 1395 et seq.) is amended by redesignating part D as part F and by inserting after part C the following new part:

''PART D—VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

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

''SEC. 1860D. (a) DEFINITIONS.—In this part:

''(1) ADMINISTRATOR.—The term 'Administrator' means the Administrator of the Medicare Competitive Agency as established under section 1860D–25.

''(2) COVERED DRUG.—

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

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.—The term 'covered drug' does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3).

''(ii) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered if payment for such drug is available under part A or B (or under part E for an eligible beneficiary who elects to receive enhanced medicare benefits under that part), but shall be so considered if such payment is not available because benefits under part A or B (or part E, as applicable) have been exhausted.

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

''(4) ELIGIBLE ENTITY.—The term 'eligible entity' means any risk-bearing entity that the Administrator determines to be appropriate to provide eligible beneficiaries with the benefits under a Medicare Prescription Drug plan, including—

''(A) a pharmaceutical benefit management company;

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

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

''(D) another entity; or

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

''(5) INITIAL COVERAGE LIMIT.—The term 'initial coverage limit' means the limit as established under section 1860D–6(c)(3), or, in the case of coverage that is not standard coverage, the comparable limit (if any) established under the coverage.

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

''(7) MEDICARE PRESCRIPTION DRUG PLAN.—The term 'Medicare Prescription Drug plan' means prescription drug coverage that is offered under a policy, contract, or plan—

''(A) by an eligible entity pursuant to, and in accordance with, a contract between the Administrator and the entity under section 1860D–7(b); and

''(B) that has been approved under section 1860D–13.

''(8) PRESCRIPTION DRUG ACCOUNT.—The term 'Prescription Drug Account' means the Prescription Drug Account (as established under section 1860D–26) in the Federal Supplementary Medical Insurance Trust Fund under section 1841.

''(9) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term 'qualified prescription drug coverage' means the coverage described in section 1860D–6(a)(1).

''(10) STANDARD COVERAGE.—The term 'standard coverage' means the coverage described in section 1860D–6(c).

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

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

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

''(3) any reference to a contract under section 1857 included a reference to a contract under section 1860D–7(b); and

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

''Subpart 1—Establishment of Voluntary Prescription Drug Delivery Program

''ESTABLISHMENT OF VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

''SEC. 1860D–1. (a) PROVISION OF BENEFIT.—

''(1) IN GENERAL.—The Administrator shall provide for and administer a voluntary prescription drug delivery program under which each eligible beneficiary enrolled under this part shall be provided with access to qualified prescription drug coverage as follows:

''(A) MEDICARE+CHOICE PLAN.—An eligible beneficiary who is enrolled under this part and enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization shall receive coverage of benefits under this part through such plan if such plan provides qualified prescription drug coverage.

''(B) MEDICARE PRESCRIPTION DRUG PLAN.—An eligible beneficiary who is enrolled under this part but is not enrolled in a Medicare+Choice plan that provides qualified prescription drug coverage shall receive coverage of benefits under this part through enrollment in a Medicare Prescription Drug plan that is offered in the geographic area in which the beneficiary resides.

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

''(3) SCOPE OF BENEFITS.—The program established under this part shall provide for coverage of all therapeutic classes of covered drugs.

''(4) PROGRAM TO BEGIN IN 2005.—The Administrator shall establish the program under this part in a manner so that benefits are first provided for months beginning with January 2005.

''(b) ACCESS TO ALTERNATIVE PRESCRIPTION DRUG COVERAGE.—In the case of an eligible beneficiary who has creditable prescription drug coverage (as defined in section 1860D–2(b)(1)(F)), such beneficiary—

''(1) may continue to receive such coverage and not enroll under this part; and

''(2) pursuant to section 1860D–2(b)(1)(C), is permitted to subsequently enroll under this part without any penalty and obtain access to qualified prescription drug coverage in the manner described in subsection (a) if the beneficiary involuntarily loses such coverage.

''(c) FINANCING.—The costs of providing benefits under this part shall be payable from the Prescription Drug Account.

''ENROLLMENT UNDER PROGRAM

''SEC. 1860D–2. (a) ESTABLISHMENT OF ENROLLMENT PROCESS.—

''(1) PROCESS SIMILAR TO PART B ENROLLMENT.—The Administrator 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. Such process shall be similar to the process for enrollment in part B under section 1837, including the deeming provisions of such section.

''(2) CONDITION OF ENROLLMENT.—An eligible beneficiary must be enrolled under this part in order to be eligible to receive access to qualified prescription drug coverage.

''(b) SPECIAL ENROLLMENT PROCEDURES.—

''(1) LATE ENROLLMENT PENALTY.—

''(A) INCREASE IN PREMIUM.—Subject to the succeeding provisions of this paragraph, in the case of an eligible beneficiary whose coverage period under this part began pursuant to an enrollment after the beneficiary's initial enrollment period under part B (determined pursuant to section 1837(d)) and not pursuant to the open enrollment period described in paragraph (2), the Administrator shall establish procedures for increasing the amount of the monthly beneficiary obligation under section 1860D–17 applicable to

such beneficiary by an amount that the Administrator determines is actuarially sound for each full 12-month period (in the same continuous period of eligibility) in which the eligible beneficiary could have been enrolled under this part but was not so enrolled.

''(B) PERIODS TAKEN INTO ACCOUNT.—For purposes of calculating any 12-month period under subparagraph (A), there shall be taken into account—

''(i) the months which elapsed between the close of the eligible beneficiary's initial enrollment period and the close of the enrollment period in which the beneficiary enrolled; and

''(ii) in the case of an eligible beneficiary who reenrolls under this part, the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which the beneficiary reenrolled.

''(C) PERIODS NOT TAKEN INTO ACCOUNT.—

''(i) IN GENERAL.—For purposes of calculating any 12-month period under subparagraph (A), subject to clauses (ii) and (iii), there shall not be taken into account months for which the eligible beneficiary can demonstrate that the beneficiary had creditable prescription drug coverage (as defined in subparagraph (F)).

''(ii) BENEFICIARY MUST INVOLUNTARILY LOSE COVERAGE.—Clause (i) shall only apply with respect to coverage—

''(I) in the case of coverage described in clause (ii) of subparagraph (F), if the plan terminates, ceases to provide, or reduces the value of the prescription drug coverage under such plan to below the actuarial value of standard coverage (as determined under section 1860D–6(f));

''(II) in the case of coverage described in clause (i), (iii), or (iv) of subparagraph (F), if the beneficiary loses eligibility for such coverage; or

''(III) in the case of a beneficiary with coverage described in clause (v) of subparagraph (F), if the issuer of the policy terminates coverage under the policy.

''(iii) PARTIAL CREDIT FOR CERTAIN MEDIGAP COVERAGE.—In the case of a beneficiary that had creditable prescription drug coverage described in subparagraph (F)(v) that does not provide coverage of the cost of prescription drugs the actuarial value of which (as defined by the Administrator) to the beneficiary equals or exceeds the actuarial value of standard coverage (as determined under section 1860D–6(f)), the Administrator shall determine a percentage of the period in which the beneficiary had such creditable prescription drug coverage that will be taken into account under subparagraph (B) (and not considered to be such creditable prescription drug coverage under clause (i)).

''(D) PERIODS TREATED SEPARATELY.—Any increase in an eligible beneficiary's monthly beneficiary obligation under subparagraph (A) with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which the beneficiary may have.

''(E) CONTINUOUS PERIOD OF ELIGIBILITY.—

''(i) IN GENERAL.—Subject to clause (ii), for purposes of this paragraph, an eligible beneficiary's 'continuous period of eligibility' is the period that begins with the first day on which the beneficiary is eligible to enroll under section 1836 and ends with the beneficiary's death.

''(ii) SEPARATE PERIOD.—Any period during all of which an eligible beneficiary satisfied paragraph (1) of section 1836 and which terminated in or before the month preceding the month in which the beneficiary attained age 65 shall be a separate 'continuous period of eligibility' with respect to the beneficiary (and each such period which terminates shall be deemed not to have existed for purposes of subsequently applying this paragraph).

''(F) CREDITABLE PRESCRIPTION DRUG COVERAGE DEFINED.—For purposes of this part, the term 'creditable prescription drug coverage' means any of the following:

''(i) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care for the Elderly (PACE) under section 1934, through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997), and 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, but only if the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Administrator) to the beneficiary equals or exceeds the actuarial value of standard coverage (as determined under section 1860D–6(f)).

''(ii) PRESCRIPTION DRUG COVERAGE UNDER A GROUP HEALTH PLAN.—Any outpatient prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Program under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan (as defined in section 1860D–20(f)(1)), but only if the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Administrator) to the beneficiary equals or exceeds the actuarial value of standard coverage (as determined under section 1860D–6(f)).

''(iii) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program, but only if the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Administrator) to the beneficiary equals or exceeds the actuarial value of standard coverage (as determined under section 1860D–6(f)).

''(iv) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans, and survivors and dependents of veterans, under chapter 17 of title 38, United States Code, but only if the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Administrator) to the beneficiary equals or exceeds the actuarial value of standard coverage (as determined under section 1860D–6(f)).

''(v) PRESCRIPTION DRUG COVERAGE UNDER MEDIGAP POLICIES.—Subject to subparagraph (C)(iii), 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)).

''(2) OPEN ENROLLMENT PERIOD FOR CURRENT BENEFICIARIES IN WHICH LATE ENROLLMENT PROCEDURES DO NOT APPLY.—In the case of an individual who is an eligible beneficiary as of January 1, 2005, the Administrator shall establish procedures under which such beneficiary may enroll under this part during the open enrollment period without the application of the late enrollment procedures established under paragraph (1)(A). For purposes of the preceding sentence, the open enrollment period shall be the 7-month period that begins on April 1, 2004, and ends on November 30, 2004.

''(3) SPECIAL ENROLLMENT PERIOD FOR BENEFICIARIES WHO INVOLUNTARILY LOSE CREDITABLE PRESCRIPTION DRUG COVERAGE.—

''(A) ESTABLISHMENT.—The Administrator shall establish a special open enrollment period (as described in subparagraph (B)) for an eligible beneficiary that loses creditable prescription drug coverage.

''(B) SPECIAL OPEN ENROLLMENT PERIOD.—The special open enrollment period described in this subparagraph is the 63-day period that begins—

''(i) in the case of a beneficiary with coverage described in clause (ii) of paragraph (1)(F), the date on which the plan terminates, ceases to provide, or substantially reduces (as defined by the Administrator) the value of the prescription drug coverage under such plan;

''(ii) in the case of a beneficiary with coverage described in clause (i), (iii), or (iv) of paragraph (1)(F), the date on which the beneficiary loses eligibility for such coverage; or

''(iii) in the case of a beneficiary with coverage described in clause (v) of paragraph (1)(F), the date on which the issuer of the policy terminates coverage under the policy.

''(c) PERIOD OF COVERAGE.—

''(1) IN GENERAL.—Except as provided in paragraph (2) and subject to paragraph (3), an eligible beneficiary's coverage under the program under this part shall be effective for the period provided in section 1838, as if that section applied to the program under this part.

''(2) OPEN AND SPECIAL ENROLLMENT.—

''(A) OPEN ENROLLMENT.—An eligible beneficiary who enrolls under the program under this part pursuant to subsection (b)(2) shall be entitled to the benefits under this part beginning on January 1, 2005.

''(B) SPECIAL ENROLLMENT.—Subject to paragraph (3), an eligible beneficiary who enrolls under the program under this part pursuant to subsection (b)(3) shall be entitled to the benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

''(3) LIMITATION.—Coverage under this part shall not begin prior to January 1, 2005.

''(d) TERMINATION.—

''(1) IN GENERAL.—The causes of termination specified in section 1838 shall apply to this part in the same manner as such causes apply to part B.

''(2) COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PARTS A OR B.—

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

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

''(3) PROCEDURES REGARDING TERMINATION OF A BENEFICIARY UNDER A PLAN.—The Administrator shall establish procedures for determining the status of an eligible beneficiary's enrollment under this part if the beneficiary's enrollment in a Medicare Prescription Drug plan offered by an eligible entity under this part is terminated by the entity for cause (pursuant to procedures established by the Administrator under section 1860D–3(a)(1)).

''ELECTION OF A MEDICARE PRESCRIPTION DRUG PLAN

''SEC. 1860D–3. (a) IN GENERAL.—

''(1) PROCESS.—

''(A) ELECTION.—

''(i) IN GENERAL.—The Administrator shall establish a process through which an eligible beneficiary who is enrolled under this part but not enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization that provides qualified prescription drug coverage—

''(I) shall make an election to enroll in any Medicare Prescription Drug plan that is offered by an eligible entity and that serves the geographic area in which the beneficiary resides; and

''(II) may make an annual election to change the election under this clause.

''(ii) CLARIFICATION REGARDING ENROLLMENT.—The process established under clause (i) shall include, in the case of an eligible beneficiary who is enrolled under this part but who has failed to make an election of a Medicare Prescription Drug plan in an area, for the enrollment in the Medicare Prescription Drug plan with the lowest monthly premium that is available in the area.

''(B) REQUIREMENTS FOR PROCESS.—In establishing the process under subparagraph (A), the Administrator shall—

''(i) use rules similar to the rules for enrollment, disenrollment, and termination of enrollment with a Medicare+Choice plan under section 1851, including—

''(I) the establishment of special election periods under subsection (e)(4) of such section; and

''(II) the application of the guaranteed issue and renewal provisions of section 1851(g) (other than clause (i) and the second sentence of clause (ii) of paragraph (3)(C), relating to default enrollment); and

''(ii) coordinate enrollments, disenrollments, and terminations of enrollment under part C with enrollments, disenrollments, and terminations of enrollment under this part.

''(2) FIRST ENROLLMENT PERIOD FOR PLAN ENROLLMENT.—The process developed under paragraph (1) shall ensure that eligible beneficiaries who enroll under this part during the open enrollment period under section 1860D–2(b)(2) are permitted to elect an eligible entity prior to January 1, 2005, in order to ensure that coverage under this part is effective as of such date.

''(b) ENROLLMENT IN A MEDICARE+CHOICE PLAN.—

''(1) IN GENERAL.—An eligible beneficiary who is enrolled under this part and enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization that provides qualified prescription drug coverage shall receive access to such coverage under this part through such plan.

''(2) RULES.—Enrollment in a Medicare+Choice plan is subject to the rules for enrollment in such plan under section 1851.

''PROVIDING INFORMATION TO BENEFICIARIES

''SEC. 1860D–4. (a) ACTIVITIES.—

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

''(2) SPECIAL RULE FOR FIRST ENROLLMENT UNDER THE PROGRAM.—The activities described in paragraph (1) shall ensure that eligible beneficiaries are provided with such information at least 30 days prior to the first enrollment period described in section 1860D–3(a)(2).

''(b) REQUIREMENTS.—

''(1) IN GENERAL.—The activities described in subsection (a) shall—

''(A) be similar to the activities performed by the Administrator under section 1851(d);

''(B) be coordinated with the activities performed by—

''(i) the Administrator under such section; and

''(ii) the Secretary under section 1804; and

''(C) provide for the dissemination of information comparing the plans offered by eligible entities under this part that are available to eligible beneficiaries residing in an area.

''(2) COMPARATIVE INFORMATION.—The comparative information described in paragraph (1)(C) shall include a comparison of the following:

''(A) BENEFITS.—The benefits provided under the plan and the formularies and appeals processes under the plan.

''(B) QUALITY AND PERFORMANCE.—To the extent available, the quality and performance of the eligible entity offering the plan.

''(C) BENEFICIARY COST-SHARING.—The cost-sharing required of eligible beneficiaries under the plan.

''(D) CONSUMER SATISFACTION SURVEYS.—To the extent available, the results of consumer satisfaction surveys regarding the plan and the eligible entity offering such plan.

''(E) ADDITIONAL INFORMATION.—Such additional information as the Administrator may prescribe.

''BENEFICIARY PROTECTIONS

''SEC. 1860D–5. (a) DISSEMINATION OF INFORMATION.—

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

''(A) Access to covered drugs, including access through pharmacy networks.

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

''(C) Copayments, coinsurance, and deductible requirements.

''(D) Grievance and appeals procedures.

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

''(3) RESPONSE TO BENEFICIARY QUESTIONS.—An eligible entity offering a Medicare Prescription Drug plan shall have a mechanism for providing specific information to enrollees upon request, including information on the coverage of specific drugs and changes in its formulary on a timely basis.

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

''(5) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—The provisions of section 1851(h) shall apply to marketing material and application forms under this part in the same manner as such provisions apply to marketing material and application forms under part C.

''(b) ACCESS TO COVERED DRUGS.—

''(1) ACCESS TO NEGOTIATED PRICES FOR PRESCRIPTION DRUGS.—An eligible entity offering a Medicare Prescription Drug plan shall issue such a card (or other technology) that may be used by an enrolled beneficiary to assure access to negotiated prices under section 1860D–6(e) for the purchase of prescription drugs for which coverage is not otherwise provided under the Medicare Prescription Drug plan.

''(2) ASSURING PHARMACY ACCESS.—

''(A) IN GENERAL.—An eligible entity offering a Medicare Prescription Drug 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 Administrator and including adequate emergency access) for enrolled beneficiaries, in accordance with standards established under section 1860D–7(f) that ensure such convenient access. Such standards shall take into account reasonable distances to pharmacy services in both urban and rural areas.

''(B) USE OF POINT-OF-SERVICE SYSTEM.—An eligible entity offering a Medicare Prescription Drug 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) the plan may charge beneficiaries through adjustments in copayments any additional costs associated with the point-of-service option.

The additional copayments so charged shall not count toward the application of section 1860D–6(c).

''(3) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If an eligible entity offering a Medicare Prescription Drug plan uses a formulary, the following requirements must be met:

''(A) 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 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 a practicing physician or a practicing pharmacist (or both).

''(B) 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.

''(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).

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

''(E) 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.

''(F) APPEALS AND EXCEPTIONS TO APPLICATION.—The eligible entity must have, as part of the appeals process under subsection (e)(3), a process for timely appeals for denials of coverage based on such application of the formulary.

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

''(1) IN GENERAL.—An eligible entity shall have in place the following with respect to covered drugs:

''(A) A cost-effective drug utilization management program, including incentives to reduce costs when appropriate.

''(B) Quality assurance measures to reduce medical errors and adverse drug interactions, which—

''(i) shall include a medication therapy management program described in paragraph (2); and

''(ii) may include beneficiary education programs, counseling, medication refill reminders, and special packaging.

