

One Hundred Eighth Congress
of the
United States of America

AT THE FIRST SESSION

*Begun and held at the City of Washington on Tuesday,
the seventh day of January, two thousand and three*

An Act

To amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes.

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

**SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT;
REFERENCES TO BIPA AND SECRETARY; TABLE OF CON-
TENTS.**

(a) **SHORT TITLE.**—This Act may be cited as the “Medicare Prescription Drug, Improvement, and Modernization Act of 2003”.

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

(c) **BIPA; SECRETARY.**—In this Act:

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

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

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

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TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

SEC. 101. MEDICARE PRESCRIPTION DRUG BENEFIT.

- (a) IN GENERAL.—Title XVIII is amended—
(1) by redesignating part D as part E; and
(2) by inserting after part C the following new part:

“PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

“Subpart 1—Part D Eligible Individuals and Prescription Drug Benefits

“ELIGIBILITY, ENROLLMENT, AND INFORMATION

“SEC. 1860D–1. (a) PROVISION OF QUALIFIED PRESCRIPTION DRUG COVERAGE THROUGH ENROLLMENT IN PLANS.—

“(1) IN GENERAL.—Subject to the succeeding provisions of this part, each part D eligible individual (as defined in paragraph (3)(A)) is entitled to obtain qualified prescription drug coverage (described in section 1860D–2(a)) as follows:

“(A) FEE-FOR-SERVICE ENROLLEES MAY RECEIVE COVERAGE THROUGH A PRESCRIPTION DRUG PLAN.—A part D eligible individual who is not enrolled in an MA plan may obtain qualified prescription drug coverage through enrollment in a prescription drug plan (as defined in section 1860D–41(a)(14)).

“(B) MEDICARE ADVANTAGE ENROLLEES.—

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“(i) ENROLLEES IN A PLAN PROVIDING QUALIFIED PRESCRIPTION DRUG COVERAGE RECEIVE COVERAGE THROUGH THE PLAN.—A part D eligible individual who is enrolled in an MA–PD plan obtains such coverage through such plan.

“(ii) LIMITATION ON ENROLLMENT OF MA PLAN ENROLLEES IN PRESCRIPTION DRUG PLANS.—Except as provided in clauses (iii) and (iv), a part D eligible individual who is enrolled in an MA plan may not enroll in a prescription drug plan under this part.

“(iii) PRIVATE FEE-FOR-SERVICE ENROLLEES IN MA PLANS NOT PROVIDING QUALIFIED PRESCRIPTION DRUG COVERAGE PERMITTED TO ENROLL IN A PRESCRIPTION DRUG PLAN.—A part D eligible individual who is enrolled in an MA private fee-for-service plan (as defined in section 1859(b)(2)) that does not provide qualified prescription drug coverage may obtain qualified prescription drug coverage through enrollment in a prescription drug plan.

“(iv) ENROLLEES IN MSA PLANS PERMITTED TO ENROLL IN A PRESCRIPTION DRUG PLAN.—A part D eligible individual who is enrolled in an MSA plan (as defined in section 1859(b)(3)) may obtain qualified prescription drug coverage through enrollment in a prescription drug plan.

“(2) COVERAGE FIRST EFFECTIVE JANUARY 1, 2006.—Coverage under prescription drug plans and MA–PD plans shall first be effective on January 1, 2006.

“(3) DEFINITIONS.—For purposes of this part:

“(A) PART D ELIGIBLE INDIVIDUAL.—The term ‘part D eligible individual’ means an individual who is entitled to benefits under part A or enrolled under part B.

“(B) MA PLAN.—The term ‘MA plan’ has the meaning given such term in section 1859(b)(1).

“(C) MA–PD PLAN.—The term ‘MA–PD plan’ means an MA plan that provides qualified prescription drug coverage.

“(b) ENROLLMENT PROCESS FOR PRESCRIPTION DRUG PLANS.—

“(1) ESTABLISHMENT OF PROCESS.—

“(A) IN GENERAL.—The Secretary shall establish a process for the enrollment, disenrollment, termination, and change of enrollment of part D eligible individuals in prescription drug plans consistent with this subsection.

