107TH CONGRESS } HOUSE OF REPRESENTATIVES { REPT. 107–551
2d Session } { Part 1

MEDICARE MODERNIZATION AND PRESCRIPTION DRUG ACT OF 2002 (TITLE I: MEDICARE PRESCRIPTION DRUG BENEFIT)

JUNE 26, 2002.—Ordered to be printed

Mr. TAUZIN, from the Committee on Energy and Commerce, submitted the following

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 4984]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 4984) to amend title XVIII of the Social Security Act to provide for a medicare prescription drug benefit, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

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PURPOSE AND SUMMARY

The purpose of H.R. 4984 is to provide outpatient prescription drug coverage to Medicare beneficiaries. The bill creates new Prescription Drug Plans, which will provide this new coverage to any Medicare beneficiary wishing to enroll. Plans will charge beneficiaries a modest premium, deductible and co-insurance for this coverage. The plans will provide both coverage of all catastrophic costs above $3,700, and significant Federal premium and co-insurance subsidies to all beneficiaries with incomes below 175% of the Federal Poverty Level.

BACKGROUND AND NEED FOR LEGISLATION

The Medicare program has not provided a comprehensive outpatient prescription drug benefit since the implementation of the program in 1966. Some prescription drugs are reimbursed by Medicare including those administered to beneficiaries in hospitals and skilled nursing facilities as well as those administered incident to a physician visit that cannot usually be self-administered. This means that coverage is generally limited to drugs or biologicals administered by injection. In the last decade, insurance coverage for outpatient prescription drugs has become commonplace in the private sector, yet as many as 30 percent of the elderly in the United States are without any form of prescription drug coverage. The lack of a Medicare prescription drug benefit has placed a significant burden on the elderly population without coverage who often have substantial out-of-pocket costs related to prescription drugs. This legislation provides a comprehensive, voluntary outpatient prescription drug benefit to all Medicare beneficiaries, with subsidies available to enrollees with low income to minimize their out-of-pocket costs.

HEARINGS

The Subcommittee on Health held a hearing on Creating a Medicare Prescription Drug Benefit: Assessing Efforts to Help America's Low-Income Seniors on April 17, 2002. The Subcommittee received testimony from The Honorable Mark McClellan, M.D., Ph.D., Member, Council of Economic Advisors; Brian Tyler, M.D., Senior Vice President for Business Development and Strategy; Michael Hillerby, Deputy Chief of Staff, Nevada Governor Kenny Guinn; Craig Fuller, President and CEO, National Association of Chain Drug Stores; Patricia Neumann, Sc.D., Director of Kaiser's Medicare Policy Project, Vice President, Kaiser Family Foundation; Beatrice Braun, M.D., Board of Directors, American Association of Retired Persons; Jeanne Lambrew, Ph.D., Associate Professor, George Washington University.

The Subcommittee on Health held a hearing on Medicare Reform: Providing Prescription Drug Coverage for Seniors on May 16, 2001. The Subcommittee received testimony from Dan Crippen, Director, Congressional Budget Office; Beatrice Braun, M.D., Member, Board of Directors, AARP; Jeanne Lambrew, Ph.D., Associate Professor, Department of Health Services, Management and Policy, George Washington University; Robert Chess, Chairman, Inhale Therapeutics Systems, on behalf of The Biotechnology Industry.

The Subcommittee on Health held a hearing on Medicare Reform: Providing Prescription Drug Coverage for Seniors on February 16, 2001. The Subcommittee received testimony from Sylvia Kessler, National Committee to Preserve Social Security and Medicare; John Jones, Vice President, Legal and Regulatory Affairs, PacifiCare Health Systems; Robert Moroni, Assistant Director, Health Care Plans, General Motors Corporation; Diane Rowland, Kaiser Family Foundation; Bill Weller, Assistant Vice President and Chief Actuary, Health Insurance Association of America; Barbara Buckley, Assemblywoman, State of Nevada; James F. Smith, R.Ph., Senior Vice President, Health Care Services.

COMMITTEE CONSIDERATION

On Friday, June 21, 2002, the Full Committee met in open mark-up session and favorably ordered reported a Committee Print on Medicare Prescription Drug Benefit by a record vote of 30 yeas and 23 nays, as amended, a quorum being present. Chairman Tauzin then introduced H.R. 4984 to reflect the Committee's action.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. The following are the record votes taken on the amendments offered to the measure, including the names of those members voting for and against. A motion by Mr. Tauzin to order H.R. 4984 reported to the House, as amended, was agreed to by a record vote of 30 yeas and 23 nays.

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 32

BILL: H.R. 4984, Medicare Prescription Drug Benefit.

AMENDMENT: An en bloc amendment offered by Mr. Tauzin, No. 1.

DISPOSITION: **AGREED TO**, by a roll call vote of 30 yeas to 24 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin	X			Mr. Dingell		X	
Mr. Bilirakis	X			Mr. Waxman		X	
Mr. Barton				Mr. Markey		X	
Mr. Upton	X			Mr. Hall		X	
Mr. Stearns	X			Mr. Boucher		X	
Mr. Gillmor	X			Mr. Towns			
Mr. Greenwood	X			Mr. Pallone		X	
Mr. Cox	X			Mr. Brown		X	
Mr. Deal	X			Mr. Gordon			
Mr. Burr	X			Mr. Deutsch		X	
Mr. Whitfield	X			Mr. Rush		X	
Mr. Ganske	X			Ms. Eshoo		X	
Mr. Norwood	X			Mr. Stupak		X	
Mrs. Cubin	X			Mr. Engel		X	
Mr. Shimkus	X			Mr. Sawyer		X	
Mrs. Wilson	X			Mr. Wynn		X	
Mr. Shadegg	X			Mr. Green		X	
Mr. Pickering	X			Ms. McCarthy		X	
Mr. Fossella	X			Mr. Strickland		X	
Mr. Blunt	X			Ms. DeGette		X	
Mr. Davis	X			Mr. Barrett		X	
Mr. Bryant	X			Mr. Luther		X	
Mr. Ehrlich	X			Ms. Capps		X	
Mr. Buyer	X			Mr. Doyle		X	
Mr. Radanovich	X			Mr. John		X	
Mr. Bass	X			Ms. Harman		X	
Mr. Pitts	X						
Ms. Bono	X						
Mr. Walden	X						
Mr. Terry	X						
Mr. Fletcher	X						

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 33

BILL: H.R. 4984, Medicare Prescription Drug Benefit.

AMENDMENT: A substitute amendment offered by Mr. Dingell, No. 2, striking Title 1.

DISPOSITION: NOT AGREED TO, by a roll call vote of 24 yeas to 30 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Markey	X		
Mr. Upton		X		Mr. Hall	X		
Mr. Stearns		X		Mr. Boucher	X		
Mr. Gillmor		X		Mr. Towns			
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon	X		
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Ganske		X		Ms. Eshoo	X		
Mr. Norwood				Mr. Stupak	X		
Mrs. Cubin		X		Mr. Engel	X		
Mr. Shimkus		X		Mr. Sawyer	X		
Mrs. Wilson		X		Mr. Wynn	X		
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy	X		
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt		X		Ms. DeGette	X		
Mr. Davis		X		Mr. Barrett	X		
Mr. Bryant		X		Mr. Luther	X		
Mr. Ehrlich		X		Ms. Capps	X		
Mr. Buyer		X		Mr. Doyle	X		
Mr. Radanovich		X		Mr. John			
Mr. Bass		X		Ms. Harman	X		
Mr. Pitts		X					
Ms. Bono		X					
Mr. Walden		X					
Mr. Terry		X					
Mr. Fletcher		X					

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 34

BILL: H.R. 4984, Medicare Prescription Drug Benefit.

AMENDMENT: An amendment offered by Ms. Capps, No. 4 for a guaranteed national plan with a $35 premium.

DISPOSITION: **NOT AGREED TO,** by a roll call vote of 24 yeas to 31 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Markey	X		
Mr. Upton		X		Mr. Hall	X		
Mr. Stearns		X		Mr. Boucher			
Mr. Gillmor		X		Mr. Towns	X		
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon	X		
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Ganske		X		Ms. Eshoo	X		
Mr. Norwood		X		Mr. Stupak	X		
Mrs. Cubin		X		Mr. Engel	X		
Mr. Shimkus		X		Mr. Sawyer	X		
Mrs. Wilson		X		Mr. Wynn	X		
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy	X		
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt		X		Ms. DeGette	X		
Mr. Davis		X		Mr. Barrett	X		
Mr. Bryant		X		Mr. Luther	X		
Mr. Ehrlich		X		Ms. Capps	X		
Mr. Buyer		X		Mr. Doyle	X		
Mr. Radanovich		X		Mr. John	X		
Mr. Bass		X		Ms. Harman			
Mr. Pitts		X					
Ms. Bono		X					
Mr. Walden		X					
Mr. Terry		X					
Mr. Fletcher		X					

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 35

BILL: H.R. 4984, Medicare Prescription Drug Benefit.

AMENDMENT: An amendment offered by Mr. Waxman, No. 6, on price disclosure.

DISPOSITION: **NOT AGREED TO,** by a roll call vote of 25 yeas to 31 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Markey	X		
Mr. Upton		X		Mr. Hall			
Mr. Stearns		X		Mr. Boucher	X		
Mr. Gillmor		X		Mr. Towns	X		
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon	X		
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Ganske		X		Ms. Eshoo	X		
Mr. Norwood		X		Mr. Stupak	X		
Mrs. Cubin		X		Mr. Engel	X		
Mr. Shimkus		X		Mr. Sawyer	X		
Mrs. Wilson		X		Mr. Wynn	X		
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy	X		
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt		X		Ms. DeGette	X		
Mr. Davis		X		Mr. Barrett	X		
Mr. Bryant		X		Mr. Luther	X		
Mr. Ehrlich		X		Ms. Capps	X		
Mr. Buyer		X		Mr. Doyle	X		
Mr. Radanovich		X		Mr. John	X		
Mr. Bass		X		Ms. Harman	X		
Mr. Pitts		X					
Ms. Bono		X					
Mr. Walden		X					
Mr. Terry		X					
Mr. Fletcher		X					

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 36

BILL: H.R. 4984, Medicare Prescription Drug Benefit.

AMENDMENT: An amendment offered by Mr. Markey, No. 7, on the confidentiality of patient information.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 24 yeas to 29 nays, and 1 present.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman			
Mr. Barton			X	Mr. Markey	X		
Mr. Upton		X		Mr. Hall	X		
Mr. Stearns		X		Mr. Boucher	X		
Mr. Gillmor		X		Mr. Towns	X		
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon	X		
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Ganske				Ms. Eshoo	X		
Mr. Norwood		X		Mr. Stupak	X		
Mrs. Cubin		X		Mr. Engel	X		
Mr. Shimkus		X		Mr. Sawyer	X		
Mrs. Wilson		X		Mr. Wynn	X		
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy	X		
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt		X		Ms. DeGette	X		
Mr. Davis		X		Mr. Barrett	X		
Mr. Bryant		X		Mr. Luther	X		
Mr. Ehrlich		X		Ms. Capps	X		
Mr. Buyer		X		Mr. Doyle	X		
Mr. Radanovich		X		Mr. John			
Mr. Bass		X		Ms. Harman	X		
Mr. Pitts		X					
Ms. Bono		X					
Mr. Walden		X					
Mr. Terry		X					
Mr. Fletcher		X					

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 37

BILL: H.R. 4984, Medicare Prescription Drug Benefit.

AMENDMENT: An amendment offered by Mr. Pallone, No. 8, for negotiating fair prices with pharmaceutical manufacturers.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 20 yeas to 30 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Markey	X		
Mr. Upton		X		Mr. Hall		X	
Mr. Stearns		X		Mr. Boucher	X		
Mr. Gillmor		X		Mr. Towns		X	
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon			
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Ganske		X		Ms. Eshoo			
Mr. Norwood		X		Mr. Stupak	X		
Mrs. Cubin		X		Mr. Engel			
Mr. Shimkus		X		Mr. Sawyer	X		
Mrs. Wilson		X		Mr. Wynn	X		
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy			
Mr. Fossella				Mr. Strickland	X		
Mr. Blunt				Ms. DeGette	X		
Mr. Davis		X		Mr. Barrett	X		
Mr. Bryant		X		Mr. Luther	X		
Mr. Ehrlich		X		Ms. Capps	X		
Mr. Buyer		X		Mr. Doyle	X		
Mr. Radanovich				Mr. John	X		
Mr. Bass		X		Ms. Harman	X		
Mr. Pitts		X					
Ms. Bono		X					
Mr. Walden		X					
Mr. Terry		X					
Mr. Fletcher		X					

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 38

BILL: H.R. 4984, Medicare Prescription Drug Benefit.

AMENDMENT: An amendment offered by Ms. Capps, No. 11, to fill the gap for individuals diagnosed with amyotrophic lateral sclerosis (ALS).

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 19 yeas to 28 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Markey	X		
Mr. Upton		X		Mr. Hall	X		
Mr. Stearns		X		Mr. Boucher	X		
Mr. Gillmor		X		Mr. Towns	X		
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon			
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Ganske		X		Ms. Eshoo			
Mr. Norwood		X		Mr. Stupak	X		
Mrs. Cubin		X		Mr. Engel			
Mr. Shimkus		X		Mr. Sawyer			
Mrs. Wilson		X		Mr. Wynn	X		
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy			
Mr. Fossella				Mr. Strickland	X		
Mr. Blunt				Ms. DeGette	X		
Mr. Davis		X		Mr. Barrett	X		
Mr. Bryant		X		Mr. Luther	X		
Mr. Ehrlich		X		Ms. Capps	X		
Mr. Buyer		X		Mr. Doyle			
Mr. Radanovich				Mr. John	X		
Mr. Bass		X		Ms. Harman			
Mr. Pitts		X					
Ms. Bono		X					
Mr. Walden		X					
Mr. Terry		X					
Mr. Fletcher		X					

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 39

BILL: H.R. 4984, Medicare Prescription Drug Benefit.

AMENDMENT: An amendment offered by Mr. Green, No. 12, to limit cost sharing.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 22 yeas to 30 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Markey	X		
Mr. Upton		X		Mr. Hall	X		
Mr. Stearns		X		Mr. Boucher	X		
Mr. Gillmor		X		Mr. Towns	X		
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon			
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Ganske		X		Ms. Eshoo			
Mr. Norwood		X		Mr. Stupak	X		
Mrs. Cubin		X		Mr. Engel			
Mr. Shimkus		X		Mr. Sawyer	X		
Mrs. Wilson		X		Mr. Wynn	X		
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy			
Mr. Fossella				Mr. Strickland	X		
Mr. Blunt		X		Ms. DeGette	X		
Mr. Davis		X		Mr. Barrett	X		
Mr. Bryant		X		Mr. Luther	X		
Mr. Ehrlich		X		Ms. Capps	X		
Mr. Buyer		X		Mr. Doyle	X		
Mr. Radanovich		X		Mr. John	X		
Mr. Bass		X		Ms. Harman	X		
Mr. Pitts		X					
Ms. Bono		X					
Mr. Walden		X					
Mr. Terry		X					
Mr. Fletcher		X					

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 40

BILL: H.R. 4984, Medicare Prescription Drug Benefit.

AMENDMENT: An amendment offered by Mr. Markey, No. 13, for cost-sharing, gap-filling subsidy for widows

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 21 yeas to 28 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Markey	X		
Mr. Upton		X		Mr. Hall	X		
Mr. Stearns		X		Mr. Boucher	X		
Mr. Gillmor		X		Mr. Towns	X		
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon			
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Ganske				Ms. Eshoo			
Mr. Norwood		X		Mr. Stupak	X		
Mrs. Cubin		X		Mr. Engel			
Mr. Shimkus		X		Mr. Sawyer	X		
Mrs. Wilson		X		Mr. Wynn	X		
Mr. Shadegg		X		Mr. Green			
Mr. Pickering		X		Ms. McCarthy			
Mr. Fossella				Mr. Strickland	X		
Mr. Blunt		X		Ms. DeGette	X		
Mr. Davis		X		Mr. Barrett	X		
Mr. Bryant		X		Mr. Luther	X		
Mr. Ehrlich		X		Ms. Capps	X		
Mr. Buyer		X		Mr. Doyle	X		
Mr. Radanovich				Mr. John	X		
Mr. Bass		X		Ms. Harman	X		
Mr. Pitts		X					
Ms. Bono		X					
Mr. Walden		X					
Mr. Terry		X					
Mr. Fletcher		X					

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 41

BILL: H.R. 4984,Medicare Prescription Drug Benefit.

AMENDMENT: An amendment offered by Mr. Brown, No. 14, for the creation of a minimum drug benefit coverage.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 20 yeas to 27 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Markey			
Mr. Upton		X		Mr. Hall	X		
Mr. Stearns		X		Mr. Boucher			
Mr. Gillmor		X		Mr. Towns	X		
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon			
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Ganske		X		Ms. Eshoo			
Mr. Norwood		X		Mr. Stupak	X		
Mrs. Cubin		X		Mr. Engel			
Mr. Shimkus				Mr. Sawyer	X		
Mrs. Wilson		X		Mr. Wynn	X		
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering				Ms. McCarthy			
Mr. Fossella				Mr. Strickland	X		
Mr. Blunt		X		Ms. DeGette	X		
Mr. Davis		X		Mr. Barrett	X		
Mr. Bryant		X		Mr. Luther	X		
Mr. Ehrlich		X		Ms. Capps	X		
Mr. Buyer		X		Mr. Doyle	X		
Mr. Radanovich				Mr. John	X		
Mr. Bass		X		Ms. Harman	X		
Mr. Pitts		X					
Ms. Bono		X					
Mr. Walden		X					
Mr. Terry		X					
Mr. Fletcher		X					

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 42

BILL: H.R. 4984, Medicare Prescription Drug Benefit.

AMENDMENT: A substitute amendment to the Green amendment offered by Mr. Deal, No. 16a, for the counting of out of pocket costs.