''(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 is designed to assure, 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 plan are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

''(B) 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.

''(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.—The eligible entity offering a Medicare Prescription Drug 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.

''(3) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—The eligible entity offering a Medicare Prescription Drug plan shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered 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.

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

''(e) COVERAGE DETERMINATIONS, RECONSIDERATIONS, AND APPEALS.—

''(1) IN GENERAL.—An eligible entity shall meet the requirements of section 1852(g) with respect to covered benefits under the Medicare Prescription Drug plan it offers under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

''(2) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a Medicare Prescription Drug plan offered by an eligible entity that provides for tiered cost-sharing for covered 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.

''(3) APPEALS OF FORMULARY DETERMINATIONS.—

''(A) IN GENERAL.—Subject to subparagraph (B), consistent with the requirements of section 1852(g), an eligible entity shall establish a process for individuals to appeal formulary determinations.

''(B) FORMULARY DETERMINATIONS.—An individual who is enrolled in a Medicare Prescription Drug plan offered by an eligible entity may appeal to obtain coverage for a covered 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.

''(f) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—An eligible entity shall meet the requirements of section 1852(h) with respect to enrollees under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to enrollees under part C.

''(g) UNIFORM PREMIUM.—An eligible entity shall ensure that the monthly premium for a Medicare Prescription Drug plan charged under this part is the same for all eligible beneficiaries enrolled in the plan.

''PRESCRIPTION DRUG BENEFITS

''SEC. 1860D–6. (a) REQUIREMENTS.—

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

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

''(B) ACTUARIALLY EQUIVALENT COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Coverage of covered drugs which meets the alternative coverage requirements of subsection (d) and access to negotiated prices under subsection (e), but only if it is approved by the Administrator, as provided under subsection (d).

''(2) PERMITTING ADDITIONAL PRESCRIPTION DRUG COVERAGE.—

''(A) IN GENERAL.—Subject to subparagraph (B) and section 1860D–13(c)(2), nothing in this part shall be construed as preventing qualified prescription drug coverage from including coverage of covered drugs that exceeds the coverage required under paragraph (1).

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

''(3) COST CONTROL MECHANISMS.—In providing qualified prescription drug coverage, the entity offering the Medicare Prescription Drug plan or the Medicare+Choice plan may use cost control mechanisms that are customarily used in employer-sponsored health care plans that offer coverage for prescription drugs, including the use of formularies, tiered copayments, selective contracting with providers of prescription drugs, and mail order pharmacies.

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

''(c) STANDARD COVERAGE.—For purposes of this part and part C, the term 'standard coverage' means coverage of covered drugs that meets the following requirements:

''(1) DEDUCTIBLE.—

''(A) IN GENERAL.—The coverage has an annual deductible—

''(i) for 2005, that is equal to $250; or

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

''(B) ROUNDING.—Any amount determined under subparagraph (A)(ii) that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

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

''(3) INITIAL COVERAGE LIMIT.—

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

''(i) for 2005, that is equal to $3,450; or

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

''(B) ROUNDING.—Any amount determined under subparagraph (A)(ii) that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

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

''(A) IN GENERAL.—Notwithstanding paragraph (3), the coverage provides benefits with cost-sharing that is equal to 10 percent after the individual has incurred costs (as described in subparagraph (C)) for covered drugs in a year equal to the annual out-of-pocket limit specified in subparagraph (B).

''(B) ANNUAL OUT-OF-POCKET LIMIT.—

''(i) IN GENERAL.—For purposes of this part, the 'annual out-of-pocket limit' specified in this subparagraph—

''(I) for 2005, is equal to $3,700; or

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

''(ii) ROUNDING.—Any amount determined under clause (i)(II) that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

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

''(i) incurred costs shall only include costs incurred for the annual deductible (described in paragraph (1)), cost-sharing (described in paragraph (2)), and amounts for which benefits are not provided because of the application of the initial coverage limit described in paragraph (3); and

''(ii) such costs shall be treated as incurred only if they are paid by the individual (or by another individual, such as a family member, on behalf of the individual), under section 1860D–19, or under title XIX and the individual (or other individual) is not reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement for such costs.

''(5) ANNUAL PERCENTAGE INCREASE.—For purposes of this part, the annual percentage increase specified in this paragraph for a year is equal to the annual percentage increase in average per capita aggregate expenditures for covered drugs in the United States for beneficiaries under this title, as determined by the Administrator for the 12-month period ending in July of the previous year.

''(d) ALTERNATIVE COVERAGE REQUIREMENTS.—A Medicare Prescription Drug plan

or Medicare+Choice plan may provide a different prescription drug benefit design from the standard coverage described in subsection (c) so long as the Administrator determines (based on an actuarial analysis by the Administrator) that the following requirements are met and the plan applies for, and receives, the approval of the Administrator for such benefit design:

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

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

''(B) ASSURING EQUIVALENT UNSUBSIDIZED VALUE OF COVERAGE.—The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard coverage. For purposes of this subparagraph, the unsubsidized value of coverage is the amount by which the actuarial value of the coverage (as determined under subsection (f)) exceeds the actuarial value of the amounts associated with the application of section 1860D–17(c) and reinsurance payments under section 1860D–20 with respect to such coverage.

''(C) ASSURING STANDARD PAYMENT FOR COSTS AT INITIAL COVERAGE LIMIT.—The coverage is designed, based upon an actuarially representative pattern of utilization (as determined under subsection (f)), to provide for the payment, with respect to costs incurred that are equal to the sum of the deductible under subsection (c)(1) and the initial coverage limit under subsection (c)(3), of an amount equal to at least such initial coverage limit multiplied by the percentage specified in subsection (c)(2).

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

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

''(e) ACCESS TO NEGOTIATED PRICES.—

''(1) ACCESS.—

''(A) IN GENERAL.—Under qualified prescription drug coverage offered by an eligible entity or a Medicare+Choice organization, the entity or organization shall provide beneficiaries with access to negotiated prices (including applicable discounts) used for payment for covered drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of the deductible, any cost-sharing, or an initial coverage limit (described in subsection (c)(3)).

''(B) MEDICAID RELATED PROVISIONS.—Insofar as a State elects to provide medical assistance under title XIX for a drug based on the prices negotiated under a Medicare Prescription Drug plan under this part, the requirements of section 1927 shall not apply to such drugs. The prices negotiated under a Medicare Prescription Drug plan with respect to covered drugs, under a Medicare+Choice plan with respect to such drugs, or under a qualified retiree prescription drug plan (as defined in section 1860D–20(f)(1)) with respect to such drugs, on behalf of eligible beneficiaries, 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) CARDS OR OTHER TECHNOLOGY.—In providing the access under paragraph (1), the eligible entity or Medicare+Choice organization shall issue a card or use other technology pursuant to section 1860D–5(b)(1).

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

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

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

''(i) an actuarial valuation of standard coverage and of the reinsurance payments under section 1860D–20;

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

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

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

''(2) USE OF OUTSIDE ACTUARIES.—Under the processes under paragraph (1)(A), eligible entities and Medicare+Choice organizations may use actuarial opinions certified by independent, qualified actuaries to establish actuarial values, but the Administrator shall determine whether such actuarial values meet the requirements under subsection (c)(1).

''REQUIREMENTS FOR ENTITIES OFFERING MEDICARE PRESCRIPTION DRUG PLANS; ESTABLISHMENT OF STANDARDS

''SEC. 1860D–7. (a) GENERAL REQUIREMENTS.—An eligible entity offering a Medicare Prescription Drug plan shall meet the following requirements:

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

''(2) ASSUMPTION OF FINANCIAL RISK.—

''(A) IN GENERAL.—Subject to subparagraph (B) and section 1860D–20, the entity assumes financial risk on a prospective basis for the benefits that it offers under a Medicare Prescription Drug plan and that is not covered under such section or section 1860D–16.

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

''(3) SOLVENCY FOR UNLICENSED ENTITIES.—In the case of an eligible entity that is not described in paragraph (1) and for which a waiver has been approved under subsection (c), such entity shall meet solvency standards established by the Administrator under subsection (d).

''(b) CONTRACT REQUIREMENTS.—The Administrator shall not permit an eligible beneficiary to elect a Medicare Prescription Drug plan offered by an eligible entity under this part, and the entity shall not be eligible for payments under section 1860D–16 or 1860D–20, unless the Administrator has entered into a contract under this subsection with the entity with respect to the offering of such plan. Such a contract with an entity may cover more than 1 Medicare Prescription Drug plan. Such contract shall provide that the entity agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

''(c) WAIVER OF CERTAIN REQUIREMENTS IN ORDER TO ENSURE BENEFICIARY CHOICE.—

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

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

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

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

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

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

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

''(1) ESTABLISHMENT AND PUBLICATION.—The Administrator, in consultation with the National Association of Insurance Commissioners, shall establish and publish, by not later than January 1, 2004, financial solvency and capital adequacy standards for entities described in paragraph (2).

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

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

''(f) OTHER STANDARDS.—The Administrator shall establish by regulation other standards (not described in subsection (d)) for eligible entities and Medicare Prescription Drug plans consistent with, and to carry out, this part. The Administrator shall publish such regulations by January 1, 2004.

''(g) PERIODIC REVIEW AND REVISION OF STANDARDS.—The Administrator shall periodically review the standards established under this section and, based on such review, may revise such standards if the Administrator determines such revision to be appropriate.

''(h) RELATION TO STATE LAWS.—

''(1) IN GENERAL.—The standards established under this part shall supersede any State law or regulation (including standards described in paragraph (2)) with respect to Medicare Prescription Drug plans which are offered by eligible entities under this part—

''(A) to the extent such law or regulation is inconsistent with such standards; and

''(B) in the same manner as such laws and regulations are superseded under section 1856(b)(3).

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

''(A) Benefit requirements.

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

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

''(3) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to—

''(A) premiums paid to the Administrator for Medicare Prescription Drug plans under this part; or

''(B) any payments made by the Administrator under this part to an eligible entity offering such a plan.

''Subpart 2—Prescription Drug Delivery System

''ESTABLISHMENT OF SERVICE AREAS

''SEC. 1860D–10. (a) ESTABLISHMENT.—

''(1) INITIAL ESTABLISHMENT.—Not later than April 15, 2004, the Administrator shall establish and publish the service areas in which Medicare Prescription Drug plans may offer benefits under this part.

''(2) PERIODIC REVIEW AND REVISION OF SERVICE AREAS.—The Administrator shall periodically review the service areas applicable under this section and, based on such review, may revise such service areas if the Administrator determines such revision to be appropriate.

''(b) REQUIREMENTS FOR ESTABLISHMENT OF SERVICE AREAS.—

''(1) IN GENERAL.—The Administrator shall establish the service areas under subsection (a) in a manner that—

''(A) maximizes the availability of Medicare Prescription Drug plans to eligible beneficiaries; and

''(B) minimizes the ability of eligible entities offering such plans to favorably select eligible beneficiaries.

''(2) SERVICE AREA MAY NOT BE SMALLER THAN A STATE.—A service area established under subsection (a) may not be smaller than a State.

''PUBLICATION OF RISK ADJUSTERS

''SEC. 1860D–11. (a) PUBLICATION.—Not later than April 15 of each year (beginning in 2004), the Administrator shall publish the risk adjusters established under subsection (b) to be used in computing—

''(1) under section 1860D–16(a) the amount of payment to Medicare Prescription Drug plans in the subsequent year; and

''(2) under section 1853(k)(2) the amount of payment to Medicare+Choice organizations that offer qualified prescription drug coverage in the subsequent year.

''(b) ESTABLISHMENT OF RISK ADJUSTERS.—

''(1) IN GENERAL.—Subject to paragraph (2), the Administrator shall establish an appropriate methodology for adjusting the amount of payment to Medicare Prescription Drug plans computed under section 1860D–16(a) to take into account, in a budget neutral manner, variation in costs based on the differences in actuarial risk of different enrollees being served.

''(2) CONSIDERATIONS.—In establishing the methodology under paragraph (1), the Administrator may take into account the similar methodologies used under section 1853(a)(3) to adjust payments to Medicare+Choice organizations (with respect to enhanced medicare benefits under part E).

''SUBMISSION OF BIDS FOR PROPOSED MEDICARE PRESCRIPTION DRUG PLANS

''SEC. 1860D–12. (a) IN GENERAL.—Each eligible entity that intends to offer a Medicare Prescription Drug plan in a year (beginning with 2005) shall submit to the Administrator, at such time and in such manner as the Administrator may specify, such information as the Administrator may require, including the information described in subsection (b).

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

''(1) A description of the benefits under the plan (as required under section 1860D–6).

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

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

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

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

''(C) the reduction in such bid and premium resulting from the payments associated with section 1860D–16(c) and payments provided under section 1860D–20.

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

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

''(c) OPTIONS REGARDING SERVICE AREAS.—

''(1) IN GENERAL.—The service area of a Medicare Prescription Drug plan shall be either—

''(A) the entire area of 1 of the service areas established by the Administrator under section 1860D–10; or

''(B) the entire area covered by the medicare program.

''(2) RULE OF CONSTRUCTION.—Nothing in this part shall be construed as prohibiting an eligible entity from submitting separate bids in multiple service areas as long as each bid is for a single service area.

''APPROVAL OF PROPOSED MEDICARE PRESCRIPTION DRUG PLANS

''SEC. 1860D–13. (a) IN GENERAL.—The Administrator shall review the information filed under section 1860D–12 and shall approve or disapprove the Medicare Prescription Drug plan. The Administrator may not approve a plan if—

''(1) the plan and the entity offering the plan comply with the requirements under this part; and

''(2) the premium accurately reflects both (A) the actuarial value of the benefits provided, and (B) the payments associated with the application of 186D–16(c) and the payments under section 1860D–20 for the standard benefit.

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

''(c) SPECIAL RULES FOR APPROVAL.—The Administrator may approve a Medicare Prescription Drug plan submitted under section 1860D–12 only if the benefits under such plan—

''(1) include the required benefits under section 1860D–6(a)(1); and

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

''(d) ASSURING ACCESS.—

''(1) NUMBER OF CONTRACTS.—The Administrator shall, consistent with the requirements of this part and the goal of containing costs under this title, approve at least 2 contracts to offer a Medicare Prescription Drug plan in an area.

''(2) GUARANTEEING ACCESS TO COVERAGE.—In order to assure access under paragraph (1) in an area and consistent with paragraph (3), the Administrator may provide financial incentives (including partial underwriting of risk) for an eligible entity to offer a Medicare Prescription Drug plan in that area, but only so long as (and to the extent) necessary to assure the access guaranteed under paragraph (1) in that area.

''(3) LIMITATION ON AUTHORITY.—In exercising authority under this subsection, the Administrator—

''(A) shall not provide for the full underwriting of financial risk for any eligible entity;

''(B) shall not provide for any underwriting of financial risk for a public eligible entity with respect to the offering of a nationwide prescription drug plan; and

''(C) shall seek to maximize the assumption of financial risk by an eligible entity.

''(4) REPORTS.—The Administrator shall, in each annual report to Congress under section 1860D–25(c)(1)(D), include information on the exercise of authority under this subsection. The Administrator also shall include such recommendations as may be appropriate to limit the exercise of such authority, including minimizing the assumption of financial risk.

''(e) ANNUAL CONTRACTS.—A contract approved under this part shall be for a 1-year period.

''COMPUTATION OF MONTHLY STANDARD COVERAGE PREMIUMS

''SEC. 1860D–14. (a) IN GENERAL.—For each year (beginning with 2005), the Administrator shall compute a monthly standard coverage premium for each Medicare Prescription Drug plan approved under section 1860D–13.

''(b) REQUIREMENTS.—The monthly standard coverage premium for a Medicare Prescription Drug plan for a year shall be equal to—

''(1) in the case of a plan offered by an eligible entity that provides standard coverage or an actuarially equivalent coverage and does not provide additional prescription drug coverage pursuant to section 1860D–6(a)(2), the monthly premium approved for the plan under section 1860D–13 for the year; and

''(2) in the case of a plan offered by an eligible entity that provides additional prescription drug coverage pursuant to section 1860D–6(a)(2)—

''(A) an amount that reflects only the actuarial value of the standard coverage offered under the plan; or

''(B) if determined appropriate by the Administrator, the monthly premium approved under section 1860D–13 for the year for the Medicare Prescription Drug plan that (as required under subparagraph (B) of such section)—

''(i) is offered by such entity in the same area as the plan; and

''(ii) does not provide additional prescription drug coverage pursuant to such section.

''COMPUTATION OF MONTHLY NATIONAL AVERAGE PREMIUM

''SEC. 1860D–15. (a) COMPUTATION.—

''(1) IN GENERAL.—For each year (beginning with 2005) the Administrator shall compute a monthly national average premium equal to the average of the monthly standard coverage premium for each Medicare Prescription Drug plan (as computed under section 1860D–14).

''(2) WEIGHTED AVERAGE.—The monthly national average premium computed under paragraph (1) shall be a weighted average, with the weight for each plan being equal to the average number of beneficiaries enrolled under such plan in the previous year.

''(b) SPECIAL RULE FOR 2005.—For purposes of applying this section for 2005, the Administrator shall establish procedures for determining the weighted average under subsection (a)(2) for 2004.

''PAYMENTS TO ELIGIBLE ENTITIES OFFERING MEDICARE PRESCRIPTION DRUG PLANS

''SEC. 1860D–16. (a) PAYMENT OF PREMIUMS.—For each year (beginning with 2005), the Administrator shall pay to each entity offering a Medicare Prescription Drug plan in which an eligible beneficiary is enrolled an amount equal to the full amount of the monthly premium approved for the plan under section 1860D–13 on behalf of each eligible beneficiary enrolled in such plan for the year, as adjusted using the risk adjusters that apply to the standard coverage published under section 1860D–11.

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

''(c) PAYMENTS TO MEDICARE+CHOICE PLANS.—For provisions related to payments to Medicare+Choice organizations offering Medicare+Choice plans that provide qualified prescription drug coverage, see section 1853(k)(2).

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

''COMPUTATION OF BENEFICIARY OBLIGATION

''SEC. 1860D–17. (a) BENEFICIARIES ENROLLED IN A MEDICARE PRESCRIPTION DRUG PLAN.—In the case of an eligible beneficiary enrolled under this part and in a Medicare Prescription Drug plan, the monthly beneficiary obligation for enrollment in such plan in a year shall be determined as follows:

''(1) MEDICARE PRESCRIPTION DRUG PLAN PREMIUMS EQUAL TO THE MONTHLY NATIONAL AVERAGE.—If the amount of the monthly premium approved by the Administrator under section 1860D–13 for a Medicare Prescription Drug plan for the year is equal to the monthly national average premium (as computed under section 1860D–15) for the year, the monthly obligation of the eligible beneficiary in that year shall be an amount equal to the applicable percent (as defined in subsection (c)) of the amount of the monthly national average premium.

''(2) MEDICARE PRESCRIPTION DRUG PLAN PREMIUMS THAT ARE LESS THAN THE MONTHLY NATIONAL AVERAGE.—If the amount of the monthly premium approved by the Administrator under section 1860D–13 for the Medicare Prescription Drug plan for the year is less than the monthly national average premium (as computed under section 1860D–15) for the year, the monthly obligation of the eligible beneficiary in that year shall be an amount equal to—

''(A) the applicable percent of the amount of the monthly national average premium; minus

''(B) the amount by which the monthly national average premium exceeds the amount of the premium approved by the Administrator for the plan.

''(3) MEDICARE PRESCRIPTION DRUG PLAN PREMIUMS THAT ARE GREATER THAN THE MONTHLY NATIONAL AVERAGE.—If the amount of the monthly premium approved by the Administrator under section 1860D–13 for a Medicare Prescription Drug plan for the year exceeds the monthly national average premium (as computed under section 1860D–15) for the year, the monthly obligation of the eligible beneficiary in that year shall be an amount equal to the sum of—

''(A) the applicable percent of the amount of the monthly national average premium; plus

''(B) the amount by which the premium approved by the Administrator for the plan exceeds the amount of the monthly national average premium.

''(b) BENEFICIARIES ENROLLED IN A MEDICARE+CHOICE PLAN.—In the case of an eligible beneficiary that is receiving qualified prescription drug coverage under a Medicare+Choice plan, the monthly obligation for such coverage shall be determined pursuant to section 1853(k)(3).

''(c) APPLICABLE PERCENT DEFINED.—For purposes of this section, except as provided in section 1860D–19 (relating to premium subsidies for low-income individuals), the term 'applicable percent' means 55 percent.

''COLLECTION OF BENEFICIARY OBLIGATION

''SEC. 1860D–18. (a) COLLECTION OF AMOUNT IN SAME MANNER AS PART B PREMIUM.—The amount of the monthly beneficiary obligation (determined under section 1860D–17) applicable to an eligible beneficiary under this part (after application of any increase under section 1860D–2(b)(1)(A)) shall be collected and credited to the Prescription Drug Account in the same manner as the monthly premium determined under section 1839 is collected and credited to the Federal Supplementary Medical Insurance Trust Fund under section 1840.

''(b) INFORMATION NECESSARY FOR COLLECTION.—In order to carry out subsection (a), the Administrator shall transmit to the Commissioner of Social Security—

''(1) at the beginning of each year, the name, social security account number, and annual beneficiary obligation owed by each individual enrolled in a Medicare Prescription Drug plan for each month during the year; and

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

''(c) COLLECTION FOR BENEFICIARIES RECEIVING QUALIFIED PRESCRIPTION DRUG COVERAGE UNDER A MEDICARE+CHOICE PLAN.—For provisions related to the collection of the monthly beneficiary obligation for qualified prescription drug coverage under a Medicare+Choice plan, see section 1853(k)(4).

''PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS

''SEC. 1860D–19. (a) IN GENERAL.—

''(1) FULL PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR INDIVIDUALS WITH INCOME BELOW 135 PERCENT OF FEDERAL POVERTY LINE.—In the case of a subsidy-eligible individual (as defined in paragraph (3)) who is determined to have income that does not exceed 135 percent of the Federal poverty line—

''(A) section 1860D–17 shall be applied—

''(i) in subsection (c), by substituting '0 percent' for '55 percent'; and

''(ii) in subparagraphs (A) and (B) of subsection (a)(3), by substituting ''the amount of the premium for the Medicare Prescription Drug plan with the lowest monthly premium in the area that the beneficiary resides'' for ''the amount of the monthly national average premium'', but only if there is no Medicare Prescription Drug plan offered in the area in which the individual resides that has a monthly premium for the year that is equal to or less than the monthly national average premium (as computed under section 1860D–15) for the year;

''(B) the annual deductible applicable under section 1860D–6(c)(1) in a year shall be reduced to an amount equal to 5 percent of the annual deductible otherwise applicable under such section for that year;

''(C) section 1860D–6(c)(2) shall be applied by substituting '2.5 percent' for '50 percent' each place it appears;

''(D) such individual shall be responsible for cost-sharing for the cost of any covered drug provided in the year (after the individual has reached such initial coverage limit and before the individual has reached the limitation under section 1860D–6(c)(4)(A)), that is equal to 50 percent; and

''(E) section 1860D–6(c)(4)(A) shall be applied by substituting '0 percent' for '10 percent'.

In no case may the application of subparagraph (A) result in a monthly beneficiary obligation that is below zero.

''(2) SLIDING SCALE PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR INDIVIDUALS WITH INCOME BETWEEN 135 AND 150 PERCENT OF FEDERAL POVERTY LINE.—

''(A) IN GENERAL.—In the case of a subsidy-eligible individual who is determined to have income that exceeds 135 percent, but is less than 150 percent, of the Federal poverty line—

''(i) section 1860D–17 shall be applied—

''(I) in subsection (c), by substituting 'subsidy percent' for '55 percent'; and

''(II) in subparagraphs (A) and (B) of subsection (a)(3), by substituting ''the amount of the premium for the Medicare Prescription Drug plan with the lowest monthly premium in the area that the beneficiary resides'' for ''the amount of the monthly national average premium'', but only if there is no Medicare Prescription Drug plan offered in the area in which the individual resides that has a monthly premium for the year that is equal to or less than the monthly national average premium (as computed under section 1860D–15) for the year; and

''(ii) such individual shall be responsible for cost-sharing for the cost of any covered drug provided in the year (after the individual has reached such initial coverage limit and before the individual has reached the limitation under section 1860D–6(c)(4)(A)), that is equal to 50 percent.

In no case may the application of clause (i) result in a monthly beneficiary obligation that is below zero.

''(B) SUBSIDY PERCENT DEFINED.—For purposes of subparagraph (A)(i), the term 'subsidy percent' means a percent determined on a linear sliding scale ranging from 0 percent for individuals with incomes at 135 percent of such level to 55 percent for individuals with incomes at 150 percent of such level.

''(3) DETERMINATION OF ELIGIBILITY.—

''(A) SUBSIDY-ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, subject to subparagraph (D), the term 'subsidy-eligible individual' means an individual who—

''(i) is enrolled under this part, including an individual receiving qualified prescription drug coverage under a Medicare+Choice plan;

''(ii) has income that is less that 150 percent of the Federal poverty line; and

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

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

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

''(i) income shall be determined in the manner described in section 1905(p)(1)(B); and

''(ii) the term 'Federal poverty line' means the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

''(D) TREATMENT OF TERRITORIAL RESIDENTS.—In the case of an individual who is not a resident of the 50 States or the District of Columbia, the individual is not eligible to be a subsidy-eligible individual but may be eligible for financial assistance with prescription drug expenses under section 1935(e).

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

''(1) ADDITIONAL BENEFITS.—In applying subparagraphs (B) and (C) of subsection (a)(1) and clauses (ii) and (iii) of subsection (a)(2)(A), nothing in this part shall be construed as preventing an eligible entity offering a Medicare Prescription Drug plan or a Medicare+Choice organization offering a Medicare+Choice plan in which qualified

drug coverage is provided from waiving or reducing the amount of the deductible or other cost-sharing otherwise applicable pursuant to section 1860D–6(a)(2).

''(2) LIMITATION ON CHARGES.—In the case of an individual receiving cost-sharing subsidies under subparagraphs (B) and (C) of subsection (a)(1) or under clauses (ii) and (iii) of subsection (a)(2)(A), the eligible entity offering a Medicare Prescription Drug plan or the Medicare+Choice organization offering a Medicare+Choice plan in which qualified drug coverage is provided may not charge more than the deductible or other cost-sharing required pursuant to such subsection.

''(c) ADMINISTRATION OF SUBSIDY PROGRAM.—The Administrator shall provide a process whereby, in the case of an individual eligible for a cost-sharing under subparagraphs (B) and (C) of subsection (a)(1) or under clauses (ii) and (iii) of subsection (a)(2)(A) and who is enrolled in a Medicare Prescription Drug plan or is enrolled in a Medicare+Choice plan under which qualified prescription drug coverage is provided—

''(1) the Administrator provides for a notification of the eligible entity or Medicare+Choice organization involved that the individual is eligible for a cost-sharing subsidy and the amount of the subsidy under such subsection;

''(2) the entity or organization involved reduces the cost-sharing otherwise imposed by the amount of the applicable subsidy and submits to the Administrator information on the amount of such reduction; and

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

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

''(d) RELATION TO MEDICAID PROGRAM.—

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

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

''REINSURANCE PAYMENTS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE

''SEC. 1860D–20. (a) REINSURANCE PAYMENTS.—

''(1) IN GENERAL.—The Administrator shall provide in accordance with this section for payment to a qualifying entity (as defined in subsection (b)) of the reinsurance payment amount (as defined in subsection (c)), which in the aggregate is 30 percent of the total payments made by a qualifying entity for standard coverage under the respective plan, for excess costs incurred in providing qualified prescription drug coverage for qualifying covered individuals (as defined in subsection (g)(1)).

''(2) BUDGET AUTHORITY.—This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Administrator to provide for the payment of amounts provided under this section.

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

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

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

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

''(c) REINSURANCE PAYMENT AMOUNT.—

''(1) IN GENERAL.—Subject to subsection (d)(2), the reinsurance payment amount under this subsection for a qualifying covered individual for a coverage year (as defined in subsection (g)(2)) is equal to the sum of the following:

''(A) For the portion of the individual's gross covered drug costs (as defined in paragraph (3)) for the year that exceeds the amount specified in paragraph (2), but does not exceed the initial coverage limit, an amount equal to 50 percent of the allowable costs (as defined in paragraph (3)) attributable to such gross covered drug costs.

''(B) For the portion of the individual's gross covered drug costs for the year that exceeds the annual out-of-pocket threshold specified in section 1860D–6(c)(4)(B), an amount equal to 80 percent of the allowable costs attributable to such gross covered drug costs.

''(2) AMOUNT SPECIFIED.—The amount specified under this paragraph—

''(A) for 2005, is equal to $2,000; and

''(B) for a subsequent year, is equal to the amount specified in this paragraph for the previous year, increased by the annual percentage increase described in section 1860D–6(c)(5).

''(3) ALLOWABLE COSTS.—For purposes of this section, the term 'allowable costs' means, with respect to gross covered drug costs (as defined in paragraph (4)) under a plan described in subsection (b) offered by a qualifying entity, the part of such costs that are actually paid (net of average percentage rebates) under the plan, but in no case more than the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were standard coverage.

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

''(d) ADJUSTMENT OF REINSURANCE PAYMENTS TO ASSURE 30 PERCENT LEVEL OF PAYMENT.—

''(1) ESTIMATION OF PAYMENTS.—The Administrator shall estimate—

''(A) the total payments to be made (without regard to this subsection) during a year under subsections (a) and (c); and

''(B) the total payments to be made by qualifying entities for standard coverage under plans described in subsection (b) during the year.

''(2) ADJUSTMENT.—The Administrator shall proportionally adjust the payments made under subsections (a) and (c) for a coverage year in such manner so that the total of the payments made under such subsections for the year is equal to 30 percent of the total payments described in subparagraph (A)(ii).

''(e) PAYMENT METHODS.—

''(1) IN GENERAL.—Payments under this section shall be based on such a method as the Administrator determines. The Administrator may establish a payment method by which interim payments of amounts under this section are made during a year based on the Administrator's best estimate of amounts that will be payable after obtaining all of the information.

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

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

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

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

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

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

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

''(B) was eligible for, but was not enrolled in, the program under this part.

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

''(A) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage of health care costs for individuals (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

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

''(g) GENERAL DEFINITIONS.—For purposes of this section:

''(1) QUALIFYING COVERED INDIVIDUAL.—The term 'qualifying covered individual' means an individual who—

''(A) is enrolled in this part and in a Medicare Prescription Drug plan;

''(B) is enrolled in this part and in a Medicare+Choice plan that provides qualified prescription drug coverage; or

''(C) is eligible for, but not enrolled in, the program under this part, and is covered under a qualified retiree prescription drug plan.

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

''Subpart 3—Medicare Competitive Agency; Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund

''ESTABLISHMENT OF MEDICARE COMPETITIVE AGENCY

''SEC. 1860D–25. (a) ESTABLISHMENT.—By not later than March 1, 2003, the Secretary shall establish within the Department of Health and Human Services an agency to be known as the Medicare Competitive Agency.

''(b) ADMINISTRATOR AND DEPUTY ADMINISTRATOR.—

''(1) ADMINISTRATOR.—

''(A) IN GENERAL.—The Medicare Competitive Agency shall be headed by an Administrator (in this section referred to as the 'Administrator') who shall be appointed by the

President, by and with the advice and consent of the Senate. The Administrator shall report directly to the Secretary.

''(B) COMPENSATION.—The Administrator shall be paid at the rate of basic pay payable for level III of the Executive Schedule under section 5314 of title 5, United States Code.

''(C) TERM OF OFFICE.—The Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of an Administrator's term of office, that Administrator may continue in office until the entry upon office of such a successor. An Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(D) GENERAL AUTHORITY.—The Administrator shall be responsible for the exercise of all powers and the discharge of all duties of the Administration, and shall have authority and control over all personnel and activities thereof.

''(E) RULEMAKING AUTHORITY.—The Administrator may prescribe such rules and regulations as the Administrator determines necessary or appropriate to carry out the functions of the Administration. The regulations prescribed by the Administrator shall be subject to the rulemaking procedures established under section 553 of title 5, United States Code.

''(F) AUTHORITY TO ESTABLISH ORGANIZATIONAL UNITS.—The Administrator may establish, alter, consolidate, or discontinue such organizational units or components within the Administration as the Administrator considers necessary or appropriate, except that this subparagraph shall not apply with respect to any unit, component, or provision provided for by this section.

''(G) AUTHORITY TO DELEGATE.—The Administrator may assign duties, and delegate, or authorize successive redelegations of, authority to act and to render decisions, to such officers and employees of the Administration as the Administrator may find necessary. Within the limitations of such delegations, redelegations, or assignments, all official acts and decisions of such officers and employees shall have the same force and effect as though performed or rendered by the Administrator.

''(2) DEPUTY ADMINISTRATOR.—

''(A) IN GENERAL.—There shall be a Deputy Administrator of the Medicare Competitive Agency who shall be appointed by the President, by and with the advice and consent of the Senate.

''(B) COMPENSATION.—The Deputy Administrator shall be paid at the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(C) TERM OF OFFICE.—The Deputy Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of a Deputy Administrator's term of office, such Deputy Administrator may continue in office until the entry upon office of such a successor. A Deputy Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(D) DUTIES.—The Deputy Administrator shall perform such duties and exercise such powers as the Administrator shall from time to time assign or delegate. The Deputy Administrator shall be Acting Administrator of the Administration during the absence or disability of the Administrator and, unless the President designates another officer of the Government as Acting Administrator, in the event of a vacancy in the office of the Administrator.

''(3) SECRETARIAL COORDINATION OF PROGRAM ADMINISTRATION.—The Secretary shall ensure appropriate coordination between the Administrator and the Administrator of the Centers for Medicare & Medicaid Services in carrying out the programs under this title.

''(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

''(1) DUTIES.—

''(A) GENERAL DUTIES.—The Administrator shall carry out parts C and D, including—

''(i) negotiating, entering into, and enforcing, contracts with plans for the offering of Medicare+Choice plans under part C, including the offering of qualified prescription drug coverage under such plans; and

''(ii) negotiating, entering into, and enforcing, contracts with eligible entities for the offering of Medicare Prescription Drug plans under part D.

''(B) OTHER DUTIES.—The Administrator shall carry out any duty provided for under part C or D, including demonstration projects carried out in part or in whole under such parts, the programs of all-inclusive care for the elderly (PACE program) under section 1894, the social health maintenance organization (SHMO) demonstration projects (referred to in section 4104(c) of the Balanced Budget Act of 1997), and through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of an 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) NONINTERFERENCE.—In carrying out its duties with respect to the provision of qualified prescription drug coverage to beneficiaries under this title, the Administrator may not—

''(i) require a particular formulary or institute a price structure for the reimbursement of covered drugs;

''(ii) interfere in any way with negotiations between eligible entities and Medicare+Choice organizations and drug manufacturers, wholesalers, or other suppliers of covered drugs; and

''(iii) otherwise interfere with the competitive nature of providing such qualified prescription drug coverage through such entities and organizations.

''(D) ANNUAL REPORTS.—Not later than March 31 of each year, the Administrator shall submit to Congress and the President a report on the administration of the voluntary prescription drug delivery program under this part during the previous fiscal year.

''(2) STAFF.—

''(A) IN GENERAL.—The Administrator, with the approval of the Secretary, may employ, without regard to chapter 31 of title 5, United States Code, other than sections 3110 and 3112, such officers and employees as are necessary to administer the activities to be carried out through the Medicare Competitive Agency. The Administrator shall employ staff with appropriate and necessary expertise in negotiating contracts in the private sector.

''(B) FLEXIBILITY WITH RESPECT TO COMPENSATION.—

''(i) IN GENERAL.—The staff of the Medicare Competitive Agency shall, subject to clause (ii), be paid without regard to the provisions of chapter 51 (other than section 5101) and chapter 53 (other than section 5301) 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.

''(C) LIMITATION ON FULL-TIME EQUIVALENT STAFFING FOR CURRENT CMS FUNCTIONS BEING TRANSFERRED.—The Administrator may not employ under this paragraph a number of full-time equivalent employees, to carry out functions that were previously conducted by the Centers for Medicare & Medicaid Services and that are conducted by the Administrator by reason of this section, that exceeds the number of such full-time equivalent employees authorized to be employed by the Centers for Medicare & Medicaid Services to conduct such functions as of the date of enactment of this Act.

''(3) REDELEGATION OF CERTAIN FUNCTIONS OF THE CENTERS FOR MEDICARE AND MEDICAID SERVICES.—

''(A) IN GENERAL.—The Secretary, the Administrator, and the Administrator of the Centers for Medicare & Medicaid Services shall establish an appropriate transition of responsibility in order to redelegate the administration of part C from the Secretary and the Administrator of the Centers for Medicare & Medicaid Services to the Administrator as is appropriate to carry out the purposes of this section.