DISPOSITION: **AGREED TO**, by a roll call vote of 31 yeas to 22 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin	X			Mr. Dingell		X	
Mr. Bilirakis	X			Mr. Waxman		X	
Mr. Barton	X			Mr. Markey		X	
Mr. Upton	X			Mr. Hall		X	
Mr. Stearns	X			Mr. Boucher			
Mr. Gillmor	X			Mr. Towns		X	
Mr. Greenwood	X			Mr. Pallone		X	
Mr. Cox	X			Mr. Brown		X	
Mr. Deal	X			Mr. Gordon			
Mr. Burr	X			Mr. Deutsch		X	
Mr. Whitfield	X			Mr. Rush		X	
Mr. Ganske	X			Ms. Eshoo			
Mr. Norwood	X			Mr. Stupak		X	
Mrs. Cubin	X			Mr. Engel		X	
Mr. Shimkus	X			Mr. Sawyer		X	
Mrs. Wilson	X			Mr. Wynn		X	
Mr. Shadegg	X			Mr. Green		X	
Mr. Pickering	X			Ms. McCarthy			
Mr. Fossella	X			Mr. Strickland		X	
Mr. Blunt	X			Ms. DeGette		X	
Mr. Davis	X			Mr. Barrett		X	
Mr. Bryant	X			Mr. Luther		X	
Mr. Ehrlich	X			Ms. Capps		X	
Mr. Buyer	X			Mr. Doyle		X	
Mr. Radanovich	X			Mr. John		X	
Mr. Bass	X			Ms. Harman		X	
Mr. Pitts	X						
Ms. Bono	X						
Mr. Walden	X						
Mr. Terry	X						
Mr. Fletcher	X						

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 43

BILL: H.R. 4984, Medicare Prescription Drug Benefit.

AMENDMENT: An amendment offered by Mr. John, No. 17, to assure access to any willing pharmacy.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 25 yeas to 27 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Markey	X		
Mr. Upton		X		Mr. Hall	X		
Mr. Stearns		X		Mr. Boucher			
Mr. Gillmor		X		Mr. Towns	X		
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal	X			Mr. Gordon			
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Ganske				Ms. Eshoo			
Mr. Norwood	X			Mr. Stupak	X		
Mrs. Cubin		X		Mr. Engel	X		
Mr. Shimkus		X		Mr. Sawyer	X		
Mrs. Wilson		X		Mr. Wynn	X		
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering	X			Ms. McCarthy			
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt		X		Ms. DeGette	X		
Mr. Davis		X		Mr. Barrett	X		
Mr. Bryant		X		Mr. Luther	X		
Mr. Ehrlich		X		Ms. Capps	X		
Mr. Buyer		X		Mr. Doyle	X		
Mr. Radanovich		X		Mr. John	X		
Mr. Bass		X		Ms. Harman	X		
Mr. Pitts		X					
Ms. Bono		X					
Mr. Walden		X					
Mr. Terry		X					
Mr. Fletcher		X					

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 44

BILL: H.R. 4984, Medicare Prescription Drug Benefit.

AMENDMENT: An amendment offered by Mr. Stupak, No. 18, for discounts under the Rx card.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 20 yeas to 32 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Markey			
Mr. Upton		X		Mr. Hall		X	
Mr. Stearns		X		Mr. Boucher			
Mr. Gillmor		X		Mr. Towns	X		
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon			
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Ganske		X		Ms. Eshoo			
Mr. Norwood		X		Mr. Stupak	X		
Mrs. Cubin		X		Mr. Engel	X		
Mr. Shimkus		X		Mr. Sawyer	X		
Mrs. Wilson		X		Mr. Wynn	X		
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy			
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt		X		Ms. DeGette	X		
Mr. Davis		X		Mr. Barrett	X		
Mr. Bryant		X		Mr. Luther	X		
Mr. Ehrlich		X		Ms. Capps	X		
Mr. Buyer		X		Mr. Doyle	X		
Mr. Radanovich		X		Mr. John	X		
Mr. Bass		X		Ms. Harman	X		
Mr. Pitts		X					
Ms. Bono		X					
Mr. Walden		X					
Mr. Terry		X					
Mr. Fletcher		X					

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 45

BILL: H.R. 4984, Medicare Prescription Drug Benefit.

AMENDMENT: An amendment offered by Mr. Stupak, No. 19, for access to the Federal Supply Schedule prices.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 20 yeas to 32 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Markey			
Mr. Upton		X		Mr. Hall		X	
Mr. Stearns		X		Mr. Boucher			
Mr. Gillmor		X		Mr. Towns	X		
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon			
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Ganske		X		Ms. Eshoo			
Mr. Norwood		X		Mr. Stupak	X		
Mrs. Cubin		X		Mr. Engel	X		
Mr. Shimkus		X		Mr. Sawyer	X		
Mrs. Wilson		X		Mr. Wynn	X		
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy			
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt		X		Ms. DeGette	X		
Mr. Davis		X		Mr. Barrett	X		
Mr. Bryant		X		Mr. Luther	X		
Mr. Ehrlich		X		Ms. Capps	X		
Mr. Buyer		X		Mr. Doyle	X		
Mr. Radanovich		X		Mr. John	X		
Mr. Bass		X		Ms. Harman	X		
Mr. Pitts		X					
Ms. Bono		X					
Mr. Walden		X					
Mr. Terry		X					
Mr. Fletcher		X					

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 46

BILL: H.R. 4984, Medicare Prescription Drug Benefit.

AMENDMENT: An amendment offered by Mr. Stupak, No. 20, to allow for the totally voluntary nature of the program.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 22 yeas to 28 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton				Mr. Markey			
Mr. Upton		X		Mr. Hall	X		
Mr. Stearns		X		Mr. Boucher	X		
Mr. Gillmor				Mr. Towns	X		
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon			
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Ganske		X		Ms. Eshoo			
Mr. Norwood		X		Mr. Stupak	X		
Mrs. Cubin		X		Mr. Engel	X		
Mr. Shimkus		X		Mr. Sawyer	X		
Mrs. Wilson		X		Mr. Wynn	X		
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy			
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt		X		Ms. DeGette	X		
Mr. Davis		X		Mr. Barrett	X		
Mr. Bryant				Mr. Luther	X		
Mr. Ehrlich		X		Ms. Capps	X		
Mr. Buyer		X		Mr. Doyle	X		
Mr. Radanovich		X		Mr. John	X		
Mr. Bass		X		Ms. Harman	X		
Mr. Pitts		X					
Ms. Bono		X					
Mr. Walden		X					
Mr. Terry		X					
Mr. Fletcher		X					

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 47

BILL: H.R. 4984, Medicare Prescription Drug Benefit.

AMENDMENT: An amendment offered by Mr. Waxman, No. 23, to strike language.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 22 yeas to 30 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin		X		Mr. Dingell	X		
Mr. Bilirakis		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Markey			
Mr. Upton		X		Mr. Hall	X		
Mr. Stearns		X		Mr. Boucher	X		
Mr. Gillmor				Mr. Towns	X		
Mr. Greenwood		X		Mr. Pallone	X		
Mr. Cox		X		Mr. Brown	X		
Mr. Deal		X		Mr. Gordon			
Mr. Burr		X		Mr. Deutsch	X		
Mr. Whitfield		X		Mr. Rush	X		
Mr. Ganske		X		Ms. Eshoo			
Mr. Norwood		X		Mr. Stupak	X		
Mrs. Cubin		X		Mr. Engel	X		
Mr. Shimkus		X		Mr. Sawyer	X		
Mrs. Wilson		X		Mr. Wynn	X		
Mr. Shadegg		X		Mr. Green	X		
Mr. Pickering		X		Ms. McCarthy			
Mr. Fossella		X		Mr. Strickland	X		
Mr. Blunt		X		Ms. DeGette	X		
Mr. Davis		X		Mr. Barrett	X		
Mr. Bryant		X		Mr. Luther	X		
Mr. Ehrlich		X		Ms. Capps	X		
Mr. Buyer		X		Mr. Doyle	X		
Mr. Radanovich		X		Mr. John	X		
Mr. Bass		X		Ms. Harman	X		
Mr. Pitts		X					
Ms. Bono		X					
Mr. Walden		X					
Mr. Terry		X					
Mr. Fletcher		X					

COMMITTEE ON ENERGY AND COMMERCE -- 107TH CONGRESS
ROLL CALL VOTE # 48

BILL: H.R. 4984, Medicare Prescription Drug Benefit.

MOTION: Motion by Mr. Tauzin to order H.R. 4984 reported to the House, amended.

DISPOSITION: **AGREED TO**, by a roll call vote of 30 yeas to 23 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Tauzin	X			Mr. Dingell		X	
Mr. Bilirakis	X			Mr. Waxman		X	
Mr. Barton	X			Mr. Markey		X	
Mr. Upton	X			Mr. Hall		X	
Mr. Stearns	X			Mr. Boucher		X	
Mr. Gillmor				Mr. Towns		X	
Mr. Greenwood	X			Mr. Pallone		X	
Mr. Cox	X			Mr. Brown		X	
Mr. Deal	X			Mr. Gordon			
Mr. Burr	X			Mr. Deutsch		X	
Mr. Whitfield	X			Mr. Rush		X	
Mr. Ganske	X			Ms. Eshoo			
Mr. Norwood	X			Mr. Stupak		X	
Mrs. Cubin	X			Mr. Engel		X	
Mr. Shimkus	X			Mr. Sawyer		X	
Mrs. Wilson	X			Mr. Wynn		X	
Mr. Shadegg	X			Mr. Green		X	
Mr. Pickering	X			Ms. McCarthy			
Mr. Fossella	X			Mr. Strickland		X	
Mr. Blunt	X			Ms. DeGette		X	
Mr. Davis	X			Mr. Barrett		X	
Mr. Bryant	X			Mr. Luther		X	
Mr. Ehrlich	X			Ms. Capps		X	
Mr. Buyer	X			Mr. Doyle		X	
Mr. Radanovich	X			Mr. John		X	
Mr. Bass	X			Ms. Harman		X	
Mr. Pitts	X						
Ms. Bono	X						
Mr. Walden	X						
Mr. Terry	X						
Mr. Fletcher	X						

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee has held oversight or legislative hearings on this legislation and made findings that are reflected in this report.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

H.R. 4984 will create a new, voluntary Medicare outpatient prescription drug benefit, available to all Medicare beneficiaries.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 4984, to amend title XVIII of the Social Security Act to provide for a Medicare prescription drug benefit, would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 24, 2002.

Hon. W.J. "BILLY" TAUZIN,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for the Medicare Modernization and Prescription Drug Act of 2002, as ordered reported by the Committee on Energy and Commerce on June 21, 2002.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Julia Christensen.

Sincerely,

STEVEN LIEBERMAN
(For Dan L. Crippen, Director).

Enclosure.

Medicare Modernization and Prescription Drug Act of 2002

Summary: The bill would establish an outpatient prescription drug benefit in Medicare and would modify Medicare's payment rates or coverage rules for many services, including those furnished by hospitals, skilled nursing facilities, home health agencies, physi-

cians, physical and speech therapists, occupational therapists, and managed care plans. CBO estimates those provisions would increase direct spending by $4.3 billion in 2003 and by $341 billion over the 2003–2012 period.

The bill would authorize the collection of civil penalties for the failure of interstate Internet pharmacies to comply with disclosure requirements. Those collections would be classified as revenues (i.e., governmental receipts). However, CBO assumes that there would be substantial compliance with the disclosure requirements and that the effect on revenues would be negligible. Because the bill would affect direct spending and revenues, pay-as-you go procedures would apply.

The bill would also affect discretionary spending. It would require the Centers for Medicare and Medicaid Services to modify how Medicare regulations and policies are developed, communicated, and enforced. It also would establish a Medicare Benefits Administration to administer the outpatient drug benefit and the Medicare+Choice program. The bill also would establish an Office of Rare Diseases at the National Institutes of Health, require several studies, and authorize several grant programs. CBO has not completed an estimate of the costs of activities subject to appropriations of the necessary amounts.

The bill contains intergovernmental mandates, including a number of preemptions of state law, as defined in the Unfunded Mandates Reform Act (UMRA). CBO estimates that the preemption of state premium taxes would result in revenue losses to states of about $70 million in 2005 (the first year the mandate is effective) increasing to about $100 million in 2009. Those losses would exceed the threshold established in UMRA ($62 million in 2005, adjusted annually for inflation). CBO estimates that other mandates and preemptions in the bill would impose minimal or no costs on states, local, or tribal governments.

The bill would modify several existing private-sector mandates on insurers that offer Medicare supplemental (medigap) coverage and would impose new requirements on Internet pharmacies and group health plans. CBO estimates that the direct cost of the mandates in the bill would not exceed the threshold specified in UMRA ($115 million in 2002, adjusted annually for inflation).

Estimated cost to the Federal Government: The estimated budgetary impact of the bill is summarized in Table 1 and major components of those costs are outlined below. The costs of this legislation fall within budget functions 550 (health) and 570 (Medicare).

Major provisions: The following discussion highlights changes in gross outlays directly attributable to provisions of the act. In addition, the estimate includes three interactions: the effect of changes in Medicare Part B outlays on receipts from Part B premiums, the effect of changes in Part B premiums and cost sharing on federal Medicaid spending, and the effect of changes in Medicare payment rates on federal Medicaid spending subject to the "upper payment limit" (UPL).

About 25 percent of new Part B outlays would be covered by premium payments by beneficiaries. CBO estimates that those premium payments would total ($4.8 billion from 2003 through 2012. Such payments would be recorded as offsetting receipts (a credit against direct spending).

Medicaid pays some or all of premiums and cost sharing for individuals dually eligible for Medicaid and Medicare and for other low-income Medicare beneficiaries not poor enough to qualify for full Medicaid benefits. In addition to changing the Part B premium, the bill would change cost sharing for services furnished in hospital outpatient departments and would change payment rates for many services (which would affect cost sharing). CBO estimates that the changes in premiums and cost sharing would increase federal Medicaid costs by about $0.3 billion over the 2003–2012 period.

TABLE 1.—ESTIMATED IMPACT ON DIRECT SPENDING OF THE MEDICARE MODERNIZATION AND PRESCRIPTION DRUG ACT OF 2002, AS ORDERED REPORTED BY THE COMMITTEE ON ENERGY AND COMMERCE ON JUNE 21, 2002

	By fiscal year, outlays in billions of dollars—										
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2003–12
MEDICARE OUTLAYS											
Title I: Medicare Prescription Drug Benefit	0	0	22.3	36.1	40.6	45.8	51.3	57.5	64.3	72.4	390.4
Title II: Medicare-Choice:											
201 M+C payment improvements	0.5	1.1	0.5	0	0	0	0	0	0	0	2.2
211 M+C competition program	0	0	0.6	0.9	0.9	0.3	−0.4	−0.6	−0.6	−0.5	0.7
Other provisions	*	*	*	*	*	*	*	*	*	*	0.1
Subtotal, title II	05	1.2	1.2	0.9	0.9	0.3	−0.4	−0.6	−0.6	−0.5	2.9
Title III: Rural Health Care Improvements:											
302 Disproportionate share adjustment	0.0	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	1.6
303 Standardized payment amount	0.3	0.6	0.6	0.7	0.7	0.8	0.8	0.9	0.9	1.0	7.2
306 Home Health 10 percent rural add-on	0.1	0.3	0.1	*	0	0	0	0	0	0	0.6
Other provisions	*	*	*	*	*	*	*	*	*	*	0.1
Subtotal, title III	0.4	1.0	0.9	0.9	0.9	1.0	1.0	1.1	1.2	1.2	9.5
Title IV: Part A:											
401 Hospital update	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.4	0.5	3.6
402 Indirect medical education	0.4	0.3	0	0	0	0	0	0	0	0	0.7
404 Phase-in federal rate in Puerto Rico	*	*	*	*	*	*	*	*	*	*	0.2
411 Skilled Nursing Facility payment rates	0.4	0.5	0.6	0.1	0	0	0	0	0	0	1.6
421 Hospice Consultation Services	0	*	*	*	*	*	*	*	*	*	0.2
Other provisions	*	*	*	*	*	*	0	0	0	0	0.1
Subtotal, title IV	1.1	1.2	0.9	0.5	0.4	0.4	0.4	0.5	0.5	0.5	6.4
Title V: Part B:											
501 Updates for physicians' services	1.6	4.4	6.6	5.7	2.9	−0.4	−2.5	−3.0	−2.5	−1.4	11.5
511 Competitive acquisition	0	−0.2	−0.4	−0.7	−0.8	−0.9	−1.0	−1.1	−1.2	−1.3	0.6
512 Ambulance	0.2	0.2	0.1	0.1	*	0	0	0	0	0	0.6
513 Therapy cap: 2 year extension of moratorium	0.4	0.5	0.1	*	*	*	*	*	*	*	1.0
514 Hospital outpatient services	0	0.2	0.5	0.7	0.8	0.8	0.8	1.0	1.8	3.1	9.7
515 Routine physical	0	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	1.3
516 Renal dialysis services	*	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.7
Other provisions	*	0.1	0.1	*	*	*	*	*	*	0.1	0.2
Subtotal, title V	2.2	5.4	7.2	6.0	3.0	−0.3	−2.5	−2.9	−1.6	0.7	17.3
Title VI: Parts A and B:											
Home Health Provisions	0.4	0.2	*	−0.1	−0.1	−0.1	−0.1	−0.1	−0.1	−0.1	*

TABLE 1.—ESTIMATED IMPACT ON DIRECT SPENDING OF THE MEDICARE MODERNIZATION AND PRESCRIPTION DRUG ACT OF 2002, AS ORDERED REPORTED BY THE COMMITTEE ON ENERGY AND COMMERCE ON JUNE 21, 2002—Continued

	By fiscal year, outlays in billions of dollars—										
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2003–12
611 Limit on high cost medical education programs	*	*	−0.1	−0.2	−0.2	−0.3	−0.3	−0.4	−0.5	−0.5	−2.6
612 Redistribute unused residency positions	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.0
Other provisions	0	*	*	*	0	0	0	0	0	0	*
Subtotal, title VI	0.3	0.3	*	−0.1	−0.2	−0.2	−0.3	−0.4	−0.4	−0.5	−1.6
Title VII: Medicare Benefits Administration	0	0	0	0	0	0	0	0	0	0	0
Title VIII: Regulatory Reform	*	*	*	*	*	*	*	*	*	*	0.1
Title IX: Medicaid, Public Health, and other Provisions	0	0	0	0	0	0	0	0	0	0	0
Subtotal, Gross Medicare Outlays	4.5	8.9	32.6	44.2	45.7	47.0	49.7	55.1	63.4	73.9	425.0
Premium Collections	−0.7	−1.6	−2.0	−1.6	−0.9	*	0.7	0.8	0.5	−0.1	−4.8
Subtotal, Net Medicare Outlays	3.8	7.3	30.6	42.6	44.8	47.0	50.3	55.9	63.9	73.8	420.1
MEDICAID OUTLAYS											
Title I: Medicare Prescription Drug Benefit	0	*	−3.8	−8.2	−8.7	−9.5	−10.6	−11.8	−13.3	−14.8	−81.0
902 Disproportionate Share Payments	0.4	0.3	0.3	0.2	0.2	0.2	0.2	0.1	0.1	*	2.0
Spending Subject to Upper Payment Limit	0.1	0.1	0.1	*	*	*	*	*	*	*	0.2
Medicaid Payments of Medicare Premiums	0.1	0.2	0.2	0.2	0.1	*	−0.1	−0.1	−0.1	−0.1	0.3
Subtotal, Medicaid	0.5	0.6	−3.3	−7.8	−8.4	−9.4	−10.5	−11.8	−13.3	−14.9	−78.3
OTHER DIRECT SPENDING [1]											
Title I: Medicare Prescription Drug Benefit	0	0	−0.1	−0.2	−0.2	−0.2	−0.2	−0.3	−0.3	−0.3	−1.7
702 Pharmacy Grant Program	*	0.1	0.2	0.2	0.2	*	*	*	*	*	0.6
Subtotal, other direct spending	*	0.1	0.1	*	−0.1	−0.2	−0.2	−0.3	−0.3	−0.3	−1.1
TOTAL CHANGES IN DIRECT SPENDING											
Estimated Outlays	4.3	8.0	27.4	34.8	36.3	37.5	39.6	43.9	50.3	58.7	340.7

[1] Federal savings in the Federal Employees Health Benefits program. Department of Defense spending on health benefits for Medicare-eligible retirees, and spending from the Combined Benefits Funds for the United Mine Workers Association.