''(B) TRANSFER OF DATA AND INFORMATION.—The Secretary shall ensure that the Administrator of the Centers for Medicare & Medicaid Services transfers to the Administrator such information and data in the possession of the Administrator of the Centers for Medicare & Medicaid Services as the Administrator requires to carry out the duties described in paragraph (1).

''(C) CONSTRUCTION.—Insofar as a responsibility of the Secretary or the Administrator of the Centers for Medicare & Medicaid Services is redelegated to the Administrator under this section, any reference to the Secretary or the Administrator of the Centers for Medicare & Medicaid Services in this title or title XI with respect to such responsibility is deemed to be a reference to the Administrator.

''(d) OFFICE OF BENEFICIARY ASSISTANCE.—

''(1) ESTABLISHMENT.—The Secretary shall establish within the Medicare Competitive Agency an Office of Beneficiary Assistance to carry out functions relating to medicare beneficiaries under this title, including making determinations of eligibility of individuals for benefits under this title, providing for enrollment of medicare beneficiaries under this title, and the functions described in paragraph (2). The Office shall be a separate operating division within the Administration.

''(2) DISSEMINATION OF INFORMATION ON BENEFITS AND APPEALS RIGHTS.—

''(A) DISSEMINATION OF BENEFITS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries, by mail, by posting on the Internet site of the Medicare Competitive Agency, and through the toll-free telephone number provided for under section 1804(b), information with respect to the following:

''(i) Benefits, and limitations on payment (including cost-sharing, stop-loss provisions, and formulary restrictions) under parts C and D.

''(ii) Benefits, and limitations on payment under parts A, B, and E, including information on medicare supplemental policies under section 1882.

Such information shall be presented in a manner so that medicare beneficiaries may compare benefits under parts A, B, D, and E, and medicare supplemental policies with benefits under Medicare+Choice plans under part C.

''(B) DISSEMINATION OF APPEALS RIGHTS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries in the manner provided under subparagraph (A) a description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original

medicare fee-for-service program under parts A and B (including beneficiaries who elect to receive enhanced medicare benefits under part E), the Medicare+Choice program under part C, and the voluntary prescription drug delivery program under part D.

''(3) MEDICARE OMBUDSMAN.—

''(A) IN GENERAL.—Within the Office of Beneficiary Assistance, there shall be a Medicare Ombudsman, appointed by the Secretary from among individuals with expertise and experience in the fields of health care and advocacy, to carry out the duties described in subparagraph (B).

''(B) DUTIES.—The Medicare Ombudsman shall—

''(i) receive complaints, grievances, and requests for information submitted by a medicare beneficiary, with respect to any aspect of the medicare program;

''(ii) provide assistance with respect to complaints, grievances, and requests referred to in clause (i), including—

''(I) assistance in collecting relevant information for such beneficiaries, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, Medicare+Choice organization, an eligible entity under part D, or the Secretary; and

''(II) assistance to such beneficiaries with any problems arising from disenrollment from a Medicare+Choice plan under part C or a prescription drug plan under part D; and

''(iii) submit annual reports to Congress, the Secretary, and the Medicare Competitive Policy Advisory Board describing the activities of the Office, and including such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.

''(C) COORDINATION WITH STATE OMBUDSMAN PROGRAMS AND CONSUMER ORGANIZATIONS.—The Medicare Ombudsman shall, to the extent appropriate, coordinate with State medical Ombudsman programs, and with State- and community-based consumer organizations, to—

''(i) provide information about the medicare program; and

''(ii) conduct outreach to educate medicare beneficiaries with respect to manners in which problems under the medicare program may be resolved or avoided.

''(e) MEDICARE COMPETITIVE POLICY ADVISORY BOARD.—

''(1) ESTABLISHMENT.—There is established within the Medicare Competitive Agency the Medicare Competitive Policy Advisory Board (in this section referred to as the 'Board'). The Board shall advise, consult with, and make recommendations to the Administrator with respect to the administration of parts C and D, including the review of payment policies under such parts.

''(2) REPORTS.—

''(A) IN GENERAL.—With respect to matters of the administration of parts C and D, the Board shall submit to Congress and to the Administrator 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 such parts, including the stability and solvency of the programs under such parts and the topics described in subparagraph (B). Each such report shall be published in the Federal Register.

''(B) TOPICS DESCRIBED.—Reports required under subparagraph (A) may include the following topics:

''(i) FOSTERING COMPETITION.—Recommendations or proposals to increase competition under parts C and D for services furnished to medicare beneficiaries.

''(ii) EDUCATION AND ENROLLMENT.—Recommendations for the improvement of efforts to provide medicare beneficiaries information and education on the program under this title, and specifically parts C and D, and the program for enrollment under the title.

''(iii) QUALITY.—Recommendations on ways to improve the quality of benefits provided under plans under parts C and D.

''(iv) DISEASE MANAGEMENT PROGRAMS.—Recommendations on the incorporation of disease management programs under parts C and D.

''(v) RURAL ACCESS.—Recommendations to improve competition and access to plans under parts C and D in rural areas.

''(C) 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.

''(3) DUTY OF ADMINISTRATOR.—With respect to any report submitted by the Board under paragraph (2)(A), not later than 90 days after the report is submitted, the Administrator shall submit to Congress and the President an analysis of recommendations made by the Board in such report. Each such analysis shall be published in the Federal Register.

''(4) MEMBERSHIP.—

''(A) APPOINTMENT.—Subject to the succeeding provisions of this paragraph, the Board shall consist of 7 members to be appointed as follows:

''(i) Three members shall be appointed by the President.

''(ii) Two members shall be appointed by the Speaker of the House of Representatives, with the advice of the chairman and the ranking minority member of the Committees on Ways and Means and on Energy and Commerce of the House of Representatives.

''(iii) Two members 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.

''(B) 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 and experience in health care benefits management, exceptionally qualified to perform the duties of members of the Board.

''(C) PROHIBITION ON INCLUSION OF FEDERAL EMPLOYEES.—No officer or employee of the United States may serve as a member of the Board.

''(5) COMPENSATION.—Members of the Board shall receive, for each day (including travel time) they are engaged in the performance of the functions of the Board, compensation at rates not to exceed the daily equivalent to the annual rate in effect for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(6) TERMS OF OFFICE.—

''(A) IN GENERAL.—The term of office of members of the Board shall be 3 years.

''(B) TERMS OF INITIAL APPOINTEES.—As designated by the President at the time of appointment, of the members first appointed—

''(i) one shall be appointed for a term of 1 year;

''(ii) three shall be appointed for terms of 2 years; and

''(iii) three shall be appointed for terms of 3 years.

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

''(D) VACANCY.—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.

''(7) CHAIR.—The Chair of the Board shall be elected by the members. The term of office of the Chair shall be 3 years.

''(8) MEETINGS.—The Board shall meet at the call of the Chair, but in no event less than 3 times during each fiscal year.

''(9) DIRECTOR AND STAFF.—

''(A) APPOINTMENT OF DIRECTOR.—The Board shall have a Director who shall be appointed by the Chair.

''(B) IN GENERAL.—With the approval of the Board, the Director may appoint, without regard to chapter 31 of title 5, United States Code, such additional personnel as the Director considers appropriate.

''(C) FLEXIBILITY WITH RESPECT TO COMPENSATION.—

''(i) IN GENERAL.—The Director and staff of the Board shall, subject to clause (ii), be paid without regard to the provisions of chapter 51 and chapter 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.

''(D) ASSISTANCE FROM THE ADMINISTRATOR.—The Administrator shall make available to the Board such information and other assistance as it may require to carry out its functions.

''(10) CONTRACT AUTHORITY.—The Board may contract with and compensate government and private agencies or persons to carry out its duties under this subsection, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

''(f) FUNDING.—There is authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (including the Prescription Drug Account), such sums as are necessary to carry out this section.

''PRESCRIPTION DRUG ACCOUNT IN THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

''SEC. 1860D–26. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1841 an account to be known as the 'Prescription Drug Account' (in this section referred to as the 'Account').

''(2) FUNDS.—The Account shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, the Account as provided in this part.

''(3) SEPARATE FROM REST OF TRUST FUND.—Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund.

''(b) PAYMENTS FROM ACCOUNT.—

''(1) IN GENERAL.—The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary certifies are necessary to make payments to operate the program under this part, including payments to eligible entities under section 1860D–16, payments under 1860D–19 for low-income subsidy payments for cost-sharing, reinsurance payments under section 1860D–20, and payments with respect to administrative expenses under this part in accordance with section 201(g).

''(2) TRANSFER TO PARTS A AND B TRUST FUNDS FOR MEDICARE+CHOICE PAYMENTS.—The Managing Trustee shall establish procedures

for the transfer of funds from the Account, in an amount determined appropriate by the Secretary, to the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in order to reimburse such trust funds for payments to Medicare+Choice organizations for the provision of qualified prescription drug coverage pursuant to section 1853(k).

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

''(4) TREATMENT IN RELATION TO PART B PREMIUM.—Amounts payable from the Account shall not be taken into account in computing actuarial rates or premium amounts under section 1839.

''(c) DEPOSITS INTO ACCOUNT.—

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

''(2) APPROPRIATIONS TO COVER BENEFITS AND ADMINISTRATIVE COSTS.—There are appropriated to the Account in a fiscal year, out of any moneys in the Treasury not otherwise appropriated, an amount equal to the amount by which—

''(A) the payments and transfers made from the Account under subsection (b) in the year; exceed

''(B) the premiums collected under section 1860D–18 and 1853(k)(4) (for beneficiaries receiving qualified prescription drug coverage under a Medicare+Choice plan).''.

(b) CONFORMING AMENDMENTS TO FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—Section 1841 (42 U.S.C. 1395t) is amended—

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

(A) by striking ''and'' before ''such amounts''; and

(B) by inserting before the period the following: '', and such amounts as may be deposited in, or appropriated to, the Prescription Drug Account established by section 1860D–26'';

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

(3) in subsection (h), by inserting after ''1840(d)'' the following: ''and section 1860D–18 (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund)''; and

(4) in subsection (i), by inserting after ''section 1840(b)(1)'' the following: '', section 1860D–18 (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund),''.

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

SEC. 102. STUDY AND REPORT ON PERMITTING PART B ONLY INDIVIDUALS TO ENROLL IN MEDICARE VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM.

(a) STUDY.—The Administrator of the Medicare Competitive Agency (as established under section 1860D–25 of the Social Security Act (as added by section 301(a))) shall conduct a study on the need for rules relating to permitting individuals who are enrolled under part B of title XVIII of the Social Security Act but are not entitled to benefits under part A of such title to buy into the medicare voluntary prescription drug delivery program under part D of such title (as so added).

(b) REPORT.—Not later than January 1, 2004, the Administrator of the Medicare Competitive Agency shall submit a report to Congress on the study conducted under subsection (a), together with any recommendations for legislation that the Administrator determines to be appropriate as a result of such study.

SEC. 103. ADDITIONAL REQUIREMENTS FOR ANNUAL FINANCIAL REPORT AND OVERSIGHT ON MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

''(l) COMBINED REPORT ON OPERATION AND STATUS OF THE TRUST FUND AND THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (INCLUDING THE PRESCRIPTION DRUG ACCOUNT).—In addition to the duty of the Board of Trustees to report to Congress under subsection (b), on the date the Board submits the report required under subsection (b)(2), the Board shall submit to Congress a report on the operation and status of the Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under section 1841, including the Prescription Drug Account within such Trust Fund, (in this subsection referred to as the 'Trust Funds'). Such report shall include the following information:

''(1) OVERALL SPENDING FROM THE GENERAL FUND OF THE TREASURY.—A statement of total amounts obligated during the preceding fiscal year from the General Revenues of the Treasury to the Trust Funds, separately stated in terms of the total amount and in terms of the percentage such amount bears to all other amounts obligated from such General Revenues during such fiscal year, for each of the following amounts:

''(A) MEDICARE BENEFITS.—The amount expended for payment of benefits covered under this title.

''(B) ADMINISTRATIVE AND OTHER EXPENSES.—The amount expended for payments not related to the benefits described in subparagraph (A).

''(2) HISTORICAL OVERVIEW OF SPENDING.—From the date of the inception of the program of insurance under this title through the fiscal year involved, a statement of the total amounts referred to in paragraph (1), separately stated for the amounts described in subparagraphs (A) and (B) of such paragraph.

''(3) 10-YEAR AND 50-YEAR PROJECTIONS.—An estimate of total amounts referred to in paragraph (1), separately stated for the amounts described in subparagraphs (A) and (B) of such paragraph, required to be obligated for payment for benefits covered under this title for each of the 10 fiscal years succeeding the fiscal year involved and for the 50-year period beginning with the succeeding fiscal year.

''(4) RELATION TO OTHER MEASURES OF GROWTH.—A comparison of the rate of growth of the total amounts referred to in paragraph (1), separately stated for the amounts described in subparagraphs (A) and (B) of such paragraph, to the rate of growth for the same period in—

''(A) the gross domestic product;

''(B) health insurance costs in the private sector;

''(C) employment-based health insurance costs in the public and private sectors; and

''(D) other areas as determined appropriate by the Board of Trustees.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to fiscal years beginning on or after the date of enactment of this Act.

(c) CONGRESSIONAL HEARINGS.—It is the sense of Congress that the committees of jurisdiction of Congress shall hold hearings on the reports submitted under section 1817(l) of the Social Security Act (as added by subsection (a)).

SEC. 104. REFERENCE TO MEDIGAP PROVISIONS.

For provisions related to medicare supplemental policies under section 1882 of the Social Security Act (42 U.S.C. 1395ss), see section 202.

SEC. 105. MEDICAID AMENDMENTS.

(a) DETERMINATIONS OF ELIGIBILITY FOR LOW-INCOME SUBSIDIES.—

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

(A) in subsection (a)—

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

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

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

''(66) provide for making eligibility determinations under section 1935(a).''.

(2) NEW SECTION.—Title XIX (42 U.S.C. 1396 et seq.) is 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 PRESCRIPTION DRUG BENEFIT

''SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGIBILITY DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—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—

''(1) make determinations of eligibility for premium and cost-sharing subsidies under (and in accordance with) section 1860D–19;

''(2) inform the Administrator of the Medicare Competitive Agency of such determinations in cases in which such eligibility is established; and

''(3) otherwise provide such Administrator with such information as may be required to carry out part D of title XVIII (including section 1860D–19).

''(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:

''(A) For expenditures attributable to costs incurred during 2005, the otherwise applicable Federal matching rate shall be increased by 20 percent of the percentage otherwise payable (but for this subsection) by the State.

''(B) For expenditures attributable to costs incurred during 2006, the otherwise applicable Federal matching rate shall be increased by 40 percent of the percentage otherwise payable (but for this subsection) by the State.

''(C) For expenditures attributable to costs incurred during 2007, the otherwise applicable Federal matching rate shall be increased by 60 percent of the percentage otherwise payable (but for this subsection) by the State.

''(D) For expenditures attributable to costs incurred during 2008, the otherwise applicable Federal matching rate shall be increased by 80 percent of the percentage otherwise payable (but for this subsection) by the State.

''(E) For expenditures attributable to costs incurred after 2008, 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 similar eligibility determinations.''.

(b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID RESPONSIBILITY FOR PREMIUM AND COST-SHARING SUBSIDIES 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 added 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 for a calendar quarter in a year (beginning with 2005) the amount computed under this subsection is equal to the product of the following:

''(A) STANDARD PRESCRIPTION DRUG COVERAGE UNDER MEDICARE.—With respect to 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)—

''(i) the total amount of payments made (or not collected from the individuals) in the quarter under section 1860D–19 (relating to premium and cost-sharing prescription drug subsidies for low-income medicare beneficiaries) that are attributable to such individuals; and

''(ii) the actuarial value of standard coverage (as determined under section 1860D–6(f)) provided for all such individuals.

''(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.

''(C) PHASE-OUT PROPORTION.—The phase-out proportion (as defined in paragraph (2)) for the quarter.

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

''(A) 2005 is 90 percent;

''(B) 2006 is 80 percent;

''(C) 2007 is 70 percent;

''(D) 2008 is 60 percent; or

''(E) a year after 2008 is 50 percent.''.

(c) MEDICAID PROVIDING WRAP-AROUND BENEFITS.—Section 1935, as added by subsection (a)(2) and amended by subsection (b)(2), is 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 enrolled under part D of title XVIII and entitled to medical assistance for prescribed drugs under this title, medical assistance shall continue to be provided under this title for prescribed drugs to the extent payment is not made under the Medicare Prescription Drug plan or the Medicare+Choice plan selected by the individual to receive part D benefits.

''(2) CONDITION.—A State may require, as a condition for the receipt of medical assistance under this title with respect to prescription drug benefits for an individual eligible to enroll in part D, that the individual elect to enroll under such part.''.

(d) TREATMENT OF TERRITORIES.—

(1) IN GENERAL.—Section 1935, as added by subsection (a)(2) and amended by subsections (b)(2) and (c), is 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 drugs (as defined in section 1860D(a)(2)) 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) 2005, is equal to $20,000,000; or

''(ii) a subsequent year, is equal to the aggregate amount specified in this subparagraph for the previous year increased by the annual percentage increase specified in section 1860D–6(c)(5) 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(f) (42 U.S.C. 1308(f)) is amended by inserting ''and section 1935(e)(1)(B)'' after ''Subject to subsection (g)''.

(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 a Medicare Prescription Drug plan under part D of title XVIII with respect to covered drugs, under a Medicare+Choice plan under part C of such title with respect to such drugs, or under a qualified retiree prescription drug plan (as defined in section 1860D–20(f)(1)) with respect to such drugs, on behalf of eligible beneficiaries (as defined in section 1860D(a)(3).''.

SEC. 106. EXPANSION OF MEMBERSHIP AND DUTIES OF MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC).

(a) EXPANSION OF MEMBERSHIP.—

(1) IN GENERAL.—Section 1805(c) (42 U.S.C. 1395b–6(c)) is amended—

(A) in paragraph (1), by striking ''17'' and inserting ''19''; and

(B) in paragraph (2)(B), by inserting ''experts in the area of pharmacology and prescription drug benefit programs,'' after ''other health professionals,''.

(2) INITIAL TERMS OF ADDITIONAL MEMBERS.—

(A) IN GENERAL.—For purposes of staggering the initial terms of members of the Medicare Payment Advisory Commission under section 1805(c)(3) of the Social Security Act (42 U.S.C. 1395b–6(c)(3)), the initial terms of the 2 additional members of the Commission provided for by the amendment under paragraph (1)(A) are as follows:

(i) One member shall be appointed for 1 year.