Notes:
*=Between −$50 million and $50 million.
Numbers may not add up to totals because of rounding.

State Medicaid programs use Medicare payment rates to calculate the maximum amount, known as the upper payment limit, that they can pay for services furnished by hospitals and nursing homes. In recent years, many states have increased their Medicaid payments up to the UPL in order to draw down additional federal funds. The bill would raise Medicare payment rates for services furnished by hospitals and skilled nursing facilities, thus boosting the UPL and allowing states to receive additional federal Medicaid funds. CBO estimates that the bill would increase federal Medicaid spending subject to the UPL by $0.2 billion over the 2003–2012 period.

TITLE I—MEDICARE OUTPATIENT PRESCRIPTION DRUG BENEFIT

Title I would create a voluntary outpatient prescription drug benefit, beginning in 2005, under a new Part D of the Medicare program. The prescription drug benefit would be offered by competing private drug plans that would be a financial risk for covering the cost of the benefit. Premiums would be charged to participating beneficiaries and subsidized, in part, by the Medicare program. The bill would establish a program to subsidize premiums and cost sharing for certain low-income beneficiaries, and would reduce federal Medicaid payments to states through 2012 by a proportion of the spending for subsidized premiums and cost sharing attributed to Medicare enrollees who are entitled to prescription drug coverage under Medicaid.

CBO estimates that the Part D provision would increase direct spending by about $308 billion over the 2003–2012 period (see Table 2). Of that 10-year total, $301 billion represents outlays for federal payments to plans offering qualified prescription drug coverage and $92 billion is for spending by Medicare for the low-income subsidy program. Those costs would be partially offset by $96 billion in federal savings associated with the new drug program, because Part D would replace or supplement drug coverage that some Medicare enrollees obtain through Medicaid, the Federal Employees Health Benefits program, the Department of Defense, or the Combined Benefits Funds of the United Mine Workers Association. Other effects of the program—largely the result of increased enrollment of Medicare enrollees in Medicaid, offset, in part, by the reduction through 2012 in federal Medicaid payments to states—would increase federal spending by $11 billion through 2012, CBO estimates.

TABLE 2.—EFFECT ON DIRECT SPENDING OF ESTABLISHING A PRESCRIPTION DRUG BENEFIT IN MEDICARE: TITLE I OF THE MEDICARE MODERNIZATION AND PRESCRIPTION DRUG ACT OF 2002

	By fiscal year, outlays in billions of dollars—										
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2003–12
CHANGES IN DIRECT SPENDING											
Medicare Spending on Prescription Drugs	0	0	19	29	32	35	39	44	49	54	301
Spending by Medicaid and Other Programs on Drugs for Medicare Enrollees	0	0	−4	−9	−10	−12	−13	−14	−16	−18	−96
Low-income Subsidy	0	0	4	8	10	11	13	14	16	17	92
Other Direct Spending [1]	0	*	*	*	*	1	2	2	3	3	11
Total Federal Spending	0	*	18	28	32	36	41	45	51	57	308
Memorandum:											
Monthly Premium	n.a.	n.a.	$34	$36	$39	$42	$46	$51	$55	$60	
Dedutible	n.a.	n.a.	$250	$276	$303	$333	$364	$398	$435	$475	

[1] Other Direct spending includes changes in Medicare and Medicaid spending associated with increases in the number of Medicare beneficiaries enrolled in Medicaid and reductions in federal Medicaid payments to states.

Notes:
* =Cost or savings of less than $500 million.
n.a.= not applicable because the benefit would not take effect until 2005.
Numbers may not add up to tools because of rounding.

Under the prescription drug benefit, plan sponsors would offer either "standard coverage" or actuarially equivalent coverage, if approved by the Medicare Benefits Administration. For 2005, stand-

ard coverage would have a $250 deductible; 20 percent cost sharing for cost between $250 and $1,000; and 50 percent cost sharing for costs between $1,000 and $2,000. Beneficiaries would be responsible for 100 percent of costs above $2,000 until the beneficiary reaches the catastrophic limit at $3,700 in out-of-pocket spending. In subsequent years, those amounts would be increased by the percentage change in per-capita spending for outpatient prescription drugs among the Medicare population.

The beneficiary would stop paying for covered prescription drugs after reaching the catastrophic limit (out-of-pocket spending of $3,700 in 2005). However, only payments made by the beneficiary, the low-income subsidy, or by Medicaid would count toward that catastrophic limit; payments or reimbursements made by other insurance or third-party payers would not count toward that limit.

Each plan would establish its own premium. CBO estimates that premiums would average about $34 in 2005, increasing to $60 in 2012.

The Medicare program would subsidize the drug benefit through two payments to plans: reimbursement of 36 percent of the plan's spending for the standard benefit and "individual reinsurance" payments for high-cost beneficiaries that, in aggregate, equal 30 percent of total spending for standard benefits.

Individuals with incomes below 150 percent of the federal poverty level would be eligible for a full subsidy of the lowest premium in the market and the cost sharing for drug spending below $2,000. For individuals with incomes between 150 percent and 175 percent of the federal poverty level, there would be a full subsidy of cost sharing for costs below $2,000 and there would be a sliding-scale subsidy of the lowest premium in the market. (In 2002, the federal poverty level is $8,860 for an individual and $11,940 for a couple.)

TITLE II—MEDICARE+CHOICE REVITALIZATION AND COMPETITION

Title II would increase rates paid to Medicare+Choice plans in calendar years 2003 and 2004, and would establish a new Medicare+Choice payment system based on competitive bidding, beginning in 2005. The bill also would extend several expiring programs and demonstration programs involving group plans. CBO estimates the provisions in title II would increase direct spending by $0.5 billion in 2003 and by $2.9 billion over the 2003–2012 period.

CBO estimates that a requirement in current law will hold increases in rates paid to nearly all Medicare+Choice plans to 2 percent in both 2003 and 2004. The bill would eliminate that requirement and modify the payment formula to pay the largest of four amounts: a minimum payment amount, a blend of local and national amounts based on inflated historical per-capita costs in the fee-for-service sector, estimated current per-capita costs in the fee-for-service sector, and a minimum increase of 3 percent. (The minimum payment amounts would be $425 in most counties and $525 in counties in a metropolitan area with a population greater than 250,000, updated from 2001 by the increase in per-capita spending in the Medicare program.) That provision would affect spending during fiscal years 2003 through 2005, increasing outlays by $0.5 billion in 2003 and by a cumulative total of $2.2 billion.

The bill would establish a competitive bidding program for Medicare+Choice plans, beginning in 2005. Under the program,

plans would submit bids for the cost of providing standard benefits under Parts A and B of Medicare and the standard drug benefit under Part D. Those bids for standard Part A and Part B benefits would be compared to a benchmark amount, which in 2005 through 2007 would be the larger of the minimum payment amount and estimated current per-capita costs in the fee-for-service sector. Beginning in 2008, the benchmark amount would be the larger of the minimum payment amount and 95 percent of per-capita costs in the fee-for-service sector. If a plan were to bid below the benchmark amount, Medicare would pay the plan the bid plus an amount that would approximate 75 percent of the difference between the bid and the benchmark amount (after adjusting for differences in risk attributable to the health status of the plan's enrollees). The plans could rebate that additional payment to Medicare enrollees, or could use it to pay for additional benefits. CBO estimates that the competition program would increase spending during the 2005–2008 period and reduce spending beginning in 2009, with spending through 2012 increasing by a total of $0.7 billion.

TITLE III—RURAL HEALTH CARE IMPROVEMENTS

Title III would increase payment rates for inpatient services furnished by hospitals in rural areas or metropolitan areas with a population under one million, and for services furnished by home health agencies located in rural areas. CBO estimates those provisions would increase spending by $0.4 billion in 2003 and by about $9.5 billion through 2012. Two provisions—increasing the standardized payment amount and increasing payments to hospitals that qualify for a payment adjustment as a disproportionate share hospital—account for $8.8 billion of that 10-year total.

TITLE IV—PROVISIONS RELATING TO MEDICARE PART A

Title IV would increase payment rates for inpatient services furnished by hospitals, skilled nursing facilities, and hospices. CBO estimates the provisions in title IV would increase spending by $1.1 billion in 2003 and by $6.4 billion over the 2003–2012 period.

The bill would increase the 2003 update to payment rates for hospital inpatient services paid under the prospective payment system from 0.55 percentage points below the "market basket index" measure of changes in hospital input prices to 0.25 percentage points below that index. Hospitals designated as sole community hospitals would receive an update in 2003 equal to the market basket index. CBO estimates that provision would increase spending by $0.3 billion in 2003 and $3.6 billion over the 2003–2012 period.

Temporary increases in payments to teaching hospitals and skilled nursing facilities account for most of the remaining costs of title IV. Teaching hospitals would receive higher payments for two years, at an estimated cumulative cost of $0.7 billion, and skilled nursing facilities would receive higher payment rates for three years, at a cumulative cost of $1.6 billion.

TITLE V—PROVISIONS RELATING TO MEDICARE PART B

CBO estimates that the provisions of title V would increase Medicare spending by $2.2 billion in 2003 and $17.3 billion over

the 2003–2012 period. The provisions with the largest budgetary effects include changes in payments for physicians' services, assumption of some cost sharing for services furnished by hospital outpatient departments, establishment of a competitive acquisition program for durable medical equipment and certain orthotics, coverage of some routine physical examinations, and a two-year delay in the implementation of caps on payments for certain therapy services.

Compared to current law, CBO estimates that the bill would increase payments for services paid under the physician fee schedule during 2003 through 2007, with outlays increasing by $1.6 billion in 2003 and by $21.3 billion through 2007. However, the bill would reduce payments for those services in 2008 and subsequent years, with a net increase in spending during the 2003–2012 period of $11.5 billion.

Before the Balanced Budget Act of 1997 (BBA), beneficiaries paid cost sharing of 20 percent of charges for hospital outpatient services and the program paid 80 percent of allowed charges. Allowed charges generally were a much lower amount than charges. As a result, beneficiaries, on average, were paying about half of payments to hospitals for outpatient services. The BBA and subsequent legislation are phasing in increases in payments for outpatient services while limiting cost sharing, with the objective of reducing the share paid by beneficiaries to 20 percent. The bill would accelerate the Medicare program's assumption of cost sharing in excess of 20 percent, beginning in 2004. CBO estimates that provision would increase spending by $9.7 billion over the 2003–2012 period.

The bill would expand and make permanent a demonstration project in which certain durable medical equipment and orthotics are acquired through competitive bidding instead of paying on the basis of a fee schedule. CBO estimates that provision would reduce spending by $7.7 billion through 2012.

Beginning in 2004, the bill would require Medicare to pay for a routine physical examination, and associated services, when furnished within six months of when a beneficiary first enrolls in Medicare. Beneficiaries already enrolled in Medicare would not be eligible for this benefit. CBO estimates this provision would cost $1.3 billion over the 2003–2012 period.

TITLE VI—PROVISIONS RELATING TO MEDICARE PARTS A AND B

Title VI would modify payment rates for home health services, limit subsidies to hospitals with graduate medical education (GME) programs and permit redistribution of subsidized GME slots, and establish several demonstration programs. CBO estimates that the provisions of title VI would increase Medicare spending by $0.3 billion in 2003 and would reduce spending by $1.6 billion over the 2003–2012 period.

Under current law, there will be a so-called "15 percent" reduction in 2003 in rates paid for services to furnished by home health agencies (the actual reduction would be about 7 percent). The bill would eliminate the reduction, but would provide for smaller annual updates to payment rates in subsequent years. CBO estimates that provision would increase federal spending by $0.4 billion in

2003 and reduce spending by less than $50 million over the 2003–2012 period.

Under current law, a limit on subsidies for GMC programs—at 140 percent of the adjusted national average per-resident amount—will expire at the end of 2002. The bill would extend that limit through 2012, reducing federal spending by about $2.6 billion over the 2003–2012 period. Current law caps the number of residency slots at each teaching hospital that are eligible for GME subsidies. The bill would permit unused residency slots to be redistributed to hospitals that have reached their caps. CBO estimates that provision would increase spending by $1 billion over the 2003–2012 period.

TITLE VII—MEDICARE BENEFITS ADMINISTRATION

The bill would establish a Medicare Benefits Administration within the Department of Health and Human Services to administer the Medicare+Choice competition program and the prescription drug benefit. The bill also would provide $150 million a year during 2004 through 2007 for a program for grants to pharmacies. CBO estimates that title VII would increase direct spending by $0.6 billion over the 2003–2012 period.

TITLE VIII—REGULATORY REDUCTION AND CONTRACTING REFORM

Title VIII would establish a procedure for obtaining a determination before a service is furnished whether Medicare will pay for that service. CBO estimates that provision would increase direct spending by about $0.1 billion over the 2003–2012 period.

TITLE IX—MEDICAID, PUBLIC HEALTH, AND OTHER HEALTH PROVISIONS

CBO estimates that the provisions of title IX would have no effect on direct spending.

Pay-as-you-go considerations: The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects through 2006 are counted.

	By fiscal year, in millions of dollars—										
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Changes in outlays	0	4,100	7,700	26,600	34,000	35,700	37,200	39,500	43,700	50,200	58,500
Changes in receipts	0	0	0	0	0	0	0	0	0	0	0

Estimated impact on state, local, and tribal governments: The bill contains intergovernmental mandates, including a number of preemptions of state law, as defined in the Unfunded Mandates Reform Act. CBO estimates that the preemption of state premium taxes would result in revenue losses to states of about $70 million in 2005 (the first year the mandate is effective) increasing to about $100 million in 2009. Those losses would exceed the threshold established in UMRA ($62 million in 2005, adjusted annually for inflation). CBO estimates that other mandates and preemptions in

the bill would impose minimal or no costs on state, local, or tribal governments. Provisions of the bill affecting Medicaid would result in net savings to state and local governments of about $48 billion over the 2003–2012 period, and additional spending for disproportionate share hospitals would total $1.5 billion over the same period.

Mandates

The bill would prohibit states from imposing premium taxes on prescription drug plans (PDPs), and this prohibition would be an intergovernmental mandate as defined in UMRA. Participation in PDPs would result in a shift away from taxable plans. Such a shift, in combination with the preemption of state taxing authority for the new plans, would result in a loss of tax revenues. CBO estimates that approximately 10 million people would change their insurance coverage for prescription drugs from taxable plans to PDPs. As a result, states would be unable to collect premium taxes (ranging from 0.2 percent to 3.0 percent of premiums) on those plans. CBO estimates that state losses of premium tax revenue as a result of this preemption would range from about $70 million in 2005 to $100 million in 2009.

The bill also would allow the Secretary of Health and Human Services to waive state licensure requirements for PDPs in cases where a state fails to act on a license application within 90 days or where a state denial is based on discriminatory treatment or solvency requirements that differ from those in the bill. In cases where the Secretary waives licensure requirements, states would lose fees associated with those licenses. CBO cannot estimate the magnitude of such losses because we have no basis for predicting the number of cases where a waiver would be possible or would be granted.

Health plans that provide prescription drug coverage, including retiree prescription drug plans and state pharmaceutical programs, would be required to disclose whether the coverage they offer provides benefits at least equivalent to the benefits under the PDP. That disclosure requirement would be an intergovernmental mandate as defined by UMRA; however CBO estimates that the costs of the mandate would be minimal.

The bill would preempt state solvency standards for PDP sponsors and would supercede all state laws governing Medicare+Choice plans, with the exception of licensing or solvency requirements. While these preemptions would limit the application of state laws, they would impose no duties on states that would result in additional spending.

Other impacts

The net effect of the bill on state Medicaid spending is expected to be savings totaling about $48 billion over the 2003–2012 period. On the one hand, state Medicaid programs would benefit as coverage responsibility for individuals that are dually eligible for Medicaid and Medicare shift from Medicaid to Medicare. However, some of these savings would be offset by new prescription drug spending for new enrollees who are dually eligible for both Medicare and Medicaid. CBO estimates that savings to states from these provisions would total about $60 billion over the 2003–2012

period. On the other hand, the federal government would withhold funds from states' quarterly reimbursements for Medicaid, reducing state savings over the same period by about $12 billion.

States would be required to determine whether an individual would be eligible for premium and cost-sharing assistance under Medicare. The costs associated with this additional requirement would decrease over time because the matching rate from the federal government would increase annually until 2014 when it would equal 100 percent. In addition, increased allotments for disproportionate share hospitals in states would increase state Medicaid spending by about $1.5 billion. Because states may alter their programmatic and financial responsibilities to offset these costs, they would not be intergovernmental mandates as defined in UMRA.

State and local governments that provide health insurance to their employees may benefit from federal reinsurance payments provided for in the bill. They may alter their current prescription drug plans to qualify for reinsurance payments or they may contract with outside PDPs that qualify. In either case, those governments could realize savings in their health plans for retirees. Because CBO cannot predict how states might restructure the prescription drug component of their health plans, we cannot estimate the size of any federal reinsurance payments that would accrue to those governments.

Estimated Impact on the private sector: The bill would modify or create a number of mandates on private-sector entities. CBO estimates that the direct cost of the mandates in the bill would not exceed the threshold specified in UMRA ($115 million in 2002, adjusted annually for inflation).

Section 104 of the bill would modify several existing private-sector mandates on insurers that offer Medicare supplement (medigap) coverage. One change would bar insurers from offering policies that include prescription drug coverage (policy categories H, I, and J) except to beneficiaries currently enrolled in the plans. However, insurers would be allowed to offer to beneficiaries who enroll in the Part D program two new medigap policies whose coverage would complement the Part D coverage. In addition, insurers who sell medigap policies without prescription drug coverage (policy categories A–G) would have to make those policies available, on a similar basis as they do to beneficiaries newly eligible to purchase medigap coverage, to any beneficiary who enrolls in the new Medicare Part D program and who, at the time of enrollment in Part D, held an H, I, or J policy.

CBO estimates that most Medicare beneficiaries who would purchase medigap plans with prescription drug coverage under current law would join the new Part D program under the bill and would also purchase one of the two new medigap drug plans. As a result, nearly all of the profits lost by insurers due to restrictions on current medigap plans would be offset by profits earned ion the new drug plans.

The bill would also impose three new private-sector mandates. Section 1860A would require health plans that provide prescription drug coverage, including retiree prescription drug plans and state pharmaceutical programs, to certify that the coverage they offer provides benefits at least equivalent to the benefits under Part D. Such a certification would be needed by enrollees who wanted to

enter the Medicare drug benefit late because they had previously obtained coverage from the certifying plan. Section 850 would bar group health plans from requiring dental providers to obtain a claims determination from Medicare for dental benefits specifically excluded from Medicare coverage as a condition for obtaining a claims determination for such benefits under the group health plan. Section 912 would require pharmacies operating on the Internet to disclose their existence to state licensing boards and to post certain information on their web sites. CBO estimates that the direct cost of these mandates would be small.

Estimate prepared by: Federal Costs: Medicare outpatient prescription drug benefit—Julia Christensen, Jeanne De Sa, and Eric Rollins; Rachel Schmidt and Sarah Thomas. Medicare+Choice Competition—Niall Brennan. Other provisions—Alexis Ahlstrom, Charles Betley, Niall Brennan, Julia Christensen, Jeanne De Sa, Eric Rollins, Christopher Topoleski. Impact on State, Local, and Tribal Governments: Leo Lex. Impact on the Private Sector: Stuart Hagen.

Estimate approved by: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 3(d)(1) of Rule XIII of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for this legislation is provided in Article I, section 8, clause 3, which grants Congress the power to regulate commerce with foreign nations, among the several States, and with the Indian tribes.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 101. Establishment of a Medicare Prescription Drug Benefit

Section 101 establishes a new Voluntary Prescription Drug Benefit Program under a new Part D of title XVIII of the Social Security Act, as follows:

Sec. 1860A. Benefits; Eligibility; Enrollment; and Coverage Period

All beneficiaries entitled to Part A and enrolled in Part B of the Medicare program will be eligible to enroll in a qualified prescription drug plan (PDP) offered either through a Medicare+Choice

(M+C) plan or other sponsoring organization such as a Pharmacy Benefit Manager. Each beneficiary enrolled in Parts A and B will have a choice between two qualified PDPs.

Beneficiaries can elect to enroll in either Part D or obtain prescription drug coverage offered by a M+C plan under Part C. Beneficiaries who elect to participate in Medicare Part D will select and enroll in a plan available in their area through a process similar to Part C enrollment. Individuals who are entitled to benefits under Part A or are enrolled under Part B as of November 1, 2004 will have an initial election period of 6 months. Those who are entitled to benefits under Part A or enrolled under Part B after November 1, 2004 will have an election period that is the same as the initial enrollment period for Part C. Beneficiaries will be able to enroll and change plans during specified election periods thereafter. The election periods would coincide with M+C coverage election periods, including annual coordinated elections periods and special election periods. The Secretary will establish special enrollment periods for those who involuntarily lose alternative prescription drug coverage, miss an enrollment deadline due to a process error, met exceptional circumstances, or become eligible for prescription drug assistance under Medicaid.

H.R. 4984 establishes guaranteed issue and community-rating requirements. All eligible beneficiaries who elect to enroll in a PDP will not be excluded on the basis of a pre-existing condition or their economic status and will be guaranteed continuous coverage while enrolled in the program. When a beneficiary is not continuously enrolled in a PDP, a sponsor or M+C plan may adjust the premium or impose a pre-existing condition exclusion that is consistent with the risk of enrolling that beneficiary. A PDP sponsor is prohibited from establishing a service area in a manner that would discriminate based on health or economic status of potential enrollees.

Elections take effect at the same time that elections take effect for M+C plans. The initial period of coverage under the program will begin January 1, 2005. The Administrator will provide for the termination of an election when coverage is terminated under both Parts A and B and in the same instances as is permitted for M+C plans to terminate an individual's election.

Sec. 1860B. Requirements for Qualified Prescription Drug Coverage

This section specifies the requirements for qualified prescription drug coverage. Qualified coverage is defined as either "standard coverage" or actuarially equivalent coverage. All PDP plans will be required to make available to their enrollees the benefit of all price discounts. They will also provide coverage of outpatient prescription drugs on formulary.

Requirements for 2005 include an annual deductible of $250, beneficiary cost sharing of 20% of the first $1000 of expenditures, 50% of the next $1000 of expenditures, and a limitation of total out-of-pocket expenditures of $3,700—or the actuarial equivalent of each. Incurred costs include costs incurred for the annual deductible, cost-sharing, and amounts for which benefits are not provided because of application of the initial coverage limits; such costs are incurred only if paid by the individual or a direct family member, paid on behalf of a low-income individual under the subsidy provisions, or paid under the Medicaid program. In 2006 and subse-

quently, the annual dollar amounts will be increased by the annual percentage increase in average per capita aggregate expenditures for covered outpatient drugs for Medicare beneficiaries for the 12–month period ending in July of the previous year.

A PDP or M+C plan can provide a benefit different from the standard coverage requirement as long as it is actuarially equivalent in value, provides for payment of incurred costs up to the initial coverage limit of at least the same percentage of costs under standard coverage, and maintains the same stop loss protection as under standard coverage.

Beneficiaries enrolled in either a PDP or a M+C plan offering qualifying prescription drug coverage will have access to negotiated prices, including discounts. This access will be provided even when no benefits are payable because of the application of cost-sharing or initial coverage limits. The PDP sponsors or M+C plans will fully disclose to the Secretary the degree to which discounts and rebates are passed along to the beneficiaries. Manufacturers would be required to disclose pricing information to the Administrator under the same conditions currently required for Medicaid.

The Secretary will determine the actuarial valuation of coverage including reinsurance subsidy payments. PDP sponsors and M+C plans will also be allowed to use qualified independent actuaries to establish the valuation of coverage.

A covered outpatient drug includes prescription drugs and biological products. It excludes drugs or classes of drugs that are excluded from Medicaid covered drugs (except smoking cessation drugs) and those drugs that are paid under Parts A or B of Medicare. If a plan meets the beneficiary protection requirements in section 1860C, it could use a formulary for certain covered outpatient drugs. A PDP or M+C plan could exclude from coverage, subject to reconsideration and appeals, any drug that does not meet Medicare's definition of medically necessary or was not prescribed in accordance with the plan or Part D.

Sec. 1860C. Beneficiary Protections for Qualified Prescription Drug Coverage

Plans will be required to provide each enrolled beneficiary information about the plan's benefit structure, its affiliated networks of pharmacy providers, any applicable formulary requirements including cost-sharing schemes and their right to file grievances and/or seek benefit appeal. Plans will be required to respond to beneficiary inquiries and make available information regarding any changes in the plan's formulary.

The PDP sponsor will ensure convenient access to a sufficient number of pharmacies that dispense drugs to patients, and cannot provide mail-order only delivery of drugs. Beneficiaries will also have the option of going to a pharmacy out of the network but the plan will have the ability to change the cost-sharing associated with drugs dispensed by out-of-network pharmacies. Every sponsor of a PDP will have a pharmacy and therapeutic committee that will develop and maintain a formulary. The formulary will be a list of covered drugs including at least two drugs for every therapeutic category.

PDP sponsors will be required to establish and maintain quality assurance, utilization management, and medication therapy man-

agement programs to protect the health and safety of enrollees. Utilization management programs will include incentives to use generic drugs and other cost-effective therapeutic alternatives, when medically appropriate.

PDP sponsors will be required to maintain meaningful procedures for hearing and resolving of enrollee grievances. Enrollees may appeal to obtain coverage for a prescription drug that is not on the plan formulary when the prescribing physician determines that the drug on formulary is not as effective or safe for the enrollee. PDP sponsors will protect the confidentiality and accuracy of all enrollee records and provide access to expedited coverage determinations.

The Committee believes that CMS should undertake quality improvement efforts related to outpatient prescription drugs through its contracts with the Medicare Quality Improvement Organizations, or other qualified entities. The Administrator of the Medicare Benefits Administration should coordinate with the Administrator of CMS with regard to these activities and, to the extent available, make Part D claims data available to the QIOs or other entities for quality improvement efforts.

Sec. 1860D. Requirements for Prescription Drug Plan (PDP) Sponsors; Contracts; Establishment of Standards

Sponsors of PDPs will be licensed under State law as a risk bearing entity eligible to offer health insurance or coverage in each state in which the plan operates. Plans that contract with the Secretary to provide covered drugs to enrollees will be required to assume full financial risk for such benefits. All PDP sponsors must contract with the Secretary and agree to comply with all plan requirements and terms and conditions of payment.

The Secretary will grant waivers to PDP sponsors who are unlicensed in a state where they offer a PDP if any of the grounds for application approval are met. The Secretary will establish financial solvency standards for non-licensed sponsors of PDPs by October 1, 2003. The Secretary will establish regulations for other standards in a timely manner.

The standards established for M+C plans and PDP sponsors would override any state law or regulation affecting M+C plans or PDP sponsors.

Sec. 1860E. Process for Beneficiaries to Select Qualified Prescription Drug Coverage

The Administrator will establish a process for beneficiaries to select qualified prescription drug coverage. The selection process will include annual, coordinated election periods, dissemination of comparative information regarding price, quality, and other features, and the coordination with M+C elections. Enrollees in M+C plans offering prescription drug coverage can only elect to receive drug coverage through that plan.

The Administrator will provide a choice of at least two qualifying plans in each area. Qualifying plans are defined as PDPs or Medicare+Choice plans that include prescription drug coverage. In order to guarantee access to coverage, the Administrator may provide financial incentives to plans. These incentives must seek to maximize the assumption of risk by PDP or M+C plan sponsors

and cannot underwrite all of the financial risk for any PDP sponsor, nor provide for any underwriting of financial risk for a public PDP sponsor.

Sec. 1860F. Submission of Bids

PDP sponsors will be required to submit specified bid information, in the same manner as M+C plans are currently required to do. This information will describe the qualified drug coverage to be provided, the actuarial value of the coverage, the monthly premium to be charged for the coverage, the portion of the premium attributable to benefits in excess of the standard coverage and the reduction in the premium resulting from reinsurance subsidies. The Administrator will review this information and use it to negotiate the terms and conditions of PDPs. A PDP's bid may not vary among individuals enrolled in the plan in the same service area, except for the charging of late enrollment penalties.

PDP sponsors may encourage enrollees to pay their premiums through electronic fund transfer mechanisms and may permit enrollees to deduct premiums from their Social Security checks. PDPs will be paid in the same way as M+C plans currently receive payment based upon bid amounts, except that such payments shall be made from the Medicare Prescription Drug Trust Fund.

PDP sponsors, in areas where there is no available standard prescription drug coverage, will accept the benchmark bid amount as payment in full for the premium charge for individuals who are eligible for an income-related premium subsidy. Standard prescription drug coverage is defined as qualified prescription drug coverage or coverage that has an actuarially equivalent value to the standard coverage.

Sec. 1860G. Premium and Cost-Sharing Subsidies for Low-Income Individuals

Individuals with incomes below 150% of the Federal Poverty Level (FPL) are entitled to receive a subsidy for the full value of the premium and the deductible. Cost-sharing obligations for these individuals may not exceed $2 for multiple-source or generic drugs and $5 for non-preferred drugs. PDPs may reduce cost sharing to zero for generic drugs.

Individuals with income under 175% of FPL will receive full cost-sharing assistance. Individuals with incomes between 150 and 175% of FPL will receive a premium subsidy based on an income-related sliding scale. Individuals are eligible for these subsidies if they have elected to obtain qualified prescription drug coverage, their income is below 175% of FPL and they satisfy a resources requirement. Plans will be allowed to waive or reduce cost-sharing amounts. For individuals receiving cost-sharing subsidies, the PDP sponsor may not charge more than $5 per prescription. Eligibility and income determinations will be made by State Medicaid plans.

Federal Poverty Level thresholds for determining subsidy eligibility for subsidies will be indexed to increase by an annual percentage that reflects the growth in Medicare prescription drug costs per beneficiary for the year involved.

The premium subsidy amount is the benchmark bid amount for qualified prescription drug coverage offered by the PDP or M+C plan in which the individual is enrolled. For PDPs, the benchmark

bid amount is defined as the bid amount for enrollment under a plan that provides standard coverage or alternative coverage with an actuarially equivalent value, without regard to any subsidy or late enrollment penalty. For PDPs that offer alternative prescription drug coverage with higher actuarial values than the standard coverage, the benchmark bid amount equals the bid for plans with standard coverage. For M+C plans the benchmark bid amount is the portion of the bid amount that is attributable to the statutory drug benefits.

The Administrator will notify PDP sponsors or M+C plans that an individual is eligible for a subsidy and the amount of the subsidy. The sponsor or plan will then reduce the premiums or cost sharing, which would otherwise be imposed, by the amount of the subsidy. The Administrator will periodically and on a timely basis reimburse the sponsor or organization for the amount of the reductions.

Part D coverage will be the primary payor for the dual eligible population. The Administrator will coordinate prescription drug benefits under Part D with the benefits provided under Medicaid, with particular focus upon coordination of payments and prevention of fraud and abuse.

Sec. 1860H. Subsidies for All Medicare Beneficiaries for Qualified Prescription Drug Coverage

In order to reduce beneficiary premiums, mitigate adverse selection among PDPs and M+C plans and to promote the participation of PDP sponsors, the Administrator will provide subsidies to qualifying entities. The section will constitute budget authority in advance of appropriations and represents the obligation of the Administrator to provide payment of amounts provided under this section. The subsidies will include both direct subsidies to PDP and M+C plans—which will account for 36% of the total 66% subsidy, and subsidies through reinsurance for excess costs incurred in providing qualified prescription drug coverage.

Entities qualified to receive subsidies will be PDP sponsors, M+C plans offering qualifying prescription drug coverage and the sponsor of a qualified retiree prescription drug plan through employment-based retiree health coverage.

The reinsurance payment amount for PDP and M+C plans will be equal to the sum of an amount equal to 30% of allowable costs attributable to gross covered drug costs between $1,000 and $2,000 and 80% of the costs above the annual out-of-pocket cap.

Allowable costs are defined as the portion of the gross covered prescription drug costs that are actually paid by the plan, but which cannot be more than the part of the costs that would have been paid by the plan if the drug coverage under the plan were standard coverage. Gross covered drug costs are defined as the costs incurred under the plan for covered prescription 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 payment for such drugs is made.

In subsequent years, these dollar amounts are increased by the percentage increase in average per capita aggregate expenditures

for drugs. These amounts would be rounded to the nearest multiple of $10.

The Administrator will be required to estimate the total payments to be made throughout the program during the year and the total payments to be made by qualifying entities for standard coverage. The Administrator will proportionately adjust payments so that the total of the payments made for the year are equal to 65% of the total payments to qualified retiree prescription drug plans and the ratio of the total of payments for direct subsidies to the total of payments for reinsurance for PDPs and M+C organizations equals 36 to 30. The Administrator may also adjust payments made for direct subsidies, based on specified risk factors, to the extent that the Administrator determines such adjustments are appropriate to avoid risk selection.

The Administrator will determine the payment method, which may include an interim method where payments are based upon estimates. Payments will be made from the Medicare Prescription Drug Trust Fund.

A Qualified Retiree Prescription Drug Plan will be defined as employment-based retiree health coverage. The plan sponsor of such coverage will annually attest to the Administrator that (1) the coverage meets or exceeds the requirements for qualified prescription drug coverage, (2) the plan maintains and affords the Administrator access to records necessary to ensure the adequacy of prescription drug coverage, and (3) the accuracy of the payments made. Payments cannot be made for individuals unless they are enrolled under Part D, are covered under the plan, and are entitled to obtain coverage through a PDP or M+C plan but elected not to do so.

A Qualifying Covered Individual is defined as an individual who is enrolled with a PDP, an M+C plan that provides qualified prescription drug coverage or is covered under a qualified retiree prescription drug plan.

Sec. 1860I. Medicare Prescription Drug Trust Fund

This provision creates a new trust fund in the United States Treasury. The trust fund will be managed in the same manner as the "Federal Supplementary Medical Insurance Trust Fund." Payments from the trust fund will be made from time to time for: the low-income subsidies, the federal subsidies, reinsurance amounts, and administrative expenses.

This provision allows for a transfer of funds from the Medicaid account to the Trust Fund in the amount that would have been spent for the federal share of Medicaid payments for prescription drugs. It also creates appropriations to cover the federal share of the prescription drug benefit.

Sec. 1860J. Definitions; Treatment of References to Provisions in Part C

A "covered outpatient drug" is defined as a drug or biologic that is dispensed with a prescription, is not already an excluded drug under Medicaid, is approved by the Food and Drug Administration (FDA) and is not covered under Medicare Part A or B.

"Initial coverage limit" is defined as costs above the $250 deductible up to $2,000 and those costs above $3,700 true out-of- pocket expenditure.

"Medicare Prescription Drug Trust Fund' is defined as the trust fund created under section 1860I(a).

"PDP sponsor" is defined as an entity that is certified by the Administrator to offer qualified prescription drug coverage.

"Prescription drug plan" is defined as health benefits coverage that is offered under a policy, contract, or plan by a PDP sponsor to Medicare beneficiaries; provides prescription drug coverage; and meets the requirements for issuing coverage consistent with the new benefit.

This section applies the provisions of the new prescription drug benefit to M+C, if the M+C plan provides qualified prescription drug coverage. Any references in current law to Part D are deemed a reference to Part E upon enactment. It allows for PDP sponsors to negotiate price discounts without being subject to anti-kickback violations, and requires the Secretary to submit to Congress legislative proposals to correct any technical and conforming changes that may be needed within 6 months of enactment.