(ii) One member shall be appointed for 2 years.

(B) COMMENCEMENT OF TERMS.—Such terms shall begin on January 1, 2004.

(b) EXPANSION OF DUTIES.—Section 1805(b)(2) (42 U.S.C. 1395b–6(b)(2)) is amended by adding at the end the following new subparagraph:

''(D) VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM.—Specifically, the Commission shall review, with respect to the voluntary prescription drug delivery program under part D, competition among eligible entities offering Medicare Prescription Drug plans and beneficiary access to such plans and covered drugs, particularly in rural areas.''.

SEC. 107. MISCELLANEOUS ADMINISTRATIVE PROVISIONS.

(a) ADMINISTRATOR AS MEMBER OF THE BOARD OF TRUSTEES OF THE MEDICARE TRUST FUNDS.—Sections 1817(b) and 1841(b) (42 U.S.C. 1395i(b), 1395t(b)) are each amended by striking ''and the Secretary of Health and Human Services, all ex officio,'' and inserting ''the Secretary of Health and Human Services, and the Administrator of the Medicare Competitive Agency, all ex officio,''.

(b) INCREASE IN GRADE TO EXECUTIVE LEVEL III FOR THE ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

(1) IN GENERAL.—Section 5314 of title 5, United States Code, is amended by adding at the end the following:

''Administrator of the Centers for Medicare & Medicaid Services.''.

(2) CONFORMING AMENDMENT.—Section 5315 of such title is amended by striking ''Administrator of the Health Care Financing Administration.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection take effect on March 1, 2003.

TITLE II—OPTION FOR ENHANCED MEDICARE BENEFITS

SEC. 201. OPTION FOR ENHANCED MEDICARE BENEFITS.

(a) ESTABLISHMENT.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 101, is amended by inserting after part D the following new part:

''PART E—ENHANCED MEDICARE BENEFITS

''ENTITLEMENT TO ELECT TO RECEIVE ENHANCED MEDICARE BENEFITS

''SEC. 1860E–1. (a) IN GENERAL.—The Secretary shall establish procedures under which each eligible beneficiary shall be entitled to elect to receive enhanced medicare benefits under this part instead of the benefits under parts A and B.

''(b) ENHANCED MEDICARE BENEFITS TO BE AVAILABLE IN 2005.—The Secretary shall establish the procedures under subsection (a) in a manner such that enhanced medicare benefits are first provided for months beginning with January 2005.

''(c) PRESERVATION OF ORIGINAL MEDICARE FEE-FOR-SERVICE BENEFITS.—Nothing in this part shall be construed to limit the right of

an individual who is entitled to benefits under part A or enrolled under part B to receive benefits under such part if an election to receive enhanced medicare benefits under this part is not in effect with respect to such individual.

''SCOPE OF ENHANCED MEDICARE BENEFITS

''SEC. 1860E–2. (a) IN GENERAL.—Except for the modifications described in the succeeding provisions of this section, enhanced medicare benefits shall be identical to the benefits that are available under parts A and B.

''(b) UNIFIED DEDUCTIBLE.—

''(1) IN GENERAL.—In the case of an eligible beneficiary who has elected to receive enhanced medicare benefits under this part—

''(A) the amount otherwise payable under part A and the total amount of expenses incurred by an eligible beneficiary during a year which would (except for this section) constitute incurred expenses from which benefits payable under section 1833(a) are determinable, shall be reduced under sections 1813(b) and 1833(b) by the amount of the unified deductible under paragraph (2); and

''(B) the eligible beneficiary shall be responsible for the payment of such amount.

''(2) AMOUNT OF UNIFIED DEDUCTIBLE.—

''(A) IN GENERAL.—The amount of the unified deductible under this subsection shall be—

''(i) for 2005, $300; or

''(ii) for a subsequent year, the amount specified in this subparagraph for the preceding year increased by the percentage increase in the per capita actuarial value of benefits under parts A and B for such subsequent year.

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

''(3) APPLICATION.—The unified deductible under this subsection for a year shall be applied—

''(A) with respect to benefits under part A, on the basis of the amount that is payable for such benefits without regard to any other copayments or coinsurance and before the application of any such copayments or coinsurance;

''(B) with respect to benefits under part B, on the basis of the total amount of the expenses incurred by an eligible beneficiary during a year which would, except for the application of the deductible, constitute incurred expenses from which benefits payable under section 1833(a) are determinable, without regard to any other copayments or coinsurance and before the application of any such copayments or coinsurance; and

''(C) instead of the deductibles described in sections 1813(b) and 1833(b).

''(c) SERIOUS ILLNESS PROTECTION.—

''(1) IN GENERAL.—In the case of an eligible beneficiary who has elected to receive enhanced medicare benefits under this part, if the amount of the out-of-pocket cost-sharing of such beneficiary for a calendar year equals or exceeds the serious illness protection threshold for that year—

''(A) the beneficiary shall not be responsible for additional out-of-pocket cost-sharing incurred during that year; and

''(B) the Secretary shall establish procedures under which the Secretary shall pay on behalf of the beneficiary the amount of the additional out-of-pocket cost-sharing described in subparagraph (A) from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, in such proportion as the Secretary determines appropriate.

''(2) SERIOUS ILLNESS PROTECTION THRESHOLD.—

''(A) IN GENERAL.—The amount of the serious illness protection threshold under this subsection shall be—

''(i) for 2005, $6,000; or

''(ii) for a subsequent year, the amount specified in this subparagraph for the preceding year increased by the percentage increase in the per capita actuarial value of benefits under parts A and B for such subsequent year.

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

''(3) OUT-OF-POCKET COST-SHARING DEFINED.—In this subsection, the term 'out-of-pocket cost-sharing' means, with respect to an eligible beneficiary, the amount of costs incurred by the beneficiary that are attributable to deductibles, coinsurance, and copayments imposed under part A or B (as modified by this part), without regard to whether the beneficiary or another person, including a State program or other third-party coverage, has paid for such costs.

''(d) ENHANCED HOSPITAL BENEFITS.—

''(1) ELIMINATION OF DURATIONAL LIMITS ON INPATIENT HOSPITAL SERVICES.—In the case of an eligible beneficiary who has elected to receive enhanced medicare benefits under this part—

''(A) there shall be no spell of illness limit or lifetime limit on inpatient hospital services under subsections (a)(1) and (b)(1) of section 1812 during the period in which the election of the beneficiary to receive enhanced medicare benefits under this part is in effect; and

''(B) section 1812(c) shall not be applied during such period.

''(2) REVISION OF INPATIENT HOSPITAL COINSURANCE.—

''(A) IN GENERAL.—In the case of an eligible beneficiary who has elected to receive enhanced medicare benefits under this part, after the application of the unified deductible under subsection (b), instead of imposing any coinsurance under the second sentence of section 1813(a)(1), the amount payable under part A for inpatient hospital services or inpatient critical access hospital services furnished to the eligible beneficiary during any year, shall be reduced by the amount of the inpatient hospital copayment specified in subparagraph (B) for each period of hospitalization and the beneficiary shall be responsible for payment of such amount for each such period.

''(B) AMOUNT OF INPATIENT HOSPITAL COPAYMENT.—

''(i) IN GENERAL.—The amount of the inpatient hospital copayment under this paragraph shall be—

''(I) for 2005, $400; or

''(II) for a subsequent year, the amount specified in this clause for the preceding year increased by the percentage increase in the per capita actuarial value of benefits under parts A and B for such subsequent year.

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

''(C) PERIOD OF HOSPITALIZATION DEFINED.—In this subsection, the term 'period of hospitalization' means the period that begins on the date that the eligible beneficiary is admitted to the hospital and ends on the date on which the beneficiary has not been hospitalized for a 72-hour period.

''(D) COLLECTION OF COPAYMENTS.—For purposes of section 1866(a)(2)(A), hospitals shall substitute the imposition of the inpatient hospital copayment under this paragraph for the hospital coinsurance described in the second sentence of section 1813(a)(1).

''(e) ELIMINATION OF COST-SHARING FOR PREVENTIVE HEALTH CARE ITEMS AND SERVICES.—

''(1) IN GENERAL.—In the case of an eligible beneficiary who has elected to receive enhanced medicare benefits under this part, the unified deductible under subsection (b) and deductibles and the coinsurance otherwise applicable under subsections (a) and (b) of section 1833 shall not be applied with respect to expenses incurred for any preventive health care items and services (and no charges may be imposed under section 1866(a)(2) where such deductibles and coinsurance are not imposed).

''(2) PREVENTIVE HEALTH CARE ITEMS AND SERVICES DEFINED.—In this subsection, the term 'preventive health care items and services' means any of the following health care items and services:

''(A) Screening mammography under section 1861(s)(13).

''(B) Screening pap smear and screening pelvic examinations under section 1861(s)(14).

''(C) Bone mass measurement under section 1861(s)(15).

''(D) Prostate cancer screening tests under section 1861(s)(2)(P).

''(E) Colorectal cancer screening under section 1861(s)(2)(R).

''(F) Blood testing strips, lancets, and blood glucose monitors for individuals with diabetes under section 1861(n).

''(G) Diabetes outpatient self-management training services under section 1861(s)(2)(S).

''(H) Pneumococcal, influenza, and hepatitis B vaccines and administration under section 1861(s)(10).

''(I) Screening for glaucoma under section 1861(s)(2)(U).

''(J) Medical nutrition therapy services under section 1861(s)(2)(V).

''(f) SIMPLIFICATION OF COST-SHARING.—In the case of an eligible beneficiary who has elected to receive enhanced medicare benefits under this part, the following cost-sharing rules shall apply:

''(1) MODIFICATION OF SKILLED NURSING FACILITY COST-SHARING.—Instead of the coinsurance established under section 1813(b) for extended care services, under section 1888(e)—

''(A) the payment amount under paragraph (1)(B) of such section shall be equal to the amount otherwise provided minus the amount described in subparagraph (B); and

''(B) the eligible beneficiary shall be responsible for a copayment amount for each of the 100 days of care for which payment is made on behalf of an eligible beneficiary under that section equal to—

''(i) for 2005, $60; and

''(ii) for a subsequent year, the amount specified in this subparagraph for the preceding year increased by the percentage increase in the per capita actuarial value of benefits under parts A and B for such subsequent year.

If any amount determined under this subparagraph is not a multiple of $1, such amount shall be rounded to the nearest multiple of $1.

''(2) APPLICATION OF HOME HEALTH SERVICE COINSURANCE.—

''(A) IN GENERAL.—The amount of the payment otherwise made under section 1895 for home health services (other than such services for which payment is made under section 1834(a)) shall be reduced by the amount described in clause (ii).

''(B) COPAYMENT AMOUNT.—

''(i) IN GENERAL.—Subject to clause (ii), the eligible beneficiary shall be responsible for a copayment amount for each of the first 5 visits during an episode of care for which payment is made on behalf of an eligible beneficiary under section 1895 equal to—

''(I) for 2005, $10; and

''(II) for a subsequent year, the amount specified in this clause for the preceding year increased by the percentage increase in the per capita actuarial value of benefits under parts A and B for such subsequent year.

If any amount determined under this clause is not a multiple of $1, such amount shall be rounded to the nearest multiple of $1.

''(ii) ANNUAL LIMIT.—For each year in which an election to receive enhanced medicare benefits under this part is in effect, the eligible beneficiary shall not be responsible for the payment of any copayment amount under this subparagraph after the date on which the amount of payments made as a result of the application of this paragraph equals $300.

''(3) BLOOD DEDUCTIBLE.—The Secretary shall not apply the deductible under sections 1813(a)(2) and 1833(b) for blood or blood cells furnished to an eligible beneficiary during the period in which an election of the beneficiary to receive enhanced medicare benefits under this part is in effect.

''PAYMENT OF BENEFITS

''SEC. 1860E–3. Payment for enhanced medicare benefits on behalf of an eligible beneficiary who has elected to receive such benefits under this part shall be made in the same manner as payment for such benefits would have been made under parts A and B, subject to the modifications described in section 1860E–2, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, in such proportion as the Secretary determines appropriate.

''ELIGIBLE BENEFICIARIES; ELECTION OF ENHANCED MEDICARE BENEFITS; TERMINATION OF ELECTION

''SEC. 1860E–4. (a) ELIGIBLE BENEFICIARY DEFINED.—For purposes of this part, the term 'eligible beneficiary' has the meaning given that term in section 1860D(a)(3).

''(b) ELECTION OF ENHANCED MEDICARE BENEFITS.—

''(1) ELECTION BY INDIVIDUALS WHO BECOME ELIGIBLE BENEFICIARIES AFTER JANUARY 1, 2005.—

''(A) INITIAL ELECTION.—Any individual whose initial election period begins after September 30, 2004, shall be deemed to have elected to receive enhanced medicare benefits under this part as of the date on which such individual first becomes entitled to benefits under part A or eligible to enroll for benefits under part B, whichever is later, unless that individual affirmatively elects (in such form and manner as the Secretary may specify) to receive benefits under parts A and B.

''(B) INITIAL ELECTION PERIOD.—For purposes of this paragraph, the term 'initial election period' means, with respect to an individual, the period that begins on the first day of the third month before the month in which such individual first becomes entitled to benefits under part A or eligible to enroll for benefits under part B, whichever is later, and ends 7 months later.

''(C) EFFECT OF ELECTION.—If an individual makes an election under subparagraph (A) and such individual is not entitled to benefits under part A or enrolled for benefits under part B at the time of such election, such individual shall be deemed—

''(i) to have elected to enroll for benefits under such part under section 1818 or 1837 (as appropriate) if such individual is eligible to enroll for benefits under such section, as of the date of such election; or

''(ii) if such individual is not eligible to enroll for benefits under section 1818 or 1837, to have elected to enroll under part B as of the first date on which the individual is eligible to enroll under such part.

''(2) SPECIAL ELECTION PERIODS.—The Secretary shall establish special election periods for individuals under this part who have elected not to make an election (or to be deemed to have made such an election) under this part that are similar to the special enrollment periods under section 1837(i) for individuals described in such section.

''(3) TRANSITIONAL ELECTION FOR INDIVIDUALS WHO BECOME ELIGIBLE BENEFICIARIES ON OR BEFORE JANUARY 1, 2005.—

''(A) IN GENERAL.—In the case of an individual who is an eligible beneficiary as of January 1, 2005, the Secretary shall establish procedures under which such beneficiary may affirmatively elect to receive enhanced medicare benefits under this part during the 7-month period that begins on April 1, 2004, and ends on November 30, 2004, for such election to take effect on January 1, 2005.

''(B) EFFECT OF MEDICARE+CHOICE ENROLLMENT.—If an eligible beneficiary enrolls in a Medicare+Choice plan under part C during November 2004, such individual shall be deemed to have elected to receive enhanced medicare benefits under subparagraph (A).

''(4) CHANGES IN ELECTION.—

''(A) IN GENERAL.—An individual who has elected (or is deemed to have elected) to receive enhanced medicare benefits under this part under paragraph (1), (2), or (3) may change such election during an annual, coordinated election period and such election shall take effect on January 1 of the subsequent year. In no case shall such a change of election take effect on a date other than on January 1 of a year (unless the election is automatic pursuant to a termination resulting from a loss or termination of coverage under part A or part B).

''(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term 'annual, coordinated election period' means, with respect to a calendar year (beginning with 2005), the month of November preceding such year.

''(5) PROCEDURES.—The Secretary shall establish procedures for the termination and reinstatement of an election under this section.

''(c) COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PART A OR B.—

''(1) IN GENERAL.—The Secretary shall terminate an individual's coverage under this part if the individual is no longer enrolled in both parts A and B.

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

''PREMIUM ADJUSTMENTS; LATE ELECTION PENALTY

''SEC. 1860E–5. (a) GENERAL RULE OF NO CHANGE IN AMOUNT OF PREMIUMS.—Except as provided in this section, an election to receive enhanced medicare benefits under this part shall not affect the amount of any premium charged under part A or B.

''(b) LATE ELECTION PENALTY.—

''(1) IN GENERAL.—In the case of an eligible beneficiary who does not elect to receive enhanced medicare benefits under this part during an election period described in paragraph (1), (2), or (3) of section 1860E–4(b) of that beneficiary, reinstates such an election under the procedures established under paragraph (5) of such section, or otherwise does not have such an election continuously in effect from the first date on which such election could be in effect, the premium otherwise imposed under part B (taking into account any late enrollment penalty under section 1839(b)) shall be increased during the period in which such individual has an election to receive enhanced medicare benefits under this part in effect by an amount that the Secretary determines is actuarially sound (based on the financial impact on the program under this part of the late election of the beneficiary or of the reinstatement of an election of the beneficiary) for each full 12-month period (in the same continuous period of eligibility) in which the eligible beneficiary could have elected to receive enhanced medicare benefits under this part but did not elect to receive such benefits.

''(2) PROCEDURES.—In applying the late election penalty under paragraph (1), the Secretary shall establish procedures for applying the penalty under this subsection that are similar to the procedures for applying the late enrollment penalty under section 1839(b).

''(c) LATE REVERSAL OF ELECTION PENALTY.—

''(1) IN GENERAL.—In the case of an eligible beneficiary who has elected to receive enhanced medicare benefits under this part and terminates such election under the procedures established under section 1860E–4(b)(5) on a date that is more than 1 year after the date on which such beneficiary first elected to receive enhanced medicare benefits under this part, the premium otherwise imposed under part B (taking into account any late enrollment penalty under section 1839(b)) shall be increased during the period in which such individual is enrolled under such part by an amount that the Secretary determines is actuarially sound based on the financial impact on the program under this part of the reversal of the election of the beneficiary.

''(2) PROCEDURES.—In applying the late reversal of election penalty under paragraph (1), the Secretary shall establish procedures for applying the penalty under this subsection that are similar to the procedures for applying the late enrollment penalty under section 1839(b).''.

(b) PROVIDING INFORMATION TO BENEFICIARIES.—During 2004, the Secretary shall provide for an extensive, national educational and publicity campaign to inform eligible beneficiaries (and prospective eligible beneficiaries) regarding the enhanced medicare benefits to be made available under part E of title XVIII of the Social Security Act (as added by subsection (a)).