The Administrator must complete a study and make recommendations to Congress by January 1, 2004 on how to move Medicare Part B covered drugs into the new Medicare Part D outpatient prescription drug program.

This section is effective upon enactment.

Sec. 102. Offering of Qualified Prescription Drug Coverage under the Medicare+Choice Program

This provision requires M+C plans to offer, at a minimum, qualified prescription drug coverage if they wish to offer drug coverage to beneficiaries who have elected to receive the new Medicare prescription drug benefit. This does not require M+C plans to offer any drug coverage, and they can offer different coverage to Medicare beneficiaries that elect not to participate in the new Medicare prescription drug benefit. It requires M+C plans to comply with all the same requirements as those that apply to PDP sponsors, and submit the appropriate information to the Administrator except for information that the Administrator determines is duplicative. M+C plans that offer qualified coverage to low-income beneficiaries will be eligible for premium and cost-sharing subsidies, and for direct and re-insurance subsidy payments for all other eligible enrolled Medicare beneficiaries. The annual coordinated election period for 2005 will occur in the six-month period beginning in November 2004.

This section applies to coverage provided on or after January 1, 2005.

Sec. 103. Medicaid Amendments

Section 103 adds a new Section 1935 to the Social Security Act entitled "Special Provisions Relating to Medicare Prescription Drug Benefit." The provision requires States, as a condition of receiving Federal assistance, to make eligibility determinations for premium and cost-sharing assistance for Part D, inform the MBA Administrator of cases where eligibility has been established, and otherwise provide information to the MBA Administrator as required to carry

out Part D. It also allows for enhanced administrative payments for the purpose of determining eligibility for the low- income benefit.

The provision provides for a phased-in Federal assumption of the costs associated with providing dual-eligible Medicaid beneficiaries qualified drug coverage under Medicare Part D. Over a ten-year period the Federal Government would assume the state share of Medicaid costs related to premium and cost-sharing assistance for Medicare dually eligible individuals.

The provision includes clarification that when individuals are dually entitled to prescription drug coverage under Part D and drug coverage under Medicaid, Medicare will be the primary payor. The provision allows States to require, as a condition for receipt of Medicaid drug benefits, that a dually-entitled individual elect qualified prescription drug coverage under Medicare.

Territories will be able to get low-income funds, beginning at $20 million a year and escalating by the annual percentage increase in prescription drug costs for Medicare beneficiaries. In order to obtain these funds, Territories would be required to formulate a plan on how they would dedicate the funds to assist low-income Medicare beneficiaries in obtaining covered outpatient prescription drugs.

This section is effective upon enactment.

Section 104. Medigap Transition

Section 104 specifies that no new Medigap prescription drug policies can be sold on or after January 1, 2005. Beneficiaries who have current Medigap prescription drug insurance can maintain such coverage. Individuals who currently have Medigap policies with prescription drug coverage, who elect to terminate such coverage and enroll in Part D, would be able to enroll in a Medigap policy without prescription drug coverage within 63 days of the termination of prior coverage. In providing such plans, the Medigap issuer may not deny or condition the issuance of such plans, may not discriminate in the pricing of such policy based upon health status, claims experience, receipt of health care, or medical condition and may not impose an exclusion of benefits based upon a preexisting condition. Two new Medigap policies will also be created, the first of which will cover 50% of the cost sharing except for preventative benefits, when the percentage of coverage will be 100%. This plan will also limit annual out-of-pocket expenditures to $4,000 in 2005, with that number subsequently adjusted for inflation. The second new plan would be similar to the first plan, but would replace 50% cost sharing with 75% and set the limit on annual out-of-pocket expenditures at $2,000.

This section is effective upon enactment.

Section 105. Medicare Prescription Drug Discount Card Endorsement Program

Section 105 requires the Secretary to establish a program to endorse prescription drug discount card programs and provide information regarding such programs to Medicare beneficiaries.

The Secretary cannot endorse a prescription drug discount card program unless it (1) passes on discounts on prescription drugs, including those negotiated with drug manufacturers; (2) prohibits mail-order only delivery of drugs; (3) provides pharmaceutical sup-

port services; (4) provides information to beneficiaries necessary for them to make informed choices among endorsed programs; (5) demonstrates experience in operating such a program; (6) has adequate procedures to assure quality service; and, (7) meets additional requirements relating to other beneficiary protections that may be identified by the Secretary.

The Secretary will operate the program in such a way as to promote informed choices by beneficiaries, oversee compliance with the requirements of the program, disqualify plans that do not comply with these requirements, and prevent a Medicare beneficiary from being enrolled in more than one endorsed program at a time.

The Secretary will provide for an appropriate transition and eventual discontinuance of this program at the time that prescription drug benefits become available under Part D.

This section is effective upon enactment.

Section 106. GAO Study of the Effectiveness of the New Prescription Drug Program

Section 106 directs the Comptroller General to study the effectiveness of the prescription drug program provided under Part D and submit a report to Congress by January 1, 2006.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

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TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION

* * * * * * *

PART A—GENERAL PROVISIONS

* * * * * * *

SEC. 1108. ADDITIONAL GRANTS TO PUERTO RICO, THE VIRGIN ISLANDS, GUAM, AND AMERICAN SAMOA; LIMITATION ON TOTAL PAYMENTS.

(a) * * *

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(f) Subject to subsection (g) *and section 1935(e)(1)(B)*, the total amount certified by the Secretary under title XIX with respect to a fiscal year for payment to—

(1) * * *

* * * * * * *

CRIMINAL PENALTIES FOR ACTS INVOLVING FEDERAL HEALTH CARE PROGRAMS

SEC. 1128B. (a) * * *

(b)(1) * * *

* * * * * * *

(3) Paragraphs (1) and (2) shall not apply to—

(A) * * *

* * * * * * *

(E) any payment practice specified by the Secretary in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987; [and]

(F) any remuneration between an organization and an individual or entity providing items or services, or a combination thereof, pursuant to a written agreement between the organization and the individual or entity if the organization is an eligible organization under section 1876 or if the written agreement, through a risk-sharing arrangement, places the individual or entity at substantial financial risk for the cost or utilization of the items or services, or a combination thereof, which the individual or entity is obligated to provide[.]*; and*

(G) the waiver or reduction of any cost-sharing imposed under part D of title XVIII.

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

MEDICARE PRESCRIPTION DRUG DISCOUNT CARD ENDORSEMENT PROGRAM

SEC. 1807. (a) IN GENERAL.—The Secretary (or the Medicare Benefits Administrator pursuant to section 1808(c)(3)(C)) shall establish a program—

(1) to endorse prescription drug discount card programs that meet the requirements of this section; and

(2) to make available to medicare beneficiaries information regarding such endorsed programs.

(b) REQUIREMENTS FOR ENDORSEMENT.—The Secretary may not endorse a prescription drug discount card program under this section unless the program meets the following requirements:

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

(2) PROHIBITION ON APPLICATION ONLY TO MAIL ORDER.—The program applies to drugs that are available other than solely through mail order.

(3) BENEFICIARY SERVICES.—The program provides pharmaceutical support services, such as education and counseling, and services to prevent adverse drug interactions.

(4) INFORMATION.—The program makes available to medicare beneficiaries through the Internet and otherwise information, including information on enrollment fees, prices charged to beneficiaries, and services offered under the program, that the

Secretary identifies as being necessary to provide for informed choice by beneficiaries among endorsed programs.

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

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

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

(c) PROGRAM OPERATION.—The Secretary shall operate the program under this section consistent with the following:

(1) PROMOTION OF INFORMED CHOICE.—In order to promote informed choice among endorsed prescription drug discount card programs, the Secretary shall provide for the dissemination of information which compares the costs and benefits of such programs in a manner coordinated with the dissemination of educational information on Medicare+Choice plans under part C.

(2) OVERSIGHT.—The Secretary shall provide appropriate oversight to ensure compliance of endorsed programs with the requirements of this section, including verification of the discounts and services provided.

(3) USE OF MEDICARE TOLL-FREE NUMBER.—The Secretary shall provide through the 1-800-medicare toll free telephone number for the receipt and response to inquiries and complaints concerning the program and programs endorsed under this section.

(4) DISQUALIFICATION FOR ABUSIVE PRACTICES.—The Secretary shall revoke the endorsement of a program that the Secretary determines no longer meets the requirements of this section or that has engaged in false or misleading marketing practices.

(5) ENROLLMENT PRACTICES.—A medicare beneficiary may not be enrolled in more than one endorsed program at any time.

(d) TRANSITION.—The Secretary shall provide for an appropriate transition and discontinuation of the program under this section at the time prescription drug benefits first become available under part D.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the program under this section.

* * * * * * *

PART C—MEDICARE+CHOICE PROGRAM

ELIGIBILITY, ELECTION, AND ENROLLMENT

SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS THROUGH MEDICARE+CHOICE PLANS.—

(1) IN GENERAL.—Subject to the provisions of this section, each Medicare+Choice eligible individual (as defined in para-

graph (3)) is entitled to elect to receive benefits *(other than qualified prescription drug benefits)* under this title—

(A) through the original medicare fee-for-service program under parts A and B, or

(B) through enrollment in a Medicare+Choice plan under this part**[**.**]**,

and may elect qualified prescription drug coverage in accordance with section 1860A.

* * * * * * *

(g) GUARANTEED ISSUE AND RENEWAL.—

(1) IN GENERAL.—Except as provided in this subsection *and section 1860A(c)(2)(B)*, a Medicare+Choice organization shall provide that at any time during which elections are accepted under this section with respect to a Medicare+Choice plan offered by the organization, the organization will accept without restrictions individuals who are eligible to make such election.

* * * * * * *

(j) AVAILABILITY OF PRESCRIPTION DRUG BENEFITS.—

(1) OFFER OF QUALIFIED PRESCRIPTION DRUG COVERAGE.—

(A) IN GENERAL.—A Medicare+Choice organization may not offer prescription drug coverage (other than that required under parts A and B) to an enrollee under a Medicare+Choice plan unless such drug coverage is at least qualified prescription drug coverage and unless the requirements of this subsection with respect to such coverage are met.

(B) CONSTRUCTION.—Nothing in this subsection shall be construed as—

(i) requiring a Medicare+Choice plan to include coverage of qualified prescription drug coverage; or

(ii) permitting a Medicare+Choice organization from providing such coverage to an individual who has not elected such coverage under section 1860A(b).

For purposes of this part, an individual who has not elected qualified prescription drug coverage under section 1860A(b) shall be treated as being ineligible to enroll in a Medicare+Choice plan under this part that offers such coverage.

(2) 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 1860C, including requirements relating to information dissemination and grievance and appeals, in the same manner as they apply to a PDP sponsor and a prescription drug plan under part D and shall submit to the Administrator the information described in section 1860F(a)(2). The Administrator shall waive such requirements to the extent the Administrator determines that such requirements duplicate requirements otherwise applicable to the organization or plan under this part.

(3) AVAILABILITY OF PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME ENROLLEES AND DIRECT AND REINSURANCE SUBSIDY PAYMENTS FOR ORGANIZATIONS.—For provisions—

(A) providing premium and cost-sharing subsidies to low-income individuals receiving qualified prescription drug coverage through a Medicare+Choice plan, see section 1860G; and

(B) providing a Medicare+Choice organization with direct and insurance subsidy payments for providing qualified prescription drug coverage under this part, see section 1860H.

(4) TRANSITION IN INITIAL ENROLLMENT PERIOD.—Notwithstanding any other provision of this part, the annual, coordinated election period under subsection (e)(3)(B) for 2005 shall be the 6-month period beginning with November 2004.

(5) 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 section 1860B.

* * * * * * *

PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

SEC. 1860A. BENEFITS; ELIGIBILITY; ENROLLMENT; AND COVERAGE PERIOD.

(a) PROVISION OF QUALIFIED PRESCRIPTION DRUG COVERAGE THROUGH ENROLLMENT IN PLANS.—Subject to the succeeding provisions of this part, each individual who is entitled to benefits under part A or is enrolled under part B is entitled to obtain qualified prescription drug coverage (described in section 1860B(a)) as follows:

(1) MEDICARE+CHOICE PLAN.—If the individual is eligible to enroll in a Medicare+Choice plan that provides qualified prescription drug coverage under section 1851(j), the individual may enroll in the plan and obtain coverage through such plan.

(2) PRESCRIPTION DRUG PLAN.—If the individual is not enrolled in a Medicare+Choice plan that provides qualified prescription drug coverage, the individual may enroll under this part in a prescription drug plan (as defined in section 1860J(a)(5)).

Such individuals shall have a choice of such plans under section 1860E(d).

(b) GENERAL ELECTION PROCEDURES.—

(1) IN GENERAL.—An individual eligible to make an election under subsection (a) may elect to enroll in a prescription drug plan under this part, or elect the option of qualified prescription drug coverage under a Medicare+Choice plan under part C, and to change such election only in such manner and form as may be prescribed by regulations of the Administrator of the Medicare Benefits Administration (appointed under section 1808(b)) (in this part referred to as the "Medicare Benefits Administrator") and only during an election period prescribed in or under this subsection.

(2) ELECTION PERIODS.—

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

(i) annual coordinated election periods; and

(ii) special election periods.

In applying the last sentence of section 1851(e)(4) (relating to discontinuance of a Medicare+Choice election during the first year of eligibility) under this subparagraph, in the case of an election described in such section in which the individual had elected or is provided qualified prescription drug coverage at the time of such first enrollment, the individual shall be permitted to enroll in a prescription drug plan under this part at the time of the election of coverage under the original fee-for-service plan.

(B) INITIAL ELECTION PERIODS.—

(i) INDIVIDUALS CURRENTLY COVERED.—In the case of an individual who is entitled to benefits under part A or enrolled under part B as of November 1, 2004, there shall be an initial election period of 6 months beginning on that date.

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

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

(i) in cases of individuals who have and involuntarily lose prescription drug coverage described in subsection (c)(2)(C);

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

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

(iv) in cases of individuals (as determined by the Administrator) who become eligible for prescription drug assistance under title XIX under section 1935(d).

(c) GUARANTEED ISSUE; COMMUNITY RATING; AND NONDISCRIMINATION.—

(1) GUARANTEED ISSUE.—

(A) IN GENERAL.—An eligible individual who is eligible to elect qualified prescription drug coverage under a prescription drug plan or Medicare+Choice plan at a time during which elections are accepted under this part with respect to the plan shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

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

(2) COMMUNITY-RATED PREMIUM.—

(A) IN GENERAL.—In the case of an individual who maintains (as determined under subparagraph (C)) continuous

prescription drug coverage since the date the individual first qualifies to elect prescription drug coverage under this part, a PDP sponsor or Medicare+Choice organization offering a prescription drug plan or Medicare+Choice plan that provides qualified prescription drug coverage and in which the individual is enrolled may not deny, limit, or condition the coverage or provision of covered prescription drug benefits or increase the premium under the plan based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act or any other factor.

(B) LATE ENROLLMENT PENALTY.—In the case of an individual who does not maintain such continuous prescription drug coverage (as described in subparagraph (C)), a PDP sponsor or Medicare+Choice organization may (notwithstanding any provision in this title) adjust the premium otherwise applicable or impose a pre-existing condition exclusion with respect to qualified prescription drug coverage in a manner that reflects additional actuarial risk involved. Such a risk shall be established through an appropriate actuarial opinion of the type described in subparagraphs (A) through (C) of section 2103(c)(4).

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

(i) COVERAGE UNDER PRESCRIPTION DRUG PLAN OR MEDICARE+CHOICE PLAN.—Qualified prescription drug coverage under a prescription drug plan or under a Medicare+Choice plan.

(ii) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care for the Elderly (PACE) under section 1934, through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997), or through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

(iii) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any outpatient prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States

Code, and a qualified retiree prescription drug plan as defined in section 1860H(f)(1), but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

(iv) PRESCRIPTION DRUG COVERAGE UNDER CERTAIN MEDIGAP POLICIES.—Coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)), but only if the policy was in effect on January 1, 2005, and if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

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

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

(D) CERTIFICATION.—For purposes of carrying out this paragraph, the certifications of the type described in sections 2701(e) of the Public Health Service Act and in section 9801(e) of the Internal Revenue Code shall also include a statement for the period of coverage of whether the individual involved had prescription drug coverage described in subparagraph (C).

(E) DISCLOSURE.—

(i) IN GENERAL.—Each entity that offers coverage of the type described in clause (iii), (iv), (v), or (vi) of subparagraph (C) shall provide for disclosure, consistent with standards established by the Administrator, of whether such coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

(ii) WAIVER OF LIMITATIONS.—An individual may apply to the Administrator to waive the requirement that coverage of such type provide benefits at least equivalent to the benefits under a qualified prescription drug plan, if the individual establishes that the individual was not adequately informed that such coverage did not provide such level of benefits.

(F) CONSTRUCTION.—Nothing in this section shall be construed as preventing the disenrollment of an individual from a prescription drug plan or a Medicare+Choice plan based on the termination of an election described in section 1851(g)(3), including for non-payment of premiums or for other reasons specified in subsection (d)(3), which takes

into account a grace period described in section 1851(g)(3)(B)(i).

(3) NONDISCRIMINATION.—A PDP sponsor offering a prescription drug plan shall not establish a service area in a manner that would discriminate based on health or economic status of potential enrollees.

(d) EFFECTIVE DATE OF ELECTIONS.—

(1) IN GENERAL.—Except as provided in this section, the Administrator shall provide that elections under subsection (b) take effect at the same time as the Administrator provides that similar elections under section 1851(e) take effect under section 1851(f).

(2) NO ELECTION EFFECTIVE BEFORE 2005.—In no case shall any election take effect before January 1, 2005.

(3) TERMINATION.—The Administrator shall provide for the termination of an election in the case of—

(A) termination of coverage under both part A and part B; and

(B) termination of elections described in section 1851(g)(3) (including failure to pay required premiums).

SEC. 1860B. REQUIREMENTS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

(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 (b)) and access to negotiated prices under subsection (d).

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

(2) PERMITTING ADDITIONAL OUTPATIENT PRESCRIPTION DRUG COVERAGE.—

(A) IN GENERAL.—Subject to subparagraph (B), nothing in this part shall be construed as preventing qualified prescription drug coverage from including coverage of covered outpatient drugs that exceeds the coverage required under paragraph (1), but any such additional coverage shall be limited to coverage of covered outpatient drugs.