(c) CONFORMING ADJUSTMENTS TO PART A AND B PREMIUMS.—

(1) EFFECT OF PART E ON PART A PREMIUM.—Section 1818(d)(1) (42 U.S.C. 1395i–2(d)(1)) is amended by adding at the end the following new sentence: ''In making the estimate under the previous sentence, the Secretary shall take into account the effect of elections to receive enhanced medicare benefits under part E on the amounts paid from such Trust Fund.''.

(2) EFFECT OF PART E ON PART B PREMIUM.—Section 1839(a) (42 U.S.C. 1395r(a)) is amended—

(A) in paragraph (1)—

(i) by inserting ''(including eligible beneficiaries who elect to receive enhanced medicare benefits under part E)'' after ''age 65 and over''; and

(ii) by inserting ''(including eligible beneficiaries who elect to receive enhanced medicare benefits under part E)'' after ''age 65 and older'';

(B) in paragraph (2), by inserting '', as adjusted under section 1860E–5'' before the period at the end;

(C) in paragraph (3)—

(i) by inserting ''(including eligible beneficiaries who elect to receive enhanced medicare benefits under part E)'' after ''age 65 and over''; and

(ii) by inserting ''(including eligible beneficiaries who elect to receive enhanced medicare benefits under part E)'' after ''age 65 and older''; and

(D) in paragraph (4)—

(i) in the first sentence, by inserting ''(including eligible beneficiaries who elect to receive enhanced medicare benefits under part E)'' after ''under age 65''; and

(ii) in the second sentence, by striking ''under age 65 which'' and inserting ''under age 65 (including eligible beneficiaries who elect to receive enhanced medicare benefits under part E)''.

(d) CLARIFICATION OF APPLICATION OF EXCLUSIONS FROM COVERAGE TO PART E.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended in the matter preceding paragraph (1) by inserting ''(including for enhanced medicare benefits under part E)'' after ''for items or services''.

SEC. 202. RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE; ESTABLISHMENT OF ENHANCED MEDICARE FEE-FOR-SERVICE MEDIGAP POLICIES.

(a) RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.—Section 1882 (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

''(v) RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.—

''(1) PROHIBITION ON SALE, ISSUANCE, AND RENEWAL OF POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE TO PART D ENROLLEES.—

''(A) IN GENERAL.—Notwithstanding any other provision of law, on or after January 1, 2005, no medicare supplemental policy that provides coverage of expenses for prescription drugs may be sold, issued, or renewed under this section to an individual who is enrolled under part D.

''(B) PENALTIES.—The penalties described in subsection (d)(3)(A)(ii) shall apply with respect to a violation of subparagraph (A).

''(2) ISSUANCE OF SUBSTITUTE POLICIES IF THE POLICYHOLDER OBTAINS PRESCRIPTION DRUG COVERAGE UNDER PART D.—

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

''(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as 'A', 'B', 'C', 'D', 'E', 'F' (including the benefit package classified as 'F' with a high deductible feature, as described in subsection (p)(11)), or 'G' (under the standards established under subsection (p)(2)) and that is offered and is available for issuance to new enrollees by such issuer;

''(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

''(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy during the open enrollment period established under section 1860D–2(b)(2) and who submits evidence that they meet the requirements under subparagraph (B) along with the application for such medicare supplemental policy.

''(B) INDIVIDUAL DESCRIBED.—An individual described in this subparagraph is an individual who—

''(i) enrolls in the medicare prescription drug delivery program under part D; and

''(ii) at the time of such enrollment was enrolled and terminates enrollment in a medicare supplemental policy which has a benefit package classified as 'H', 'I', or 'J' (including the benefit package classified as 'J' with a high deductible feature, as described in section 1882(p)(11)) under the standards referred to in subparagraph (A)(i) or terminates enrollment in a policy to which such standards do not apply but which provides benefits for prescription drugs.

''(C) ENFORCEMENT.—The provisions of subparagraph (A) shall be enforced as though they were included in subsection (s).

''(3) NOTICE REQUIRED TO BE PROVIDED TO CURRENT POLICYHOLDERS WITH PRESCRIPTION DRUG COVERAGE.—

''(A) IN GENERAL.—No medicare supplemental policy of an issuer shall be deemed to meet the standards in subsection (c) unless the issuer provides written notice during the 60-day period immediately preceding the period established for the open enrollment period established under section 1860D–2(b)(2), to each individual who is a policyholder or certificate holder of a medicare supplemental policy issued by that issuer that provides some coverage of expenses for prescription drugs (at the most recent available address of that individual) of—

''(i) the ability to enroll in a new medicare supplemental policy pursuant to paragraph (2); and

''(ii) the fact that, so long as such individual retains coverage under such policy, the individual shall be ineligible for coverage of prescription drugs under part D and ineligible to elect to receive enhanced medicare benefits under part E.

''(B) COORDINATION.—The notice provided under subparagraph (A) shall be coordinated with the notice required under subsection (v)(4)(A)(i).

''(4) CLARIFICATION REGARDING ONE-TIME AVAILABILITY OF A GUARANTEED ISSUE POLICY FOR BENEFICIARIES WHO LOSE COVERAGE UNDER A MEDICARE+CHOICE PLAN OF JANUARY 1, 2005, BECAUSE THEY ELECT NOT TO RECEIVE ENHANCED PART E BENEFITS.—In the case of a beneficiary who is enrolled in a Medicare+Choice plan as of December 31, 2004, will not be eligible to be enrolled under such plan as of January 1, 2005, because the beneficiary has elected not to receive enhanced medicare benefits under part E—

''(A) such beneficiary shall be deemed to be described in subsection (s)(3)(B)(ii); and

''(B) for purposes of (s)(3)(E)(ii), the date of the termination of coverage shall be January 1, 2005.''.

(b) ESTABLISHMENT OF ENHANCED MEDICARE FEE-FOR-SERVICE MEDIGAP POLICIES.—Section 1882 (42 U.S.C. 1395ss), as amended by subsection (a), is amended by adding at the end the following new subsection:

''(w) ENHANCED MEDICARE FEE-FOR-SERVICE SUPPLEMENTAL POLICIES.—

''(1) ADDITIONAL BENEFIT PACKAGES.—

''(A) ESTABLISHMENT.—

''(i) IN GENERAL.—In addition to the benefit packages classified under the standards established by subsection (p)(2), there shall be established benefit packages that may only be purchased by beneficiaries who have elected to receive enhanced medicare benefits under part E that—

''(I) complement but do not duplicate enhanced medicare benefits described in section 1860E–2;

''(II) do not provide for coverage of the unified deductible under section 1860E–2(b);

''(III) subject to clause (ii), do not provide coverage for more than 50 percent of the amount of coinsurance and copayments applicable under section 1860E–2;

''(IV) do not provide for coverage of expenses for prescription drugs;

''(V) provide a range of coverage options for beneficiaries; and

''(VI) use uniform language, definitions, and format with respect to the coverage provided under a policy.

''(ii) ONE PACKAGE REQUIRED TO COVER ALL COST-SHARING.—

''(I) IN GENERAL.—One of the benefit packages established under clause (i) shall include coverage of all coinsurance and copayments applicable under section 1860E–2.

''(II) AVAILABILITY LIMITED TO BENEFICIARIES THAT ENROLLED IN PART E DURING CERTAIN PERIODS.—The benefit package that includes the coverage described in subclause (II) shall only be made available to beneficiaries who elect to receive enhanced medicare benefits under part E during the beneficiary's initial election period (as defined in paragraph (1)(B) of section 1860D–4(b)), during a special election period described in paragraph (2) of such section, or during the transitional election period under paragraph (3) of such section.

''(B) MANNER OF ESTABLISHMENT.—The benefit packages established under this section shall be established in the manner described in subparagraph (E) of subsection (p)(1), except that for purposes of subparagraph (C) of such subsection, the standards established under this subsection shall take effect not later than January 1, 2005.

''(2) CONSTRUCTION OF BENEFITS IN OTHER MEDICARE SUPPLEMENTAL POLICIES.—Nothing in this subsection shall be construed to affect the benefit packages classified as 'A' through 'J' under the standards established by subsection (p)(2) (including the benefit packages classified as 'F' and 'J' with a high deductible feature, as described in subsection (p)(11)).

''(3) GUARANTEED ISSUANCE AND RENEWAL OF ENHANCED MEDICARE FEE-FOR-SERVICE SUPPLEMENTAL POLICIES.—The provisions of subsections (q) and (s), including provisions of subsection (s)(3) (relating to special enrollment periods in cases of termination or disenrollment), shall apply to medicare supplemental policies established under this subsection in a similar manner as such provisions apply to medicare supplemental policies issued under the standards established under subsection (p).

''(4) OPPORTUNITY OF CURRENT POLICYHOLDERS TO PURCHASE ENHANCED MEDICARE FEE-FOR-SERVICE SUPPLEMENTAL POLICIES.—

''(A) REQUIREMENTS FOR ISSUERS OF POLICIES WITH RESPECT TO CURRENT POLICYHOLDERS.—No medicare supplemental policy of an issuer with a benefit package that is established under paragraph (1) shall be deemed to meet the standards in subsection (c) unless the issuer does all of the following:

''(i) NOTICE TO CURRENT POLICYHOLDERS.—Provide written notice during the 60-day period immediately preceding the period established under section 1860E–4(b)(1), to each individual who is a policyholder or certificate holder of a medicare supplemental policy issued by that issuer (at the most recent available address of that individual) of the offer described in clause (ii) and of the fact that, so long as such individual retains coverage under such policy, the individual shall be ineligible to elect enhanced medicare benefits under part E.

''(ii) OFFER FOR CURRENT POLICYHOLDERS.—Offer the policyholder or certificate holder under the terms described in subparagraph (C), during at least the period established under section 1860E–4(b)(1), a medicare supplemental policy established under paragraph (1) with the benefit package that the Secretary determines is most comparable to the policy in which the individual is enrolled with coverage effective as of the effective date of the election of the individual under part E.

''(iii) OFFER FOR INDIVIDUALS COVERED UNDER POLICIES ISSUED BY OTHER ISSUERS IF THAT ISSUER IS NOT GOING TO OFFER ENHANCED MEDICARE FEE-FOR-SERVICE SUPPLEMENTAL POLICIES.—Offer an individual described in subparagraph (B), under the terms described in subparagraph (C), and during at least the period established under section 1860E–4(b)(1), a medicare supplemental policy established under paragraph (1) with the benefit package that the Secretary determines

is most comparable to the policy in which the individual is enrolled with coverage effective as of the effective date of the election of the individual under part E.

The notice provided under clause (i) shall be coordinated with the notice required under subsection (v)(3)(A).

''(B) INDIVIDUAL DESCRIBED.—An individual described in this subparagraph is an individual who is a policyholder or certificate holder of a medicare supplemental policy issued by an issuer who is not going to offer a policy with a benefit package established under paragraph (1).

''(C) TERMS OF OFFER DESCRIBED.—The terms described in this subparagraph are terms which do not—

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

''(ii) discriminate in the pricing of such policy because of health status, claims experience, receipt of health care, or medical condition; or

''(iii) impose an exclusion of benefits based on a preexisting condition under such policy.

''(5) PROHIBITION OF SALE OF ENHANCED POLICIES TO ORIGINAL MEDICARE FEE-FOR-SERVICE ENROLLEES; PROHIBITION OF SALE OF ORIGINAL POLICIES TO ENHANCED MEDICARE FEE-FOR-SERVICE ENROLLEES.—

''(A) PROHIBITION.—No person may sell, issue, or renew a medicare supplemental policy with—

''(i) a benefit package established under this subsection to an individual who has not elected to receive enhanced medicare benefits under part E; or

''(ii) a benefit package classified as 'A' through 'J' under the standards established by subsection (p)(2) (including the benefit packages classified as 'F' and 'J' with a high deductible feature, as described in subsection (p)(11)) to an individual who has elected to receive enhanced medicare benefits under part E.

''(B) PENALTY.—Any person who violates the provisions of subparagraph (A) shall be subject to a civil money penalty in an amount that does not exceed $25,000 (or $15,000 in the case of a seller who is not an issuer of a policy) for each such violation. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

''(6) OTHER PROHIBITIONS AND PENALTIES.—Each penalty under this section shall apply with respect to policies established under this subsection as if such policies were issued under the standards established under subsection (p), including the penalties under subsections (a), (d), (p)(8), (p)(9), (q)(5), (r)(6)(A), (s)(4), and (t)(2)(D).''.

TITLE III—MEDICARE+CHOICE COMPETITION

SEC. 301. ANNUAL CALCULATION OF BENCHMARK AMOUNTS BASED ON FLOOR RATES AND LOCAL FEE-FOR-SERVICE RATES.

(a) ANNUAL CALCULATION OF BENCHMARK AMOUNTS BASED ON FLOOR RATES AND LOCAL FEE-FOR-SERVICE RATES.—Section 1853(a) (42 U.S.C. 1395w–23(a)) is amended by adding at the end the following new paragraph:

''(4) ANNUAL CALCULATION OF BENCHMARK AMOUNTS.—For each year, the Secretary shall calculate a benchmark amount for each Medicare+Choice payment area for each month for such year with respect to coverage of enhanced medicare benefits under part E equal to the greatest of the following amounts:

''(A) MINIMUM AMOUNT.—1/12 of the annual Medicare+Choice capitation rate determined under subsection (c)(1)(B) for the payment area for the year; or

''(B) LOCAL FEE-FOR-SERVICE RATE.—The local fee-for-service rate for such area for the year (as calculated under paragraph (5)).''.

(b) ANNUAL CALCULATION OF LOCAL FEE-FOR-SERVICE RATES.—Section 1853(a) (42 U.S.C. 1395w–23(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

''(5) ANNUAL CALCULATION OF LOCAL FEE-FOR-SERVICE RATES.—

''(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the term 'local fee-for-service rate' means the amount of payment for a month in a Medicare+Choice payment area for benefits under this title and associated claims processing costs for an individual who has elected to receive enhanced medicare benefits under part E (but, if the Medicare+Choice plan offers prescription drug coverage, excluding any costs associated with part D), and not enrolled in a Medicare+Choice plan under this part. The Secretary shall annually calculate such amount in a manner similar to the manner in which the Secretary calculated the adjusted average per capita cost under section 1876, except that such calculation shall include in such amount, to the extent practicable, any amounts that would have been paid under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Veterans Affairs or the Department of Defense.

''(B) REMOVAL OF MEDICAL EDUCATION COSTS FROM CALCULATION OF LOCAL FEE-FOR-SERVICE RATE.—

''(i) IN GENERAL.—In calculating the local fee-for-service rate under subparagraph (A) for a year, the amount of payment described in such subparagraph shall be adjusted to exclude from such payment the payment adjustments described in clause (ii).

''(ii) PAYMENT ADJUSTMENTS DESCRIBED.—

''(I) IN GENERAL.—Subject to subclause (II), the payment adjustments described in this subparagraph are payment adjustments that the Secretary estimates were payable during each month for direct graduate medical education costs under section 1886(h).

''(II) TREATMENT OF PAYMENTS COVERED UNDER STATE HOSPITAL REIMBURSEMENT SYSTEM.—To the extent that the Secretary estimates that the amount of the local fee-for-service rates reflects payments to hospitals reimbursed under section 1814(b)(3), the Secretary shall estimate a payment adjustment that is comparable to the payment adjustment that would have been made under clause (i) if the hospitals had not been reimbursed under such section.

''(C) SPECIAL RULE FOR RURAL AREAS.—

''(i) IN GENERAL.—Subject to clause (ii), in calculating the local fee-for-service rates under subparagraph (A) for a year, the Secretary shall calculate such costs for rural areas (as defined in section 1886(d)(2)(D)) of a State as if each rural area were part of a single Medicare+Choice payment area.

''(ii) LIMITATION.—Payment amounts determined under subparagraph (A) may not be less than the amounts that would have been paid if clause (i) did not apply.''.

(c) CPI INCREASES IN FLOOR PAYMENT RATES.—Section 1853(c)(1)(B) (42 U.S.C. 1395w–23(c)(1)(B)) is amended—

(1) in clause (iv), by striking ''and each succeeding year,'' and inserting '', 2003, and 2004,''; and

(2) by adding at the end the following new clause:

''(v) For 2005 and each succeeding year, the minimum amount specified in this clause (or clause (iv)) for the preceding year increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.''.

(d) FURNISHING OF CLAIMS DATA BY VA AND DOD.—Upon the request of the Secretary of Health and Human Services, the Secretary of Veterans Affairs and the Secretary of Defense shall provide such claims data as the Secretary of Health and Human Services may require to determine the amount that would have been paid under the medicare program under title XVIII of the Social Security Act if individuals entitled to benefits under such program had not received services from facilities of the Department of Veterans Affairs or the Department of Defense for purposes calculating the amounts under section 1853(a)(5) of such Act (as added by subsection (b)) and section 1853(c)(8) of such Act (as added by section 312(b)).

SEC. 302. APPLICATION OF COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.

Section 1853(a)(3) is amended to read as follows:

''(3) COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.—

''(A) APPLICATION OF METHODOLOGY.—The Secretary shall apply the comprehensive risk adjustment methodology described in subparagraph (B) to 100 percent of the amount of the plan bids under section 1853(d)(1) and the weighted service area benchmark amounts calculated under section 1853(d)(3).

''(B) COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY DESCRIBED.—The comprehensive risk adjustment methodology described in this subparagraph is the risk adjustment methodology that would apply with respect to Medicare+Choice plans offered by Medicare+Choice organizations in 2004, except that if such methodology does not apply to groups of beneficiaries who are aged or disabled and groups of beneficiaries who have end-stage renal disease, the Secretary shall revise such methodology to apply to such groups.

''(C) UNIFORM APPLICATION TO ALL TYPES OF PLANS.—Subject to section 1859(e)(4), the comprehensive risk adjustment methodology established under this paragraph shall be applied uniformly without regard to the type of plan.

''(D) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require Medicare+Choice organizations to submit such data and other information as the Secretary deems necessary.

''(E) IMPROVEMENT OF PAYMENT ACCURACY.—Notwithstanding any other provision of this paragraph, the Secretary may revise the comprehensive risk adjustment methodology described in subparagraph (B) from time to time to improve payment accuracy.''.

SEC. 303. ANNUAL ANNOUNCEMENT OF BENCHMARK AMOUNTS AND OTHER PAYMENT FACTORS.