(B) DISAPPROVAL AUTHORITY.—The Administrator shall review the offering of qualified prescription drug coverage under this part or part C. If the Administrator finds that, in the case of a qualified prescription drug coverage under a prescription drug plan or a Medicare+Choice plan, that the organization or sponsor offering the coverage is engaged in activities intended to discourage enrollment of classes of eligible medicare beneficiaries obtaining coverage through the plan on the basis of their higher likelihood of utilizing prescription drug coverage, the Administrator may terminate the contract with the sponsor or organization under this part or part C.

(3) 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.

(b) STANDARD COVERAGE.—For purposes of this part, the "standard coverage" is coverage of covered outpatient drugs (as defined in subsection (f)) that meets the following requirements:

(1) DEDUCTIBLE.—The coverage has an annual deductible—

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

(B) 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.

Any amount determined under subparagraph (B) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

(2) LIMITS ON COST-SHARING.—

(A) IN GENERAL.—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)) as follows:

(i) FIRST COPAYMENT RANGE.—For costs above the annual deductible specified in paragraph (1) and up to amount specified in subparagraph (C), the cost-sharing—

(I) is equal to 20 percent; or

(II) is actuarially equivalent (using processes established under subsection (e)) to an average expected payment of 20 percent of such costs.

(ii) SECONDARY COPAYMENT RANGE.—For costs above the amount specified in subparagraph (C) and up to the initial coverage limit, the cost-sharing—

(I) is equal to 50 percent; or

(II) is actuarially consistent (using processes established under subsection (e)) with an average expected payment of 50 percent of such costs.

(B) USE OF TIERED COPAYMENTS.—Nothing in this part shall be construed as preventing a PDP sponsor from applying tiered copayments, so long as such tiered copayments are consistent with subparagraph (A).

(C) INITIAL COPAYMENT THRESHOLD.—The amount specified in this subparagraph—

(i) for 2005, is equal to $1,000; or

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

Any amount determined under clause (ii) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

(3) INITIAL COVERAGE LIMIT.—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)—

(A) for 2005, that is equal to $2,000; or

(B) 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.

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

(4) CATASTROPHIC PROTECTION.—

(A) IN GENERAL.—Notwithstanding paragraph (3), the coverage provides benefits with no cost-sharing after the individual has incurred costs (as described in subparagraph (C)) for covered outpatient drugs in a year equal to the annual out-of-pocket threshold specified in subparagraph (B).

(B) ANNUAL OUT-OF-POCKET THRESHOLD.—For purposes of this part, the "annual out-of-pocket threshold" 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 this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

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

(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 1860G, 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 outpatient drugs in the United States for medicare beneficiaries, as determined by the Administrator for the 12-month period ending in July of the previous year.

(c) ALTERNATIVE COVERAGE REQUIREMENTS.—A prescription drug plan or Medicare+Choice plan may provide a different prescription drug benefit design from the standard coverage described in subsection (b) so long as the Administrator determines (based on an actuarial analysis by the Administrator) 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 (e)) 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 (e)) exceeds the actuarial value of the subsidy payments under section 1860H 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 (e)), to provide for the payment, with respect to costs incurred that are equal to the initial coverage limit under subsection (b)(3), of an amount equal to at least the sum of the following products:

(i) FIRST COPAYMENT RANGE.—The product of—

(I) the amount by which the initial copayment threshold described in subsection (b)(2)(C) exceeds the deductible described in subsection (b)(1); and

(II) 100 percent minus the cost-sharing percentage specified in subsection (b)(2)(A)(i)(I).

(ii) SECONDARY COPAYMENT RANGE.—The product of—

(I) the amount by which the initial coverage limit described in subsection (b)(3) exceeds the initial copayment threshold described in subsection (b)(2)(C); and

(II) 100 percent minus the cost-sharing percentage specified in subsection (b)(2)(A)(ii)(I).

(2) CATASTROPHIC PROTECTION.—The coverage provides for beneficiaries the catastrophic protection described in subsection (b)(4).

(d) ACCESS TO NEGOTIATED PRICES.—

(1) IN GENERAL.—Under qualified prescription drug coverage offered by a PDP sponsor or a Medicare+Choice organization, the sponsor or organization shall provide beneficiaries with access to negotiated prices (including applicable discounts) used for payment for covered outpatient drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of cost-sharing or an initial coverage limit (described in subsection (b)(3)). Insofar as a State elects to provide medical assistance under title XIX for a drug based on the prices negotiated by a prescription drug plan under this part, the requirements of section 1927 shall not apply to such drugs. The prices negotiated by a prescription drug plan under this part, by a Medicare+Choice plan with respect to covered outpatient drugs, or by a qualified retiree prescription drug plan (as defined in section 1860H(f)(1)) with respect to such drugs on behalf of individuals entitled to benefits under part A or enrolled under part B, 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) DISCLOSURE.—The PDP sponsor or Medicare+Choice organization shall disclose to the Administrator (in a manner specified by the Administrator) the extent to which discounts or rebates made available to the sponsor or organization by a manufacturer are passed through to enrollees through pharmacies and other dispensers or otherwise. The provisions of section 1927(b)(3)(D) shall apply to information disclosed to the Administrator under this paragraph in the same manner as such provisions apply to information disclosed under such section.

(e) 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 subsidy payments under section 1860H;

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

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

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

(2) USE OF OUTSIDE ACTUARIES.—Under the processes under paragraph (1)(A), PDP sponsors 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).

(f) COVERED OUTPATIENT DRUGS DEFINED.—

(1) IN GENERAL.—Except as provided in this subsection, for purposes of this part, the term "covered outpatient drug" means—

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

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

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

(2) EXCLUSIONS.—

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

(B) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered

outpatient drug under this part shall not be so considered if payment for such drug is available under part A or B for an individual entitled to benefits under part A and enrolled under part B.

(3) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this part shall not be so considered under a plan if the plan excludes the drug under a formulary and such exclusion is not successfully appealed under section 1860C(f)(2).

(4) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A prescription drug plan or Medicare+Choice plan may exclude from qualified prescription drug coverage any covered outpatient drug—

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

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

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860C(f).

SEC. 1860C. BENEFICIARY PROTECTIONS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

(a) GUARANTEED ISSUE, COMMUNITY-RELATED PREMIUMS, ACCESS TO NEGOTIATED PRICES, AND NONDISCRIMINATION.—For provisions requiring guaranteed issue, community-rated premiums, access to negotiated prices, and nondiscrimination, see sections 1860A(c)(1), 1860A(c)(2), 1860B(d), and 1860F(b), respectively.

(b) DISSEMINATION OF INFORMATION.—

(1) GENERAL INFORMATION.—A PDP sponsor shall disclose, in a clear, accurate, and standardized form to each enrollee with a prescription drug plan offered by the sponsor under this part 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 outpatient drugs, including access through pharmacy networks.

(B) How any formulary used by the sponsor functions.

(C) Co-payments and deductible requirements, including the identification of the tiered or other co-payment level applicable to each drug (or class of drugs).

(D) Grievance and appeals procedures.

(2) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an individual eligible to enroll under a prescription drug plan, the PDP sponsor shall provide the information described in section 1852(c)(2) (other than subparagraph (D)) to such individual.

(3) RESPONSE TO BENEFICIARY QUESTIONS.—Each PDP sponsor offering a prescription drug plan shall have a mechanism for providing specific information to enrollees upon request. The sponsor shall make available on a timely basis, through an Internet website and in writing upon request, information on specific changes in its formulary.

(4) CLAIMS INFORMATION.—Each PDP sponsor offering a 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 threshold 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).

(c) ACCESS TO COVERED BENEFITS.—

(1) ASSURING PHARMACY ACCESS.—

(A) IN GENERAL.—The PDP sponsor of the 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(e) that ensure such convenient access.

(B) USE OF POINT-OF-SERVICE SYSTEM.—A PDP sponsor 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 premiums and copayments any additional costs associated with the point-of-service option.

The additional copayments so charged shall not count toward the application of section 1860B(b).

(2) USE OF STANDARDIZED TECHNOLOGY.—

(A) IN GENERAL.—The PDP sponsor of a prescription drug plan shall issue (and reissue, as appropriate) such a card (or other technology) that may be used by an enrolled beneficiary to assure access to negotiated prices under section 1860B(d) for the purchase of prescription drugs for which coverage is not otherwise provided under the prescription drug plan.

(B) STANDARDS.—

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

(ii) APPLICATION OF ADVISORY TASK FORCE.—The advisory task force established under subsection (d)(3)(B)(ii) shall provide recommendations to the Administrator under such subsection regarding the standards developed under clause (i).

(3) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If a PDP sponsor of a prescription drug plan uses a formulary, the following requirements must be met:

(A) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—The sponsor must establish a pharmacy and therapeutic committee that develops and reviews the formulary. Such committee shall include at least one physician and at least one pharmacist both with expertise in the care of elderly or dis-

abled persons and a majority of its members shall consist of individuals who are a physician or a 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) GRIEVANCES AND APPEALS RELATING TO APPLICATION OF FORMULARIES.—For provisions relating to grievances and appeals of coverage, see subsections (e) and (f).

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

(1) IN GENERAL.—The PDP sponsor shall have in place with respect to covered outpatient drugs—

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

(B) quality assurance measures and systems to reduce medical errors and adverse drug interactions, including a medication therapy management program described in paragraph (2) and for years beginning with 2006, an electronic prescription program described in paragraph (3); and

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

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

(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 pharmacists and physicians.

(D) CONSIDERATIONS IN PHARMACY FEES.—The PDP sponsor of a prescription drug program 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) ELECTRONIC PRESCRIPTION PROGRAM.—

(A) IN GENERAL.—An electronic prescription drug program described in this paragraph is a 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 Administrator.

(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 Administrator 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 and the standards described in subsection (c)(2)(B)(i) the Administrator 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 Administrator 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 Administrator shall constitute the task force under clause (ii) by not later than April 1, 2003.

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

(III) The Administrator shall develop and promulgate the national standards referred to in clause (ii) by not later than July 1, 2004.

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

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

(B) Subsection (c)(1) (relating to access to covered benefits).

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

(5) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—Each PDP sponsor shall provide that

each pharmacy or other dispenser that arranges for the dispensing of a covered outpatient drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost generic drug covered under the plan that is therapeutically equivalent and bioequivalent.

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

(1) IN GENERAL.—Each PDP sponsor shall provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the sponsor provides covered benefits) and enrollees with prescription drug plans of the sponsor under this part in accordance with section 1852(f).

(2) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—A PDP sponsor shall meet the requirements of paragraphs (1) through (3) of section 1852(g) with respect to covered benefits under the 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.

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

(f) APPEALS.—

(1) IN GENERAL.—Subject to paragraph (2), a PDP sponsor shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to drugs not included on any formulary in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

(2) FORMULARY DETERMINATIONS.—An individual who is enrolled in a prescription drug plan offered by a PDP sponsor may appeal to obtain coverage for a covered outpatient drug that is not on a formulary of the sponsor 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.

(g) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—A PDP sponsor 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.

SEC. 1860D. REQUIREMENTS FOR PRESCRIPTION DRUG PLAN (PDP) SPONSORS; CONTRACTS; ESTABLISHMENT OF STANDARDS.

(a) GENERAL REQUIREMENTS.—Each PDP sponsor of a prescription drug plan shall meet the following requirements:

(1) LICENSURE.—Subject to subsection (c), the sponsor 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 prescription drug plan.

(2) ASSUMPTION OF FINANCIAL RISK.—

(A) IN GENERAL.—Subject to subparagraph (B) and section 1860E(d)(2), the entity assumes full financial risk on a prospective basis for qualified prescription drug coverage that it offers under a prescription drug plan and that is not covered under section 1860H.

(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 SPONSORS.—In the case of a sponsor that is not described in paragraph (1), the sponsor shall meet solvency standards established by the Administrator under subsection (d).

(b) CONTRACT REQUIREMENTS.—

(1) IN GENERAL.—The Administrator shall not permit the election under section 1860A of a prescription drug plan offered by a PDP sponsor under this part, and the sponsor shall not be eligible for payments under section 1860G or 1860H, unless the Administrator has entered into a contract under this subsection with the sponsor with respect to the offering of such plan. Such a contract with a sponsor may cover more than one prescription drug plan. Such contract shall provide that the sponsor 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.

(2) NEGOTIATION REGARDING TERMS AND CONDITIONS.—The Administrator shall have the same authority to negotiate the terms and conditions of prescription drug plans under this part 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. In negotiating the terms and conditions regarding premiums for which information is submitted under section 1860F(a)(2), the Administrator shall take into account the subsidy payments under section 1860H and the adjusted community rate (as defined in section 1854(f)(3)) for the benefits covered.

(3) INCORPORATION OF CERTAIN MEDICARE+CHOICE CONTRACT REQUIREMENTS.—The following provisions of section 1857 shall apply, subject to subsection (c)(5), to contracts under this section in the same manner as they apply to contracts under section 1857(a):

(A) MINIMUM ENROLLMENT.—Paragraphs (1) and (3) of section 1857(b).

(B) CONTRACT PERIOD AND EFFECTIVENESS.—Paragraphs (1) through (3) and (5) of section 1857(c).

(C) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—Section 1857(d).

(D) ADDITIONAL CONTRACT TERMS.—Section 1857(e); except that in applying section 1857(e)(2) under this part—

(i) such section shall be applied separately to costs relating to this part (from costs under part C);

(ii) in no case shall the amount of the fee established under this subparagraph for a plan exceed 20 percent of the maximum amount of the fee that may be established under subparagraph (B) of such section; and

(iii) no fees shall be applied under this subparagraph with respect to Medicare+Choice plans.

(E) INTERMEDIATE SANCTIONS.—Section 1857(g).

(F) PROCEDURES FOR TERMINATION.—Section 1857(h).

(4) RULES OF APPLICATION FOR INTERMEDIATE SANCTIONS.—In applying paragraph (3)(E)—

(A) the reference in section 1857(g)(1)(B) to section 1854 is deemed a reference to this part; and

(B) the reference in section 1857(g)(1)(F) to section 1852(k)(2)(A)(ii) shall not be applied.

(c) WAIVER OF CERTAIN REQUIREMENTS TO EXPAND CHOICE.—

(1) IN GENERAL.—In the case of an entity that seeks to offer a 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) has been met.

(2) GROUNDS FOR APPROVAL.—The grounds for approval under this paragraph are the grounds for approval described in subparagraph (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) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that an entity is licensed in accordance with subsection (a)(1) does not deem the entity to meet other requirements imposed under this part for a PDP sponsor.

(5) REFERENCES TO CERTAIN PROVISIONS.—For purposes of this subsection, in applying provisions of section 1855(a)(2) under this subsection to prescription drug plans and PDP sponsors—

(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 shall be treated as a reference to solvency standards established under subsection (d).

(d) SOLVENCY STANDARDS FOR NON-LICENSED SPONSORS.—

(1) ESTABLISHMENT.—The Administrator shall establish, by not later than October 1, 2003, financial solvency and capital adequacy standards that an entity that does not meet the requirements of subsection (a)(1) must meet to qualify as a PDP sponsor under this part.

(2) COMPLIANCE WITH STANDARDS.—Each PDP sponsor 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 PDP sponsors with respect to such solvency standards in the manner described in section 1855(c)(2).

(e) OTHER STANDARDS.—The Administrator shall establish by regulation other standards (not described in subsection (d)) for PDP sponsors and plans consistent with, and to carry out, this part. The Administrator shall publish such regulations by October 1, 2003.

(f) RELATION TO STATE LAWS.—

(1) IN GENERAL.—The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency, except as provided in subsection (d)) with respect to prescription drug plans which are offered by PDP sponsors under this part.

(2) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to premiums paid to PDP sponsors for prescription drug plans under this part, or with respect to any payments made to such a sponsor by the Administrator under this part.

SEC. 1860E. PROCESS FOR BENEFICIARIES TO SELECT QUALIFIED PRESCRIPTION DRUG COVERAGE.

(a) IN GENERAL.—The Administrator shall establish a process for the selection of the prescription drug plan or Medicare+Choice plan which offer qualified prescription drug coverage through which eligible individuals elect qualified prescription drug coverage under this part.

(b) ELEMENTS.—Such process shall include the following:

(1) Annual, coordinated election periods, in which such individuals can change the qualifying plans through which they obtain coverage, in accordance with section 1860A(b)(2).

(2) Active dissemination of information to promote an informed selection among qualifying plans based upon price, quality, and other features, in the manner described in (and in coordination with) section 1851(d), including the provision of annual comparative information, maintenance of a toll-free hotline, and the use of non-Federal entities.

(3) Coordination of elections through filing with a Medicare+Choice organization or a PDP sponsor, in the manner described in (and in coordination with) section 1851(c)(2).

(c) MEDICARE+CHOICE ENROLLEE IN PLAN OFFERING PRESCRIPTION DRUG COVERAGE MAY ONLY OBTAIN BENEFITS THROUGH THE PLAN.—An individual who is enrolled under a Medicare+Choice plan that offers qualified prescription drug coverage may only elect to receive qualified prescription drug coverage under this part through such plan.

(d) ASSURING ACCESS TO A CHOICE OF QUALIFIED PRESCRIPTION DRUG COVERAGE.—

(1) CHOICE OF AT LEAST TWO PLANS IN EACH AREA.—

(A) IN GENERAL.—The Administrator shall assure that each individual who is entitled to benefits under part A or enrolled under part B and who is residing in an area in

the United States has available, consistent with subparagraph (B), a choice of enrollment in at least two qualifying plans (as defined in paragraph (5)) in the area in which the individual resides, at least one of which is a prescription drug plan.

(B) REQUIREMENT FOR DIFFERENT PLAN SPONSORS.—The requirement in subparagraph (A) is not satisfied with respect to an area if only one PDP sponsor or Medicare+Choice organization offers all the qualifying plans in the area.

(2) GUARANTEEING ACCESS TO COVERAGE.—In order to assure access under paragraph (1) and consistent with paragraph (3), the Administrator may provide financial incentives (including partial underwriting of risk) for a PDP sponsor to expand the service area under an existing prescription drug plan to adjoining or additional areas or to establish such a plan (including offering such a plan on a regional or nationwide basis), but only so long as (and to the extent) necessary to assure the access guaranteed under paragraph (1).

(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 PDP sponsor;

(B) shall not provide for any underwriting of financial risk for a public PDP sponsor with respect to the offering of a nationwide prescription drug plan; and

(C) shall seek to maximize the assumption of financial risk by PDP sponsors or Medicare+Choice organizations.