Section 1853(b) (42 U.S.C. 1395w–23(b)), as amended by section 532(d)(1) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (Public Law 107–188; 116 Stat. 696), is amended—

(1) in the heading, by striking ''PAYMENT RATES'' and inserting ''PAYMENT FACTORS'';

(2) by striking paragraph (1) and inserting the following:

''(1) ANNUAL ANNOUNCEMENT.—Beginning in 2004, at the same time as the Secretary publishes the risk adjusters under section 1860D–11, the Secretary shall annually announce (in a manner intended to provide notice to interested parties) the following payment factors:

''(A) The benchmark amount for each Medicare+Choice payment area (as calculated under subsection (a)(4)) for the year.

''(B) The factors to be used for adjusting payments under the comprehensive risk adjustment methodology described in subsection (a)(3)(B) with respect to each Medicare+Choice payment area for the year.'';

(3) in paragraph (3), by striking ''monthly adjusted'' and all that follows before the period at the end and inserting ''each payment factor described in paragraph (1)''; and

(4) by striking paragraph (4).

SEC. 304. SUBMISSION OF BIDS BY MEDICARE+CHOICE ORGANIZATIONS.

Section 1854(a) (42 U.S.C. 1395w–24(a)), as amended by section 532(b)(1) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (Public Law 107–188; 116 Stat. 696), is amended to read as follows:

''(a) SUBMISSION OF BIDS BY MEDICARE+CHOICE ORGANIZATIONS.—

''(1) IN GENERAL.—Not later than the second Monday in September (or July 1 of each year before 2002) and except as provided in paragraph (3), each Medicare+Choice organization shall submit to the Secretary, in such form and manner as the Secretary may specify, for each Medicare+Choice plan that the organization intends to offer in a service area in the following year—

''(A) notice of such intent and information on the service area of the plan;

''(B) the plan type for each plan;

''(C) if the Medicare+Choice plan is a coordinated care plan (as described in section 1851(a)(2)(A)) or a private fee-for-service plan (as described in section 1851(a)(2)(C)), the information described in paragraph (2) with respect to each payment area;

''(D) the enrollment capacity (if any) in relation to the plan and each payment area;

''(E) the expected mix, by health status, of enrolled individuals; and

''(F) such other information as the Secretary may specify.

''(2) INFORMATION REQUIRED FOR COORDINATED CARE PLANS AND PRIVATE FEE-FOR-SERVICE PLANS.—For a Medicare+Choice plan that is a coordinated care plan (as described in section 1851(a)(2)(A)) or a private fee-for-service plan (as described in section 1851(a)(2)(C)), the information described in this paragraph is as follows:

''(A) INFORMATION REQUIRED WITH RESPECT TO BENEFITS UNDER PART E.—Information relating to the coverage of benefits under part E as follows:

''(i) The plan bid, which shall consist of a dollar amount that represents the total amount that the plan is willing to accept (after the application of the comprehensive risk adjustment methodology under section 1853(a)(3)) for providing coverage of the benefits under part E to an individual enrolled in the plan that resides in the service area of the plan for a month.

''(ii) For the supplemental benefits package offered (if any)—

''(I) the adjusted community rate (as defined in subsection (g)(3)) of the package;

''(II) the Medicare+Choice monthly supplemental beneficiary premium (as defined in subsection (b)(2)(C));

''(III) a description of any cost-sharing; and

''(IV) such other information as the Secretary considers necessary.

''(iii) The assumptions that the Medicare+Choice organization used in preparing the plan bid with respect to numbers, in each payment area, of enrolled individuals and the mix, by health status, of such individuals.

''(B) INFORMATION REQUIRED WITH RESPECT TO PART D.—If the Medicare+Choice organization elects to offer prescription drug coverage, the information required to be submitted by an eligible entity under section 1860D–12, including the monthly premiums for standard coverage and any other qualified prescription drug coverage available to individuals enrolled under part D.

''(3) REQUIREMENTS FOR MSA PLANS.—For an MSA plan described in section 1851(a)(2)(B), the information described in this paragraph is the information that such a plan would have been required to submit under this part if the 21st Century Medicare Act had not been enacted.

''(4) REVIEW.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall review the adjusted community rates (as defined in section 1854(g)(3)), the amounts of the Medicare+Choice monthly basic and supplemental beneficiary premiums filed under this subsection and shall approve or disapprove such rates and amounts so submitted. The Chief Actuary of the Medicare Competitive Agency shall review the actuarial assumptions and data used by the Medicare+Choice organization with respect to such rates and amounts so submitted to determine the appropriateness of such assumptions and data.

''(B) EXCEPTION.—The Secretary shall not review, approve, or disapprove the amounts submitted under paragraph (3).''.

SEC. 305. ADJUSTMENT OF PLAN BIDS; COMPARISON OF ADJUSTED BID TO BENCHMARK; PAYMENT AMOUNT.

(a) IN GENERAL.—Section 1853 (42 U.S.C. 1395w–23) is amended—

(1) by redesignating subsections (d) through (i) as subsections (e) through (j), respectively; and

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

''(d) SECRETARY'S DETERMINATION OF PAYMENT AMOUNT FOR ENHANCED MEDICARE BENEFITS.—

''(1) ADJUSTMENT OF PLAN BIDS.—The Secretary shall adjust each plan bid submitted under section 1854(a) for the coverage of benefits under part E using the comprehensive risk adjustment methodology applicable under subsection (a)(3) based on the assumptions described in section 1854(a)(2)(A)(iii) that the plan used with respect to numbers of enrolled individuals.

''(2) DETERMINATION OF WEIGHTED SERVICE AREA BENCHMARK AMOUNTS.—The Secretary shall calculate a weighted service area benchmark amount for enhanced medicare benefits under part E for each plan equal to the weighted average of the benchmark amounts for enhanced medicare benefits under such part for the payment areas included in the service area of the plan using the assumptions described in section 1854(a)(2)(A)(iii) that the plan used with respect to numbers of enrolled individuals.

''(3) DETERMINATION OF PLAN BENCHMARK.—The Secretary shall calculate the plan benchmark amount by adjusting the weighted service area benchmark amount determined under paragraph (1) using—

''(A) the comprehensive risk adjustment methodology applicable under subsection (a)(3); and

''(B) the assumptions contained in the plan bid that the plan used with respect to numbers of enrolled individuals.

''(4) COMPARISON TO BENCHMARK.—The Secretary shall determine the difference between each plan bid (as adjusted under paragraph (1)) and the plan benchmark amount (as determined under paragraph (3)) for purposes of determining—

''(A) the payment amount under paragraph (5); and

''(B) the part E premium reductions and Medicare+Choice monthly basic beneficiary premiums.

''(5) DETERMINATION OF PAYMENT AMOUNT.—The Secretary shall determine the payment amount for plans as follows:

''(A) BIDS THAT EQUAL OR EXCEED THE BENCHMARK.—The amount of each monthly payment to a Medicare+Choice organization with respect to each individual enrolled in a plan shall be the plan benchmark amount.

''(B) BIDS BELOW THE BENCHMARK.—The amount of each monthly payment to a Medicare+Choice organization with respect to each individual enrolled in a plan shall be the plan benchmark amount reduced by 25 percent of the difference between the bid and the benchmark amount and further reduced by the amount of any premium reduction elected by the plan under section 1854(d)(1)(A)(i).

''(6) FACTORS USED IN ADJUSTING BIDS AND BENCHMARKS FOR MEDICARE+CHOICE ORGANIZATIONS AND IN DETERMINING ENROLLEE PREMIUMS.—Subject to paragraph (7), the Secretary shall use, for purposes of adjusting plan bids and calculating plan benchmarks under this subsection—

''(A) with respect to benefits under part E—

''(i) the benchmark amount for the Medicare+Choice payment area announced under section 1854(a)(1)(A); and

''(ii) the health status and other demographic adjustment factors for the Medicare+Choice payment area announced under section 1854(a)(1)(B); and

''(B) if the Medicare+Choice organization elects to offer prescription drug coverage, the risk adjusters published under section 1860D–11 applicable with respect to such coverage.

''(7) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If the Secretary makes a determination with respect to coverage under this title or there is a change in benefits required to be provided under this part that the Secretary projects will result in a significant increase in the costs to Medicare+Choice organizations of providing benefits under contracts under this part (for periods after any period described in section 1852(a)(5)), the Secretary shall appropriately adjust the benchmark amounts or payment amounts (as determined by the Secretary). Such projection and adjustment shall be based on an analysis by the Chief Actuary of the Competitive Medicare Agency of the actuarial costs associated with the new benefits.''.

(b) CONFORMING AMENDMENT.—Section 1853(c)(7) (42 U.S.C. 1395w–23(c)(7)) is repealed.

SEC. 306. DETERMINATION OF PREMIUM REDUCTIONS, REDUCED COST-SHARING, ADDITIONAL BENEFITS, AND BENEFICIARY PREMIUMS.

(a) CALCULATION OF BENEFICIARY PREMIUMS.—Section 1854 (42 U.S.C. 1395–24) is amended by—

(1) redesignating subsections (d) through (h) as subsections (e) through (i), respectively; and

(2) inserting after subsection (c) the following new subsection:

''(d) DETERMINATION OF PREMIUM REDUCTIONS, REDUCED COST-SHARING, ADDITIONAL BENEFITS, AND BENEFICIARY PREMIUMS.—

''(1) BIDS BELOW THE BENCHMARK.—

''(A) IN GENERAL.—If the Secretary determines under section 1853(d)(4) that the plan benchmark amount exceeds the plan bid, the Secretary shall require the plan to return 75 percent of such excess to the enrollee in the form of, at the option of the organization offering the plan—

''(i) subject to subparagraph (B), a monthly medicare premium reduction for individuals enrolled in the plan;

''(ii) a reduction in the actuarial value of plan cost-sharing for plan enrollees;

''(iii) subject to subparagraph (C), such additional benefits as the organization may specify; or

''(iv) any combination of the reductions and benefits described in clauses (i) through (iii).

''(B) LIMITATION ON PREMIUM REDUCTIONS.—The amount of the reduction under subparagraph (A)(i) with respect to any enrollee in a Medicare+Choice plan—

''(i) may not exceed the premium described in section 1839(a)(3), as adjusted under section 1860E–5; and

''(ii) shall apply uniformly to each enrollee of the Medicare+Choice plan to which such reduction applies.

''(C) REQUIREMENT OF ENROLLMENT IN PART D TO RECEIVE PRESCRIPTION DRUG BENEFITS.—An organization may not specify any additional benefit that provides for the coverage of any prescription drug (other than that required under part E).

''(2) BIDS ABOVE THE BENCHMARK.—If the Secretary determines under section 1853(d)(4) that the plan bid (as adjusted under section 1853(d)(1)) exceeds the plan benchmark amount (determined under section 1853(d)(3)), the amount of such excess shall be the Medicare+Choice monthly basic beneficiary premium (as defined in section 1854(b)(2)(A)).''.

(b) CONFORMING PART E PREMIUM REDUCTION AMENDMENTS.—

(1) ADJUSTMENT AND PAYMENT OF PART E PREMIUMS.—Section 1860E–5 (as added by section 201) is amended—

(A) in subsection (a), by inserting '', except as reduced by the amount of any reduction elected under section 1854(d)(1)(A)(i)'' before the period at the end; and

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

''(c) MEDICARE+CHOICE PREMIUM REDUCTIONS.—In the case of an individual enrolled in a Medicare+Choice plan, the Secretary shall reduce (but not below zero) the amount of the monthly beneficiary premium to reflect any reduction elected under section 1854(d)(1)(A)(i). Such premium adjustment may be provided in such manner as the Secretary may specify.''.

(2) TREATMENT OF REDUCTION FOR PURPOSES OF DETERMINING GOVERNMENT CONTRIBUTION UNDER PART E.—Section 1844(c) (42 U.S.C. 1395w) is amended by striking ''section 1854(f)(1)(E)'' and inserting ''section 1854(d)(1)(A)(i)''.

(c) SUNSET OF SPECIFIC REQUIREMENTS FOR ADDITIONAL BENEFITS.—Section 1854(g) (as redesignated by subsection (a)(1)) is amended—

(1) in paragraph (1)(A), by striking ''Each Medicare+Choice organization'' and inserting ''For years before 2005, each Medicare+Choice organization''; and

(2) in paragraph (2), by striking ''A Medicare+Choice organization'' and inserting ''For years before 2005, a Medicare+Choice organization''.

(d) LIMITATION ON ENROLLEE LIABILITY.—

(1) FOR BENEFITS UNDER PART E.—Section 1854(f)(1) (as redesignated by subsection (a)(1)) is amended to read as follows:

''(1) FOR ENHANCED MEDICARE BENEFITS.—The sum of—

''(A) the Medicare+Choice monthly basic beneficiary premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments (taking into account any reductions in cost-sharing described in subsection (d)(1)(A)(ii)) applicable on average to individuals enrolled under this part with a Medicare+Choice plan described in subparagraph (A) or (C) of section 1851(a)(2) of an organization with respect to required benefits described in section 1852(a)(1)(A) and any additional benefits described in subsection (a)(2)(A)(iii) for a year; must equal

''(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals who have elected to receive enhanced medicare benefits under part E if they were not members of a Medicare+Choice organization for the year (adjusted as determined appropriate by the Secretary to account for geographic differences and for plan cost and utilization differences).''.

(2) FOR SUPPLEMENTAL BENEFITS.—Section 1854(f)(2) (as so redesignated) is amended to read as follows:

''(2) FOR SUPPLEMENTAL BENEFITS.—If the Medicare+Choice organization provides to its members enrolled under this part in a Medicare+Choice plan described in subparagraph (A) or (C) of section 1851(a)(2) with respect to supplemental benefits relating to benefits under part E described in section 1852(a)(3)(A), the sum of the Medicare+Choice monthly supplemental beneficiary premium (multiplied by 12) charged and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such benefits for a year must equal the adjusted community rate (as defined in subsection (g)(3)) for such benefits for the year.''.

(e) PREMIUMS CHARGED; PREMIUM TERMINOLOGY.—Section 1854(b) (42 U.S.C. 1395w–24) is amended to read as follows:

''(b) MONTHLY PREMIUMS CHARGED.—

''(1) IN GENERAL.—

''(A) COORDINATED CARE AND PRIVATE FEE-FOR-SERVICE PLANS.—The monthly amount of the premium charged to an individual enrolled in a Medicare+Choice plan (other than an MSA plan) offered by a Medicare+Choice organization shall be equal to the sum of the following:

''(i) The Medicare+Choice monthly basic beneficiary premium (if any).

''(ii) The Medicare+Choice monthly supplemental beneficiary premium (if any).

''(iii) The Medicare+Choice monthly obligation for qualified prescription drug coverage (if any).

''(B) MSA PLANS.—The rules under this section that would have applied with respect to an MSA plan if the 21st Century Medicare Act had not been enacted shall continue to apply to MSA plans after the date of enactment of such Act.

''(2) PREMIUM TERMINOLOGY.—For purposes of this part:

''(A) MEDICARE+CHOICE MONTHLY BASIC BENEFICIARY PREMIUM.—The term 'Medicare+Choice monthly basic beneficiary premium' means, with respect to a Medicare+Choice plan, the amount required to be charged under subsection (d)(2) for the plan.

''(B) MEDICARE+CHOICE MONTHLY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term 'Medicare+Choice monthly obligation for qualified prescription drug coverage' means, with respect to a Medicare+Choice plan, the amount determined under section 1853(k)(3).

''(C) MEDICARE+CHOICE MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The term 'Medicare+Choice monthly supplemental beneficiary premium' means, with respect to a Medicare+Choice plan, the amount required to be charged under subsection (f)(2) for the plan, or, in the case of an MSA plan, the amount filed under subsection (a)(3).

''(D) MEDICARE+CHOICE MONTHLY MSA PREMIUM.—The term 'Medicare+Choice monthly MSA premium' means, with respect to a Medicare+Choice plan, the amount of such premium filed under subsection (a)(3) for the plan.''.

(f) CONFORMING AMENDMENTS.—

(1) Section 1851(d)(2)(D) (42 U.S.C. 1395w–21(d)(2)(D)) is amended by inserting ''and Medicare+Choice monthly obligation for qualified prescription drug coverage'' after ''Medicare+Choice monthly basic and supplemental beneficiary premiums''.

(2) Section 1851(g)(3)(B)(i) (42 U.S.C. 1395w–21(g)(3)(B)(i)) is amended by striking ''any Medicare+Choice monthly basic and supplemental beneficiary premiums'' and inserting ''any Medicare+Choice monthly basic beneficiary premium, Medicare+Choice monthly obligation for qualified prescription drug coverage, Medicare+Choice monthly supplemental beneficiary premium,''.

(3) Section 1852(c)(1)(F) (42 U.S.C. 1395w–22(c)(1)(F)) is amended to read as follows:

''(F) SUPPLEMENTAL BENEFITS.—Supplemental benefits available from the organization offering the plan, including the supplemental benefits covered and the Medicare+Choice monthly supplemental beneficiary premium for such benefits.''.

(4) Section 1853(f)(1) (as redesignated by section 305(1)) is amended by striking ''(as defined in section 1854(b)(2)(C))'' and inserting ''(as defined in section 1854(b)(2)(D))''.

(5) Section 1854(c) (42 U.S.C. 1395w–24(c)) is amended by striking ''The Medicare+Choice monthly basic and supplemental beneficiary premium'' and inserting ''The Medicare+Choice monthly basic beneficiary premium, the Medicare+Choice monthly obligation for qualified prescription drug coverage, or the Medicare+Choice monthly supplemental beneficiary premium''.

(6) Section 1854(e) (as redesignated by subsection (a)(1)) is amended by inserting ''and the Medicare+Choice monthly obligation for qualified prescription drug coverage'' after ''Medicare+Choice monthly basic and supplemental beneficiary premiums''.

(7) Section 1859(c)(4) (42 U.S.C. 1395w–28(c)(4)) is amended to read as follows:

''(4) MEDICARE+CHOICE MONTHLY BASIC BENEFICIARY PREMIUM; MEDICARE+CHOICE MONTHLY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE; MEDICARE+CHOICE MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The terms 'Medicare+Choice monthly basic beneficiary premium', 'Medicare+Choice monthly obligation for qualified prescription drug coverage', and 'Medicare+Choice monthly supplemental beneficiary premium' are defined in section 1854(b)(2).''.

SEC. 307. ELIGIBILITY, ELECTION, AND ENROLLMENT IN COMPETITIVE MEDICARE+CHOICE PLANS.

(a) ELIGIBILITY.—Section 1851(a)(3) is amended to read as follows:

''(3) MEDICARE+CHOICE ELIGIBLE INDIVIDUAL.—In this title, the term 'Medicare+Choice eligible individual' means an individual who—

''(A) is entitled to benefits under part A and enrolled under part B; and

''(B) has elected to receive enhanced medicare benefits under part E.''.