(4) REPORTS.—The Administrator shall, in each annual report to Congress under section 1808(f), include information on the exercise of authority under this subsection. The Administrator also shall include such recommendations as may be appropriate to minimize the exercise of such authority, including minimizing the assumption of financial risk.

(5) QUALIFYING PLAN DEFINED.—For purposes of this subsection, the term "qualifying plan" means a prescription drug plan or a Medicare+Choice plan that includes qualified prescription drug coverage.

SEC. 1860F. SUBMISSION OF BIDS.

(a) SUBMISSION OF BIDS AND RELATED INFORMATION.—

(1) IN GENERAL.—Each PDP sponsor shall submit to the Administrator information of the type described in paragraph (2) in the same manner as information is submitted by a Medicare+Choice organization under section 1854(a)(1).

(2) TYPE OF INFORMATION.—The information described in this paragraph is the following:

(A) Information on the qualified prescription drug coverage to be provided.

(B) Information on the actuarial value of the coverage.

(C) Information on the bid for the coverage, including an actuarial certification of—

(i) the actuarial basis for such bid;

(ii) the portion of such bid attributable to benefits in excess of standard coverage; and

(iii) the reduction in such bid resulting from the subsidy payments provided under section 1860H.

(D) Such other information as the Administrator may require to carry out this part.

(3) REVIEW.—The Administrator shall review the information filed under paragraph (2) for the purpose of conducting negotiations under section 1860D(b)(2).

(b) UNIFORM BID.—

(1) IN GENERAL.—The bid for a prescription drug plan under this section may not vary among individuals enrolled in the plan in the same service area.

(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as preventing the imposition of a late enrollment penalty under section 1860A(c)(2)(B).

(c) COLLECTION.—

(1) USE OF ELECTRONIC FUNDS TRANSFER MECHANISM OR, AT BENEFICIARY'S OPTION, WITHHOLDING FROM SOCIAL SECURITY PAYMENT.—In accordance with regulations, a PDP sponsor may encourage that enrollees under a plan make payment of the premium established by the plan under this part through an electronic funds transfer mechanism, such as automatic charges of an account at a financial institution or a credit or debit card account, or, at the option of an enrollee, through withholding from benefit payments in the manner provided under section 1840 with respect to monthly premiums under section 1839. All such amounts shall be credited to the Medicare Prescription Drug Trust Fund.

(2) OFFSETTING.—Reductions in premiums for coverage under parts A and B as a result of a selection of a Medicare+Choice plan may be used to reduce the premium otherwise imposed under paragraph (1).

(3) PAYMENT OF PLANS.—PDP plans shall receive payment based on bid amounts in the same manner as Medicare+Choice organizations receive payment based on bid amounts under section 1853(a)(1)(A)(ii) except that such payment shall be made from the Medicare Prescription Drug Trust Fund.

(d) ACCEPTANCE OF BENCHMARK AMOUNT AS FULL PREMIUM FOR SUBSIDIZED LOW-INCOME INDIVIDUALS IF NO STANDARD (OR EQUIVALENT) COVERAGE IN AN AREA.—

(1) IN GENERAL.—If there is no standard prescription drug coverage (as defined in paragraph (2)) offered in an area, in the case of an individual who is eligible for a premium subsidy under section 1860G and resides in the area, the PDP sponsor of any prescription drug plan offered in the area (and any Medicare+Choice organization that offers qualified prescription drug coverage in the area) shall accept the benchmark bid amount (under section 1860G(b)(2)) as payment in full for the premium charge for qualified prescription drug coverage.

(2) STANDARD PRESCRIPTION DRUG COVERAGE DEFINED.—For purposes of this subsection, the term "standard prescription drug coverage" means qualified prescription drug coverage that is standard coverage or that has an actuarial value equivalent to the actuarial value for standard coverage.

SEC. 1860G. PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS.

(a) INCOME-RELATED SUBSIDIES FOR INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF FEDERAL POVERTY LEVEL.—

(1) FULL PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF FEDERAL POVERTY LEVEL.—In the case of a subsidy eligible individual (as defined in paragraph (4)) who is determined to have income that does not exceed 150 percent of the Federal poverty level, the individual is entitled under this section—

(A) to an income-related premium subsidy equal to 100 percent of the amount described in subsection (b)(1); and

(B) subject to subsection (c), to the substitution for the beneficiary cost-sharing described in paragraphs (1) and (2) of section 1860B(b) (up to the initial coverage limit specified in paragraph (3) of such section) of amounts that do not exceed $2 for a multiple source or generic drug (as described in section 1927(k)(7)(A)) and $5 for a non-preferred drug.

(2) SLIDING SCALE PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR INDIVIDUALS WITH INCOME ABOVE 150, BUT BELOW 175 PERCENT, OF FEDERAL POVERTY LEVEL.—In the case of a subsidy eligible individual who is determined to have income that exceeds 150 percent, but does not exceed 175 percent, of the Federal poverty level, the individual is entitled under this section to—

(A) an income-related premium subsidy determined on a linear sliding scale ranging from 100 percent of the amount described in subsection (b)(1) for individuals with incomes at 150 percent of such level to 0 percent of such amount for individuals with incomes at 175 percent of such level; and

(B) subject to subsection (c), to the substitution for the beneficiary cost-sharing described in paragraphs (1) and (2) of section 1860B(b) (up to the initial coverage limit specified in paragraph (3) of such section) of amounts that do not exceed $2 for a multiple source or generic drug (as described in section 1927(k)(7)(A)) and $5 for a non-preferred drug.

(3) CONSTRUCTION.—Nothing in this section shall be construed as preventing a PDP sponsor from reducing to 0 the cost-sharing otherwise applicable to generic drugs.

(4) 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 eligible to elect, and has elected, to obtain qualified prescription drug coverage under this part;

(ii) has income below 175 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).

(E) TREATMENT OF CONFORMING MEDIGAP POLICIES.—For purposes of this section, the term "qualified prescription drug coverage" includes a medicare supplemental policy described in section 1860H(b)(4).

(5) INDEXING DOLLAR AMOUNTS.—

(A) FOR 2006.—The dollar amounts applied under paragraphs (1)(B) and (2)(B) for 2006 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase described in section 1860B(b)(5) for 2006.

(B) FOR SUBSEQUENT YEARS.—The dollar amounts applied under paragraphs (1)(B) and (2)(B) for a year after 2006 shall be the amounts (under this paragraph) applied under paragraph (1)(B) or (2)(B) for the preceding year increased by the annual percentage increase described in section 1860B(b)(5) (relating to growth in medicare prescription drug costs per beneficiary) for the year involved.

(b) PREMIUM SUBSIDY AMOUNT.—

(1) IN GENERAL.—The premium subsidy amount described in this subsection for an individual residing in an area is the benchmark bid amount (as defined in paragraph (2)) for qualified prescription drug coverage offered by the prescription drug plan or the Medicare+Choice plan in which the individual is enrolled.

(2) BENCHMARK BID AMOUNT DEFINED.—For purposes of this subsection, the term "benchmark bid amount" means, with respect to qualified prescription drug coverage offered under—

(A) a prescription drug plan that—

(i) provides standard coverage (or alternative prescription drug coverage the actuarial value is equivalent to that of standard coverage), the bid amount for enrollment under the plan under this part (determined without regard to any subsidy under this section or any late enrollment penalty under section 1860A(c)(2)(B)); or

(ii) provides alternative prescription drug coverage the actuarial value of which is greater than that of standard coverage, the bid amount described in clause (i) multiplied by the ratio of (I) the actuarial value of standard coverage, to (II) the actuarial value of the alternative coverage; or

(B) a Medicare+Choice plan, the portion of the bid amount that is attributable to statutory drug benefits (described in section 1853(a)(1)(A)(ii)(II)).

(c) RULES IN APPLYING COST-SHARING SUBSIDIES.—

(1) IN GENERAL.—In applying subsections (a)(1)(B) and (a)(2)(B), nothing in this part shall be construed as preventing a plan or provider from waiving or reducing the amount of cost-sharing otherwise applicable.

(2) LIMITATION ON CHARGES.—In the case of an individual receiving cost-sharing subsidies under subsection (a)(1)(B) or (a)(2)(B), the PDP sponsor may not charge more than $5 per prescription.

(3) APPLICATION OF INDEXING RULES.—The provisions of subsection (a)(4) shall apply to the dollar amount specified in paragraph (2) in the same manner as they apply to the dollar amounts specified in subsections (a)(1)(B) and (a)(2)(B).

(d) ADMINISTRATION OF SUBSIDY PROGRAM.—The Administrator shall provide a process whereby, in the case of an individual who is determined to be a subsidy eligible individual and who is enrolled in 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 PDP sponsor or Medicare+Choice organization involved that the individual is eligible for a subsidy and the amount of the subsidy under subsection (a);

(2) the sponsor or organization involved reduces the premiums or 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 sponsor or organization for the amount of such reductions.

The reimbursement under paragraph (3) with respect to cost-sharing subsidies 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.

(e) 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.

(3) COORDINATION.—The Administrator shall develop and implement a plan for the coordination of prescription drug benefits under this part with the benefits provided under the medicaid program under title XIX, with particular attention to insuring coordination of payments and prevention of fraud and

abuse. In developing and implementing such plan, the Administrator shall involve the Secretary, the States, the data processing industry, pharmacists, and pharmaceutical manufacturers, and other experts.

SEC. 1860H. SUBSIDIES FOR ALL MEDICARE BENEFICIARIES FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

(a) SUBSIDY PAYMENT.—In order to reduce premium levels applicable to qualified prescription drug coverage for all medicare beneficiaries consistent with an overall subsidy level of 66 percent, to reduce adverse selection among prescription drug plans and Medicare+Choice plans that provide qualified prescription drug coverage, and to promote the participation of PDP sponsors under this part, the Administrator shall provide in accordance with this section for payment to a qualifying entity (as defined in subsection (b)) of the following subsidies:

(1) DIRECT SUBSIDY.—In the case of an individual enrolled in a prescription drug plan, Medicare+Choice plan that provides qualified prescription drug coverage, or qualified retiree prescription drug plan, a direct subsidy equal to 36 percent of the total payments made by a qualifying entity for standard drug coverage provided under the respective plan.

(2) SUBSIDY THROUGH REINSURANCE.—The reinsurance payment amount (as defined in subsection (c)), which in the aggregate is 30 percent of such total payments, for excess costs incurred in providing qualified prescription drug coverage—

(A) for individuals enrolled with a prescription drug plan under this part;

(B) for individuals enrolled with a Medicare+Choice plan that provides qualified prescription drug coverage under part C; and

(C) for individuals who are enrolled in a qualified retiree prescription drug plan.

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) A PDP sponsor offering a 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) and paragraph (4), the reinsurance payment amount under this subsection for a qualifying covered individual (as defined in subsection (g)(1)) 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 prescription drug costs (as defined in paragraph (3)) for the

year that exceeds the initial copayment threshold specified in section 1860B(b)(2)(C), but does not exceed the initial coverage limit specified in section 1860B(b)(3), an amount equal to 30 percent of the allowable costs (as defined in paragraph (2)) attributable to such gross covered prescription drug costs.

(B) For the portion of the individual's gross covered prescription drug costs for the year that exceeds the annual out-of-pocket threshold specified in 1860B(b)(4)(B), an amount equal to 80 percent of the allowable costs attributable to such gross covered prescription drug costs.

(2) ALLOWABLE COSTS.—For purposes of this section, the term "allowable costs" means, with respect to gross covered prescription drug costs 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.

(3) GROSS COVERED PRESCRIPTION DRUG COSTS.—For purposes of this section, the term "gross covered prescription 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 prescription 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.

(4) INDEXING DOLLAR AMOUNTS.—

(A) AMOUNTS FOR 2005.—The dollar amounts applied under paragraph (1) for 2005 shall be the dollar amounts specified in such paragraph.

(B) FOR 2006.—The dollar amounts applied under paragraph (1) for 2006 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase described in section 1860B(b)(5) for 2006.

(C) FOR SUBSEQUENT YEARS.—The dollar amounts applied under paragraph (1) for a year after 2006 shall be the amounts (under this paragraph) applied under paragraph (1) for the preceding year increased by the annual percentage increase described in section 1860B(b)(5) (relating to growth in medicare prescription drug costs per beneficiary) for the year involved.

(D) ROUNDING.—Any amount, determined under the preceding provisions of this paragraph for a year, which is not a multiple of $10 shall be rounded to the nearest multiple of $10.

(d) ADJUSTMENT OF PAYMENTS.—

(1) ADJUSTMENT OF REINSURANCE PAYMENTS TO ASSURE 30 PERCENT LEVEL OF SUBSIDY THROUGH REINSURANCE.—

(A) ESTIMATION OF PAYMENTS.—The Administrator shall estimate—

(i) the total payments to be made (without regard to this subsection) during a year under subsections (a)(2) and (c); and

(ii) the total payments to be made by qualifying entities for standard coverage under plans described in subsection (b) during the year.

(B) ADJUSTMENT.—The Administrator shall proportionally adjust the payments made under subsections (a)(2) 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).

(2) RISK ADJUSTMENT FOR DIRECT SUBSIDIES.—To the extent the Administrator determines it appropriate to avoid risk selection, the payments made for direct subsidies under subsection (a)(1) are subject to adjustment based upon risk factors specified by the Administrator. Any such risk adjustment shall be designed in a manner as to not result in a change in the aggregate payments made under such subsection.

(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 Medicare Prescription Drug Trust Fund.

(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 an individual enrolled (or eligible to be enrolled) under this part 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.

(C) PROVISION OF CERTIFICATION OF PRESCRIPTION DRUG COVERAGE.—The sponsor of the plan shall provide for issuance of certifications of the type described in section 1860A(c)(2)(D).

(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 is—

(A) enrolled under this part;

(B) is covered under the plan; and

(C) is eligible to obtain qualified prescription drug coverage under section 1860A but did not elect such coverage under this part (either through a prescription drug plan or through a Medicare+Choice plan).

(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 enrolled under this part (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 with a prescription drug plan under this part;

(B) is enrolled with a Medicare+Choice plan that provides qualified prescription drug coverage under part C; or

(C) is enrolled for benefits under this title and is covered under a qualified retiree prescription drug plan.

(2) COVERAGE YEAR.—The term "coverage year" means a calendar year in which covered outpatient drugs are dispensed if a claim for payment is made under the plan for such drugs, regardless of when the claim is paid.

SEC. 1860I. MEDICARE PRESCRIPTION DRUG TRUST FUND.

(a) IN GENERAL.—There is created on the books of the Treasury of the United States a trust fund to be known as the "Medicare Prescription Drug Trust Fund" (in this section referred to as the "Trust Fund"). The Trust Fund 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, such fund as provided in this part. Except as otherwise provided in this section, the provisions of subsections (b) through (i) of section 1841 shall apply to the Trust Fund in the same manner as they apply to the Federal Supplementary Medical Insurance Trust Fund under such section.

(b) PAYMENTS FROM TRUST FUND.—

(1) IN GENERAL.—The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Administrator certifies are necessary to make—

(A) payments under section 1860G (relating to low-income subsidy payments);

(B) payments under section 1860H (relating to subsidy payments); and

(C) payments with respect to administrative expenses under this part in accordance with section 201(g).

(2) TRANSFERS TO MEDICAID ACCOUNT FOR INCREASED ADMINISTRATIVE COSTS.—The Managing Trustee shall transfer from time to time from the Trust Fund to the Grants to States for Medicaid account amounts the Administrator certifies are attributable to increases in payment resulting from the application of a higher Federal matching percentage under section 1935(b).

(c) DEPOSITS INTO TRUST FUND.—

(1) LOW-INCOME TRANSFER.—There is hereby transferred to the Trust Fund, 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 GOVERNMENT CONTRIBUTIONS.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Trust Fund, an amount equivalent to the amount of payments made from the Trust Fund under subsection (b), reduced by the amount transferred to the Trust Fund under paragraph (1).

(d) RELATION TO SOLVENCY REQUIREMENTS.—Any provision of law that relates to the solvency of the Trust Fund under this part shall take into account the Trust Fund and amounts receivable by, or payable from, the Trust Fund.

SEC. 1860J. DEFINITIONS; TREATMENT OF REFERENCES TO PROVISIONS IN PART C.

(a) DEFINITIONS.—For purposes of this part:

(1) COVERED OUTPATIENT DRUGS.—The term "covered outpatient drugs" is defined in section 1860B(f).

(2) INITIAL COVERAGE LIMIT.—The term "initial coverage limit" means such limit as established under section 1860B(b)(3), or, in the case of coverage that is not standard coverage, the comparable limit (if any) established under the coverage.

(3) MEDICARE PRESCRIPTION DRUG TRUST FUND.—The term "Medicare Prescription Drug Trust Fund" means the Trust Fund created under section 1860I(a).except in emergency cases and other exceptional circumstances recognized by the Administrator.

(4) PDP SPONSOR.—The term "PDP sponsor" means an entity that is certified under this part as meeting the requirements and standards of this part for such a sponsor.

(5) PRESCRIPTION DRUG PLAN.—The term "prescription drug plan" means health benefits coverage that—

(A) is offered under a policy, contract, or plan by a PDP sponsor pursuant to, and in accordance with, a contract between the Administrator and the sponsor under section 1860D(b);

(B) provides qualified prescription drug coverage; and

(C) meets the applicable requirements of the section 1860C for a prescription drug plan.

(6) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term "qualified prescription drug coverage" is defined in section 1860B(a).

(7) STANDARD COVERAGE.—The term "standard coverage" is defined in section 1860B(b).

(b) APPLICATION OF MEDICARE+CHOICE PROVISIONS UNDER THIS PART.—For purposes of applying provisions of part C under this part with respect to a prescription drug plan and a PDP sponsor, 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 prescription drug plan;

(2) any reference to a provider-sponsored organization included a reference to a PDP sponsor;

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

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

PART [D] *E*—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) * * *

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CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES

SEC. 1882. (a) * * *

* * * * * * *

(v) COVERAGE OF PRESCRIPTION DRUGS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, except as provided in paragraph (3) no new medicare supplemental policy that provides coverage of expenses for prescription drugs may be issued under this section on or after January 1, 2005, to an individual unless it replaces a medicare supplemental policy that was issued to that individual and that provided some coverage of expenses for prescription drugs.

(2) ISSUANCE OF SUBSTITUTE POLICIES IF OBTAIN 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", 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 not later than 63 days after the date of the termination of enrollment described in such paragraph and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

(B) INDIVIDUAL COVERED.—An individual described in this subparagraph is an individual who—

(i) enrolls in a prescription drug plan 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" 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 paragraph (4) of subsection (s) shall apply with respect to the requirements of this paragraph in the same manner as they apply to the requirements of such subsection.

(3) NEW STANDARDS.—In applying subsection (p)(1)(E) (including permitting the NAIC to revise its model regulations in response to changes in law) with respect to the change in benefits resulting from title I of the Medicare Modernization and Prescription Drug Act of 2002, with respect to policies issued to individuals who are enrolled under part D, the changes in standards shall provide only provide for substituting for the benefit packages that included coverage for prescription drugs two benefit packages that may provide for coverage of cost-sharing with respect to qualified prescription drug coverage under such part, except that such coverage may not cover the prescription drug deductible under such part. The two benefit packages shall be consistent with the following:

(A) FIRST NEW POLICY.—The policy described in this subparagraph has the following benefits, notwithstanding any other provision of this section relating to a core benefit package:

(i) Coverage of 50 percent of the cost-sharing otherwise applicable, except coverage of 100 percent of any cost-sharing otherwise applicable for preventive benefits.

(ii) No coverage of the part B deductible.

(iii) Coverage for all hospital coinsurance for long stays (as in the current core benefit package).

(iv) A limitation on annual out-of-pocket expenditures to $4,000 in 2005 (or, in a subsequent year, to such limitation for the previous year increased by an appropriate inflation adjustment specified by the Secretary).

(B) SECOND NEW POLICY.—The policy described in this subparagraph has the same benefits as the policy described in subparagraph (A), except as follows:

(i) Substitute "75 percent" for "50 percent" in clause (i) of such subparagraph.

(ii) Substitute "$2,000" for "$4,000" in clause (iv) of such subparagraph.

(4) CONSTRUCTION.—Any provision in this section or in a medicare supplemental policy relating to guaranteed renewability of coverage shall be deemed to have been met through the offering of other coverage under this subsection.

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TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

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STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) * * *

* * * * * * *

(64) provide, not later than 1 year after the date of the enactment of this paragraph, a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title; **[**and**]**

(65) provide that the State shall issue provider numbers for all suppliers of medical assistance consisting of durable medical equipment, as defined in section 1861(n), and the State shall not issue or renew such a supplier number for any such supplier unless—

(A) * * *

* * * * * * *

(B) a surety bond in a form specified by the Secretary under section 1834(a)(16)(B) and in an amount that is not less than $50,000 or such comparable surety bond as the Secretary may permit under the second sentence of such section**[**.**]***; and*

(66) provide for making eligibility determinations under section 1935(a).

* * * * * * *

PAYMENT TO STATES

SEC. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g) and (j) of this section and subsection 1923(f)) of the total amount expended during such quarter as medical assistance under the State plan*, reduced by the amount computed under section 1935(c)(1) for the State and the quarter*; plus

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PAYMENT FOR COVERED OUTPATIENT DRUGS

SEC. 1927. (a) * * *

* * * * * * *

(c) DETERMINATION OF AMOUNT OF REBATE.—

(1) BASIC REBATE FOR SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE DRUGS.—

(A) * * *

* * * * * * *

(C) BEST PRICE DEFINED.—For purposes of this section—

(i) IN GENERAL.—The term "best price" means, with respect to a single source drug or innovator multiple source drug of a manufacturer, the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the United States, excluding—

(I) * * *

* * * * * * *

(III) any prices used under a State pharmaceutical assistance program; **[**and**]**

(IV) any depot prices and single award contract prices, as defined by the Secretary, of any agency of the Federal Government**[**.**]***; and*

(V) any prices charged which are negotiated by a prescription drug plan under part D of title XVIII, by a Medicare+Choice plan under part C of such title with respect to covered outpatient drugs, or by a qualified retiree prescription drug plan (as defined in section 1860H(f)(1)) with respect to such drugs on behalf of individuals entitled to benefits under part A or enrolled under part B of such title.

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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) subject to subsection (e), a State shall—

(1) make determinations of eligibility for premium and cost-sharing subsidies under (and in accordance with) section 1860G;

(2) inform the Administrator of the Medicare Benefits Administration 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 1860G).

(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE COSTS.—

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

(A) For expenditures attributable to costs incurred during 2005, the otherwise applicable Federal matching rate shall be increased by 10 percent of the percentage otherwise payable (but for this subsection) by the State.

(B)(i) For expenditures attributable to costs incurred during 2006 and each subsequent year through 2013, the otherwise applicable Federal matching rate shall be increased by the applicable percent (as defined in clause (ii)) of the percentage otherwise payable (but for this subsection) by the State.

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

(I) 2006 is 20 percent; or

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

(C) For expenditures attributable to costs incurred after 2013, the otherwise applicable Federal matching rate shall be increased to 100 percent.

(2) COORDINATION.—The State shall provide the Administrator 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.

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

(1) IN GENERAL.—For purposes of section 1903(a)(1) subject to subsection (e), for a State that is one of the 50 States or the District of Columbia 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) MEDICARE SUBSIDIES.—The total amount of payments made in the quarter under section 1860G (relating to premium and cost-sharing prescription drug subsidies for low-income medicare beneficiaries) that are attributable 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).

(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) a subsequent year before 2014, is the phase-out proportion for calendar quarters in the previous year decreased by 10 percentage points; or

(C) a year after 2013 is 0 percent.

(d) ADDITIONAL PROVISIONS.—

(1) MEDICAID AS SECONDARY PAYOR.—In the case of an individual who is entitled to qualified prescription drug coverage under a prescription drug plan under part D of title XVIII (or under a Medicare+Choice plan under part C of such title) and medical assistance for prescribed drugs under this title, medical assistance shall continue to be provided under this title for pre-

scribed drugs to the extent payment is not made under the prescription drug plan or the Medicare+Choice plan selected by the individual.

(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 obtain qualified prescription drug coverage described in paragraph (1), that the individual elect qualified prescription drug coverage under section 1860A.

(e) TREATMENT OF TERRITORIES.—

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

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

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

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

(A) provides medical assistance with respect to the provision of covered outpatient drugs (as defined in section 1860B(f)) 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 annual percentage increase specified in section 1860B(b)(5) for the year involved.

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

REFERENCES TO LAWS DIRECTLY AFFECTING MEDICAID PROGRAM

SEC. [1935.] *1936.* (a) AUTHORITY OR REQUIREMENTS TO COVER ADDITIONAL INDIVIDUALS.—For provisions of law which make additional individuals eligible for medical assistance under this title, see the following:

(1) * * *

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DISSENTING VIEWS

The bill ordered reported from this Committee solely by a vote of its Republican Members falls far short of what is needed to provide meaningful prescription drug coverage to the Nation's 40 million senior citizens and individuals with disabilities who depend on Medicare. The Congressional Budget Office estimates that drug spending on behalf of beneficiaries will total $1.6 trillion during the time the Republican drug benefit is in effect. Yet the $310 billion Committee-passed bill covers only 19% of the anticipated spending during that time period. This means that most Medicare beneficiaries will continue to pay far more for prescription drugs than they can afford.

Republicans claimed in Committee that they could not afford to do more and criticized the Democratic substitute for its cost. A prescription drug benefit, however, that adequately meets beneficiaries' needs is achievable; it is only a matter of priorities. Senior citizens were not a priority for Republicans last year; almost half of all elderly households received absolutely no benefit from the $1.7 trillion tax cut package. Now this year, they are unwilling to devote even half of what they spent on tax cuts to provide meaningful prescription drug coverage for seniors. In 2012 alone, the tax cut would cost $229 billion—more than three times the amount that Republicans are willing to dedicate to prescription drugs in that year.

H.R. 4984 lays the groundwork for the Republicans' ultimate goal to privatize Medicare. Beneficiaries will not have the option to receive drug coverage through the Medicare program, but instead will have to enroll in a private insurance plan. Private insurance plans will make decisions about beneficiary co-insurance, and premiums as well as which drugs are included in the plan formulary.

In short, the Republican majority has chosen to push for a complex plan that puts the interests of HMOs and the drug industry ahead of the interests of beneficiaries. Its key flaws are:

1. INADEQUATE BENEFIT

• *Pay more and get less.* For most seniors in the Republican plan, the more you spend, the less coverage you get. The design of the Committee bill forces the elderly to pay a higher percentage of costs as their needs increase. Once the initial $250 deductible is met, beneficiaries have to pay 20% of the cost until there has been $1,000 in drug spending. Then the co-payment increases to 50% for spending between $1,000 and $2,000. And then the beneficiary has to pay 100% after $2,000 in drug spending. Beneficiaries are forced to pay all of their drug costs for spending between $2,000 and $4,800, while continuing to pay premiums. (Note: The Republican $3,700 out-of- pocket cap translates into $4,800 in total drug spending.)

• *Coverage Stops Mid-Year.* Nearly 50% of Medicare beneficiaries will get no drug coverage for part of the year under the Republican bill. An elderly woman who spends $400 per month on drugs would receive no coverage after May—yet she would still have to pay premiums for a full year. A disabled man who spent $200 per month on drugs would not have coverage begin until February and would see his coverage end in October. This falls far short of what seniors get today in Medicare and short of what we get as Members of Congress under our health plan.

2. NO GUARANTEED DRUG BENEFIT—NO PREDICTABLE COSTS

• *No guaranteed premium.* Insurers determine what premium beneficiaries will pay. While Republicans claim that the premium will be $35, which is 40% higher than the premium in the Democratic plan, there is nothing in the legislation to support that claim. In fact, there are no limits or guidelines regarding the setting of the premium. This is a dramatic change from Medicare today where Part B premiums are set in statute as a percentage of program costs. Under the Republican proposal, premiums will vary by plan and place.

• *No standard benefit.* The benefits outlined in the Republican bill are merely suggestions. Private plans can vary the deductible and co-insurance as well as the premium in both the "standard coverage" option and in the "alternative coverage" option. In fact, there is not even a requirement in the Republican legislation that any plan offer the "standard" benefit package. This is an invitation for plans to design benefits that "cherry pick" low-cost, healthy enrollees. It is also a recipe for beneficiary confusion. This model represents a retreat from the Medigap reforms of the early 1990s that standardized benefits, thus ensuring that plans compete on price and quality and not prey on consumer confusion. Finally, there is nothing in the bill that would ensure beneficiaries can depend on the plans remaining in their area or providing the same benefits from year-to-year. This invites the annual chaos that Congress has witnessed with the Medicare+Choice program in recent years.

• *Not a real entitlement.* The benefit outlined in the bill is not a true Medicare entitlement. Under Medicare today, beneficiaries are entitled to a set of benefits defined in law, regardless of where they live or what it costs to deliver the benefits. For example, beneficiaries in Milwaukee and Miami pay a $100 deductible for Part B and 20% co-insurance for Part B services. Beneficiaries in Bakersfield and Boston are guaranteed the same coverage for hospital care and home health services. Under the Republican plan, there is no such entitlement.

• *Limits access to specific drugs and pharmacies.* Under the bill, private plans can refuse to cover needed medications. The private plans decide what specific drugs are on their formulary and whether to provide any coverage for non-formulary drugs. Plans are not required to disclose the formulary to prospective enrollees, and plans are allowed to change the formulary during the year with "adequate" notice. Private plans also pick and choose which pharmacies are in their network; there is no requirement that all pharmacies that meet the standards be allowed to participate. This means that senior citizens could have to stop going to the phar-

macy that has been serving their needs for decades unless they purchase a separate point-of-service insurance plan with higher premiums and cost-sharing. And, because the Republican plan uses the Medicare+Choice enrollment procedures, beneficiaries will be locked into the private plan for the entire year—even if the plan drops a needed drug or local pharmacy.

• *Encourages Erosion of Employer-Sponsored Coverage.* The bill strictly limits the dollars that count toward the out-of-pocket cap by specifying that only costs which are paid by the individual and are "not reimbursed (through insurance or otherwise) by another person" count toward the out-of-pocket limit. In other words, if a beneficiary receives any assistance—other than low-income assistance—with his or her drug costs, those costs do not count toward the $3,700 limit. The bill was amended to clarify that beneficiaries would not be penalized if they received assistance from family members with the cost of their drugs; however, the definition of "true" out-of-pocket costs puts employers, unions, and others who provide retiree coverage in a bind. Employers would be forced to drop or cap coverage for retirees to wrap-around the Medicare drug benefit, because each dollar spent would not be counted toward catastrophic coverage. Retirees would lose a valuable benefit that many employers provide today.

3. INADEQUATE INVESTMENT FOR PRESCRIPTION DRUGS

• H.R. 4984 covers less than 20% of seniors' drug costs over the next ten years. This is the exact opposite of the coverage seniors receive in Medicare Part B today where Medicare covers 80% of the cost of services. Congress needs to act to make senior citizens a priority on the agenda. If seniors are truly a priority, there is no excuse not to provide a comprehensive prescription drug benefit that meets seniors' needs.

4. PRIVATIZES MEDICARE

• *No alternative but private insurance plans.* The Republican plan forces Medicare into private insurance plans in order to get prescription drugs. There is no option under the Republican bill for a senior to have Medicare provide coverage for their drugs like it provides coverage for doctor visits, hospital care, or other health services today. The bill vests private insurance companies with the power to determine what benefits get offered and for how much. This is dramatically different from Medicare today, where senior citizens and individuals with disabilities are guaranteed affordable health care.

• *Flawed private-market model.* The Republican plan relies on a model that is largely untested. The State of Nevada experimented with private drug-only insurance plans for low-income elderly and found that even with state subsidies, the $85 premium was beyond the reach of seniors. Drugs commonly used by seniors were excluded from plan formularies. Multiple benefit offerings were confusing to beneficiaries. Relying on a private insurance system will increase the costs to the beneficiary and the government due to the additional expenses related to product development, marketing, administration, and profit. Developing a new private insurance product market would be difficult in sparsely populated rural areas,

where the need is greatest, risk pools are smaller and costs often higher. Rather than use Medicare beneficiaries as guinea pigs, we should build on the Medicare model that we know works.

By rejecting the Democratic substitute, the Committee missed its opportunity to provide an affordable, comprehensive prescription drug benefit under Medicare. We urge the House to take a different position and pass the Democratic alternative.

Our plan is an entitlement that would guarantee all beneficiaries the option to purchase affordable, dependable, comprehensive prescription drug coverage at a uniform price. The program would be administered and managed through pharmacy contractors, much like carriers and fiscal intermediaries do for the rest of Medicare today. Starting in 2005, under our plan, beneficiaries would pay a $25 monthly premium, $100 annual deductible and not more than 20% co-insurance until they spend $2,000. After $2,000, the government would pay 100% of the drug costs.

Low-income beneficiaries receive additional assistance under our proposal. Those with incomes up to 150% of poverty ($13,290 for one person) will pay nothing. Those with incomes between 150–175% of poverty ($13,290—$15,505 for a single person) will not pay any cost-sharing but will pay premiums on a sliding scale.

The Democratic substitute also substantially reduces the soaring costs that seniors currently pay for prescription drugs. Under our plan, the Secretary would leverage the collective bargaining power of 40 million beneficiaries to negotiate with manufacturers for lower drug prices. Secretary Thompson recently demonstrated the effectiveness of similar bargaining power when he negotiated an 80% discount off the list price of the antibiotic Cipro during the anthrax scare last year. Pharmacy contractors would also negotiate additional savings. The savings from these negotiations would be required to be directly passed on to beneficiaries through lower prices. Pharmacy contractors would be held accountable for achieving promised discounts for beneficiaries.

The Democratic substitute guarantees senior citizens and those with disabilities the choices that matter—choice of drugs and choice of pharmacy. Under our plan, Medicare would pay toward the cost of every prescription drug. The Democratic substitute also assures access to pharmacies by prohibiting pharmacy contractors from refusing to contract with a pharmacy that agreed to meet its standards. These are the choices people want and need.

Most importantly, unlike the Republican plan, our plan will never force seniors into an HMO or similar private plan in order to get a prescription drug benefit.

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DISSENTING VIEWS OF REPRESENTATIVES MARKEY, DINGELL, AND WAXMAN

We are concerned about the privacy implications of the prescription drug discount card program endorsement provision of H.R. 4954, the Medicine Modernization and Prescription Drug Act of 2002. The discount card program fails to prevent the private medical information of seniors from being used for purposes other than operation of the discount card program without prior authorization by the beneficiary. Privatizing prescription drug benefits for seniors is itself misguided; privatizing these benefits without protecting the personal information of the beneficiary is even worse.

Contrary to the view expressed by the Majority during the Committee's markup, many of these discount card sponsors would not be covered under the existing restrictions mandated by the Health Insurance Portability and Accountability Act (HIPAA). HIPAA only applies to health care providers, health insurers, and health care clearinghouses. Since many of the drug card sponsors fit into none of these categories, they are exempt from the existing regulations. In addition, the March 6, 2002 rule published by the Centers for Medicare and Medicaid Services (CMS), which first proposed the creation of the prescription drug discount card program, contains no reference whatsoever to the applicability of the HIPAA privacy rule to these card programs. So there is no guarantee, nor even the promise of one, that a senior's medical history will not be sold by a drug discount card sponsor to those who would use that sensitive information to prey upon vulnerable seniors.

In addition, the bill also stipulates that these card program sponsors may

> Encourage that enrollees under a plan make payment of the premium established by the plan through an electronic funds transfer mechanism, such as automatic charges of an account at a financial institution or a credit or debit card account, or, at the option of an enrollee, through withholding from benefit payments.

Thus, the drug card sponsor will not only have full access to a senior's medical history and know what medications he or she is taking, they may also know the senior's:

1. Checking account number;
2. Savings account number;
3. Credit card number;
4. Brokerage money market account number;
5. Social Security number; and
6. Private annuity account number.

High-pressure telemarketers who seek to prey upon vulnerable seniors would have all the information needed to target them. These telemarketers could offer the seniors "miracle" cures for can-

cer or Alzheimer's or other diseases. They could try to sell the seniors other services or products that do not work or that they do not need. In short, they could rob seniors blind using their special access to a senior's health information and their knowledge of that senior's financial information.

The Markey amendment, which was defeated in Committee, sought to ensure that the discount card sponsors are subject to reasonable privacy regulations, such as the requirement that prior authorization be obtained before any sensitive information is used or disclosed for any purpose unrelated to the operation of the drug discount card program. Yet, as approved by the Committee, the prescription drug discount card sponsors may receive the endorsement of the Secretary of Health and Human Services without being subject to reasonable privacy regulations.

The Committee's rejection of the Markey amendment enables the drug card sponsors to buy and sell seniors' most intimate personal information as if it were a commodity, and to do so with the endorsement of the Secretary of Health and Human Services.

We respectfully dissent.

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