(b) ELECTIONS.—

(1) IN GENERAL.—Section 1851(a)(1)(A) is amended by inserting ''(including through the election of enhanced medicare benefits under part E) and, if elected by the beneficiary and offered by the Medicare+Choice plan, through the voluntary prescription drug delivery program under part D'' after ''parts A and B''.

(2) DEFAULT ELECTION.—Section 1851(c)(3) (42 U.S.C. 1395w–21(c)(3)) is amended by inserting ''to receive enhanced medicare benefits under part E of the'' after ''deemed to have chosen''.

(3) COVERAGE ELECTION PERIODS.—Section 1851(e)(1) (42 U.S.C. 1395w–21(e)(1)) is amended by striking ''entitled to benefits under part A and enrolled under part B'' and inserting ''eligible to elect to receive enhanced medicare benefits under part E''.

(4) GUARANTEED ISSUANCE AND RENEWAL.—Section 1851(g)(3)(C) (42 U.S.C. 1395w–21(g)(3)(C)) is amended—

(A) in clause (i), by inserting ''elected to receive enhanced medicare benefits under part E of the'' after ''deemed to have''; and

(B) in clause (ii), by striking ''deemed to have chosen to change coverage to'' and inserting ''deemed to have elected to receive enhanced medicare benefits under part E through the''.

(5) EFFECT OF ELECTION OF MEDICARE+CHOICE PLAN OPTION.—Section 1851(i) (42 U.S.C. 1395w–21(i)) is amended—

(A) in paragraph (1)—

(i) by striking ''1853(g), 1853(h)'' and inserting ''1853(h), 1853(i)''; and

(ii) by inserting ''(as modified under part E)'' after ''parts A and B''; and

(B) in paragraph (2), by striking ''1853(e), 1853(g), 1853(h)'' and inserting ''1853(f), 1853(h), 1853(i)''.

(c) PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.—

(1) GENERAL INFORMATION ON BENEFITS.—Section 1851(d)(3) (42 U.S.C. 1395w–21(d)(3)) is amended—

(A) by striking subparagraph (A) and inserting the following:

''(A) BENEFITS UNDER ENHANCED MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—A general description of the enhanced medicare benefits covered under the original medicare fee-for-service program under parts A and B for individuals who have elected to receive such benefits under part E, including—

''(i) covered items and services;

''(ii) beneficiary cost-sharing, such as deductibles, coinsurance, and copayment amounts; and

''(iii) any beneficiary liability for balance billing.'';

(B) by redesignating subparagraphs (B) through (E) as subparagraphs (C) through (F), respectively;

(C) by inserting after subparagraph (A) the following new subparagraph:

''(B) OUTPATIENT PRESCRIPTION DRUG COVERAGE BENEFITS.—For Medicare+Choice eligible individuals who are enrolled under part D, the information required under section 1860D–4 if the Medicare+Choice organization elects to offer prescription drug coverage.''; and

(D) in subparagraph (D) (as redesignated by subparagraph (B)), by inserting ''(with the enhanced medicare benefits under part E)'' after ''the original medicare fee-for-service program''.

(2) INFORMATION COMPARING PLAN OPTIONS.—Section 1851(d)(4) (42 U.S.C. 1395w–21(d)(4)) is amended—

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

''(ix) For Medicare+Choice eligible individuals who are enrolled under part D, the comparative information described in section 1860D–4(b)(2) if the Medicare+Choice organization elects to offer prescription drug coverage.''; and

(B) in subparagraph (D), by inserting ''with respect to eligible beneficiaries who elect to receive enhanced medicare benefits under part E'' after ''under parts A and B''.

SEC. 308. BENEFITS AND BENEFICIARY PROTECTIONS UNDER COMPETITIVE MEDICARE+CHOICE PLANS.

(a) BASIC BENEFITS.—Section 1852(a) (42 U.S.C. 1395w–22(a)(1)(A)) is amended—

(1) in paragraph (1)—

(A) by striking subparagraph (A) and inserting the following new subparagraph:

''(A) those items and services (other than hospice care) for which benefits are available under parts A and B to individuals residing in the area served by the plan and who have elected to receive enhanced medicare benefits under part E;'';

(B) by redesignating subparagraph (B) as subparagraph (C);

(C) by inserting after subparagraph (A) the following new subparagraph:

''(B) if the Medicare+Choice organization elects to offer prescription drug coverage, prescription drug coverage under part D to individuals who are enrolled under that part and who reside in the area served by the plan; and''; and

(D) in subparagraph (C) (as redesignated by paragraph (2)), by striking ''1854(f)(1)(A)'' and inserting ''1854(d)(1)'';

(2) in paragraph (2), by striking ''parts A and B (including any balance billing permitted under such parts'' and inserting ''part E (including any balance billing permitted under such part'';

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

''(D) REQUIREMENT OF ENROLLMENT IN PART D TO RECEIVE PRESCRIPTION DRUG BENEFITS.—Notwithstanding the preceding provisions of this paragraph, the Secretary may not approve any supplemental health care benefit that provides for the coverage of any prescription drug (other than that required under part E).''; and

(4) in paragraph (5), by striking ''Health Care Financing Administration'' and inserting ''Medicare Competitive Agency'' in the flush matter following subparagraph (B).

(b) ESRD ANTIDISCRIMINATION.—Section 1852(b)(1) (42 U.S.C. 1395w–22(b)(1)) is amended to read as follows:

''(1) BENEFICIARIES.—A Medicare+Choice organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.''.

(c) DISCLOSURE REQUIREMENTS.—Section 1852(c)(1)(B) (42 U.S.C. 1395w–22(c)(1)(B)) is amended by striking ''section 1851(d)(3)(A)'' and inserting ''subparagraphs (A) and (B) of section 1851(d)(3)''.

(d) ASSURING ACCESS TO SERVICES IN MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLANS.—Section 1852(d)(4)(A) is amended by striking ''part A, part B, or both, for such services, or'' and inserting ''part E for such services (and, if the Medicare+Choice organization elects to offer prescription drug coverage, that are not less than the payment rates provided under part D for such services for Medicare+Choice eligible individuals enrolled under that part); or''.

(e) INFORMATION ON BENEFICIARY LIABILITY FOR MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLANS.—Section 1852(k)(2)(C)(i) (42 U.S.C. 1395w–22(k)(2)(C)(i)) is amended by striking ''parts A and B'' and inserting ''part E, under part D for individuals enrolled under that part (if the Medicare+Choice organization elects to offer prescription drug coverage),''.

SEC. 309. PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS FOR ENHANCED MEDICARE BENEFITS UNDER PART E BASED ON RISK-ADJUSTED BIDS.

(a) IN GENERAL.—Section 1853(a)(1)(A) (42 U.S.C. 1395w–23(a)(1)(A)) is amended to read as follows:

''(1) MONTHLY PAYMENTS.—Under a contract under section 1857 and subject to subsections (f), (h), and (j) and section 1859(e)(4), the Secretary shall make, to each Medicare+Choice organization, with respect to coverage of an individual for a month under this part in a Medicare+Choice payment area, separate monthly payments with respect to—

''(A) enhanced medicare benefits under part E in accordance with subsection (d); and

''(B) if the Medicare+Choice organization elects to offer prescription drug coverage, benefits under part D in accordance with subsection (k) for individuals enrolled under that part.''.

(b) CONFORMING AMENDMENT.—Section 1853(g)(1)(A) (42 U.S.C. 1395w–23(g)(1)(A)) is amended by inserting ''as part of the enhanced medicare benefits elected under part E of'' before ''the original medicare fee-for-service program option''.

SEC. 310. SEPARATE PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS FOR PART D BENEFITS.

(a) IN GENERAL.—Section 1853 (42 U.S.C. 1395w–27) is amended by adding at the end the following new subsection:

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

''(1) SCOPE OF PRESCRIPTION DRUG BENEFITS.—

''(A) AVAILABILITY OF STANDARD COVERAGE.—If a Medicare+Choice organization elects to offer prescription drug coverage under a Medicare+Choice plan, such organization shall make such coverage (other than that required under part E) available to each enrollee under that plan who is also enrolled under part D that includes only standard coverage and that meets the requirements of this subsection.

''(B) ADDITIONAL QUALIFIED PRESCRIPTION DRUG COVERAGE.—In addition to the standard coverage option made available to each enrollee under paragraph (1), a Medicare+Choice plan may make available to each enrollee that is also enrolled under part D, other qualified prescription drug coverage (other than that required under part E) that meets the requirements of this subsection under a Medicare+Choice plan offered under this part.

''(C) REQUIREMENT OF ENROLLMENT IN PART D TO RECEIVE PRESCRIPTION DRUG BENEFITS.—A Medicare+Choice organization may not provide for the coverage of any prescription drugs (other than that required under part E) to an enrollee unless that enrollee is also enrolled under part D.

''(2) PAYMENT OF FULL AMOUNT OF PREMIUM TO ORGANIZATIONS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—For each year (beginning with 2005), the Secretary shall pay to each Medicare+Choice organization offering a Medicare+Choice plan that provides qualified prescription drug coverage in which a Medicare+Choice eligible individual is enrolled, an amount equal to the full amount of the monthly premium submitted under section 1854(a)(2)(B) on behalf of each such individual enrolled in such plan for the year, as adjusted using the risk adjusters that apply to the standard coverage under section 1853(b)(4)(B).

''(3) AMOUNT OF MEDICARE+CHOICE MONTHLY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—In the case of a Medicare+Choice eligible individual receiving qualified prescription drug coverage under a Medicare+Choice plan, the obligation for qualified prescription drug coverage of such individual in a year shall be determined as follows:

''(A) PREMIUMS EQUAL TO THE MONTHLY NATIONAL AVERAGE.—If the amount of the monthly premium for qualified prescription drug coverage submitted under section 1854(a)(2)(B) for the plan for the year is equal to the monthly national average premium (as computed under section 1860D–15) for the year, the monthly obligation of the individual in that year shall be an amount equal to the applicable percent (as defined in section 1860D–17(c)) of the amount of the monthly national average premium.

''(B) PREMIUMS THAT ARE LESS THAN THE MONTHLY NATIONAL AVERAGE.—If the amount of the monthly premium for qualified prescription drug coverage submitted under section 1854(a)(2)(B) for the plan for the year is

less than the monthly national average premium (as computed under section 1860D–15) for the year, the monthly obligation of the individual in that year shall be an amount equal to—

''(i) the applicable percent (as defined in section 1860D–17(c)) of the amount of the monthly national average premium; minus

''(ii) the amount by which the monthly national average premium exceeds the amount of the premium submitted under section 1854(a)(2)(B).

''(C) PREMIUMS THAT ARE GREATER THAN THE MONTHLY NATIONAL AVERAGE.—If the amount of the monthly premium for qualified prescription drug coverage submitted under section 1854(a)(2)(B) for the plan for the year exceeds the monthly national average premium (as computed under section 1860D–15) for the year, the monthly obligation of the individual in that year shall be an amount equal to the sum of—

''(i) the applicable percent (as defined in section 1860D–17(c)) of the amount of the monthly national average premium; plus

''(ii) the amount by which the premium submitted under section 1854(a)(2)(B) exceeds the amount of the monthly national average premium.

''(4) COLLECTION OF MEDICARE+CHOICE MONTHLY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—The provisions of section 1860D–18, including subsection (b) of such section, shall apply to the amount of the monthly premium required to be paid by a Medicare+Choice eligible individual receiving qualified prescription drug coverage under a Medicare+Choice plan (as determined under paragraph (3)) in the same manner as such provisions apply to the monthly beneficiary obligation required to be paid by an eligible beneficiary enrolled in a Medicare Prescription Drug plan.

''(5) COMPLIANCE WITH ADDITIONAL BENEFICIARY PROTECTIONS.—With respect to the offering of qualified prescription drug coverage by a Medicare+Choice organization under a Medicare+Choice plan, the organization and plan shall meet the requirements of section 1860D–5, including requirements relating to information dissemination and grievance and appeals, in the same manner as they apply to an eligible entity and a Medicare Prescription Drug plan under part D. The Secretary shall waive such requirements to the extent the Secretary determines that such requirements duplicate requirements otherwise applicable to the organization or plan under this part.

''(6) COVERAGE OF PRESCRIPTION DRUGS FOR ENROLLEES IN PLANS THAT DO NOT OFFER PRESCRIPTION DRUG COVERAGE.—If an individual who is enrolled under part D is enrolled in a Medicare+Choice plan that does not offer prescription drug coverage, such individual shall be permitted to enroll for prescription drug coverage under such part in the same manner as if such individual was not enrolled in a Medicare+Choice plan.

''(7) AVAILABILITY OF PREMIUM SUBSIDY AND COST-SHARING REDUCTIONS FOR LOW-INCOME ENROLLEES.—For provisions—

''(A) providing premium subsidies and cost-sharing reductions for low-income individuals receiving qualified prescription drug coverage through a Medicare+Choice plan, see section 1860D–19; and

''(B) providing a Medicare+Choice organization with insurance subsidy payments for providing qualified prescription drug coverage through a Medicare+Choice plan, see section 1860D–20.

''(8) QUALIFIED PRESCRIPTION DRUG COVERAGE; STANDARD COVERAGE.—For purposes of this part, the terms 'qualified prescription drug coverage' and 'standard coverage' have the meanings given such terms in paragraphs (9) and (10), respectively, of section 1860D.''.

(b) SANCTIONS FOR IMPROPER PRESCRIPTION DRUG COVERAGE.—Section 1857(g)(1) (42 U.S.C. 1395w–27(g)(1)) is amended—

(1) in subparagraph (F), by striking ''or'' after the semicolon at the end;

(2) in subparagraph (G), by adding ''or'' after the semicolon at the end; and

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

''(H) charges any individual an amount in excess of the Medicare+Choice monthly obligation for qualified prescription drug coverage under section 1853(k)(3), provides coverage for prescription drugs that is not qualified prescription drug coverage (as defined in section 1853(k)(7)), offers prescription drug coverage, but does not make standard prescription drug coverage available (as defined in such section), or provides coverage for prescription drugs (other than those covered under part E) to an individual who is not enrolled under part D;''.

SEC. 311. ADMINISTRATION BY THE MEDICARE COMPETITIVE AGENCY.

On and after January 1, 2005, the Medicare+Choice program under part C of title XVIII of the Social Security Act shall be administered by the Medicare Competitive Agency in accordance with subpart 3 of part D of such title (as added by section 101), and, in accordance with section 1860D–25(c)(3)(C) of such Act (as added by section 101), each reference to the Secretary made in this title, or the amendments made by this title, shall be deemed to be a reference to the Administrator of the Medicare Competitive Agency.

SEC. 312. CONTINUED CALCULATION OF ANNUAL MEDICARE+CHOICE CAPITATION RATES.

(a) CONTINUED CALCULATION.—

(1) IN GENERAL.—Section 1853(c) (as amended by subsection (b)) is amended by adding at the end the following new paragraph:

''(7) TRANSITION TO MEDICARE+CHOICE COMPETITION.—

''(A) IN GENERAL.—For each year (beginning with 2005) payments to Medicare+Choice plans shall not be computed under this subsection, but instead shall be based on the payment amount determined under subsection (d).

''(B) CONTINUED CALCULATION OF CAPITATION RATES.—For each year (beginning with 2004) the Secretary shall calculate and publish the annual Medicare+Choice capitation rates under this subsection and shall use the annual Medicare+Choice capitation rate determined under subsection (c)(1)(B) for purposes of determining the benchmark amount under subsection (a)(4).''.

(2) CONFORMING AMENDMENT.—Section 1853(c)(1) (42 U.S.C. 1395w–23(c)(1)) is amended by striking ''For purposes of this part, subject to paragraphs (6)(C) and (7),'' and inserting ''For purposes of making payments under this part for years before 2004 and for purposes of calculating the annual Medicare+Choice capitation rates under paragraph (7) beginning with such year, subject to paragraph (6)(C),'' in the matter preceding subparagraph (A).

(b) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES IN CONTINUED CALCULATION.—Section 1853(c) (42 U.S.C. 1395w–23(c)), as amended by subsection (a)(1), is amended by adding at the end the following new paragraph:

''(8) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—For purposes of determining the blended capitation rate under subparagraph (A) of paragraph (1) and the minimum percentage increase under subparagraph (C) of such paragraph for a year, the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in such rate, to the extent practicable, the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Veterans Affairs or the Department of Defense.''.

SEC. 313. FIVE-YEAR EXTENSION OF MEDICARE COST CONTRACTS.

(a) IN GENERAL.—Section 1876(h)(5)(C) (42 U.S.C. 1395mm(h)(5)(C)), as redesignated by section 634(1) of BIPA (114 Stat. 2763A–568), is amended by striking ''2004'' and inserting ''2009''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act.

SEC. 314. EFFECTIVE DATE.

(a) IN GENERAL.—Except as provided in section 306(b)(1)(B), section 313(b), and subsection (b), the amendments made by this title shall apply to plan years beginning on and after January 1, 2005.

(b) MEDICARE+CHOICE MSA PLANS.—Notwithstanding any provision of this title, the Secretary shall apply the payment and other rules that apply with respect to an MSA plan described in section 1851(a)(2)(B) of the Social Security Act (42 U.S.C. 1395w–21(a)(2)(B)) as if this title had not been enacted.

SA 4311. Mr. REID (for Mr. WYDEN (for himself and Mr. ALLEN) proposed an amendment to the bill S. 2037, to mobilize technology and science experts to respond quickly to the threats posed by terrorist attacks and other emergencies, by providing for the establishment of a national emergency technology guard, a technology reliability advisory board, and a center for evaluating antiterrorism and disaster response technology within the National Institute of Standards and Technology; as follows:

On page 26, line 19, after the period, insert ''In completing the report, representatives of the commercial wireless industry shall be consulted, particularly to the extent that the report addresses commercial wireless systems.''.

On page 26, strike lines 22 and 23, and insert the following:

(1) developing a system of priority access for certain governmental officials to existing commercial wireless systems, and the impact such a priority access system would have on both emergency communications capability and consumer access to commercial wireless services;

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

Ms. STABENOW. Mr. President, I ask unanimous consent that the Committee on Agriculture, Nutrition, and Forestry Subcommittee on Production and Price Competitiveness be authorized to conduct a hearing on July 18, 2002 in SR–3328A at 2:00 p.m. The purpose of this hearing will be to discuss S. 532, the Pesticide Harmonization Act.

THE PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Ms. STABENOW. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and