“(B) APPLICATION OF MA RULES.—In establishing such process, the Secretary shall use rules similar to (and coordinated with) the rules for enrollment, disenrollment, termination, and change of enrollment with an MA–PD plan under the following provisions of section 1851:

“(i) RESIDENCE REQUIREMENTS.—Section 1851(b)(1)(A), relating to residence requirements.

“(ii) EXERCISE OF CHOICE.—Section 1851(c) (other than paragraph (3)(A) of such section), relating to exercise of choice.

“(iii) COVERAGE ELECTION PERIODS.—Subject to paragraphs (2) and (3) of this subsection, section 1851(e) (other than subparagraphs (B) and (C) of paragraph (2) and the second sentence of paragraph (4)

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of such section), relating to coverage election periods, including initial periods, annual coordinated election periods, special election periods, and election periods for exceptional circumstances.

“(iv) COVERAGE PERIODS.—Section 1851(f), relating to effectiveness of elections and changes of elections.

“(v) GUARANTEED ISSUE AND RENEWAL.—Section 1851(g) (other than paragraph (2) of such section and clause (i) and the second sentence of clause (ii) of paragraph (3)(C) of such section), relating to guaranteed issue and renewal.

“(vi) MARKETING MATERIAL AND APPLICATION FORMS.—Section 1851(h), relating to approval of marketing material and application forms.

In applying clauses (ii), (iv), and (v) of this subparagraph, any reference to section 1851(e) shall be treated as a reference to such section as applied pursuant to clause (iii) of this subparagraph.

“(C) SPECIAL RULE.—The process established under subparagraph (A) shall include, in the case of a part D eligible individual who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)) who has failed to enroll in a prescription drug plan or an MA–PD plan, for the enrollment in a prescription drug plan that has a monthly beneficiary premium that does not exceed the premium assistance available under section 1860D–14(a)(1)(A)). If there is more than one such plan available, the Secretary shall enroll such an individual on a random basis among all such plans in the PDP region. Nothing in the previous sentence shall prevent such an individual from declining or changing such enrollment.

“(2) INITIAL ENROLLMENT PERIOD.—

“(A) PROGRAM INITIATION.—In the case of an individual who is a part D eligible individual as of November 15, 2005, there shall be an initial enrollment period that shall be the same as the annual, coordinated open election period described in section 1851(e)(3)(B)(iii), as applied under paragraph (1)(B)(iii).

“(B) CONTINUING PERIODS.—In the case of an individual who becomes a part D eligible individual after November 15, 2005, there shall be an initial enrollment period which is the period under section 1851(e)(1), as applied under paragraph (1)(B)(iii) of this section, as if ‘entitled to benefits under part A or enrolled under part B’ were substituted for ‘entitled to benefits under part A and enrolled under part B’, but in no case shall such period end before the period described in subparagraph (A).

“(3) ADDITIONAL SPECIAL ENROLLMENT PERIODS.—The Secretary shall establish special enrollment periods, including the following:

“(A) INVOLUNTARY LOSS OF CREDITABLE PRESCRIPTION DRUG COVERAGE.—

“(i) IN GENERAL.—In the case of a part D eligible individual who involuntarily loses creditable prescription drug coverage (as defined in section 1860D–13(b)(4)).

“(ii) NOTICE.—In establishing special enrollment periods under clause (i), the Secretary shall take into account when the part D eligible individuals are provided notice of the loss of creditable prescription drug coverage.

“(iii) FAILURE TO PAY PREMIUM.—For purposes of clause (i), a loss of coverage shall be treated as voluntary if the coverage is terminated because of failure to pay a required beneficiary premium.

“(iv) REDUCTION IN COVERAGE.—For purposes of clause (i), a reduction in coverage so that the coverage no longer meets the requirements under section 1860D–13(b)(5) (relating to actuarial equivalence) shall be treated as an involuntary loss of coverage.

“(B) ERRORS IN ENROLLMENT.—In the case described in section 1837(h) (relating to errors in enrollment), in the same manner as such section applies to part B.

“(C) EXCEPTIONAL CIRCUMSTANCES.—In the case of part D eligible individuals who meet such exceptional conditions (in addition to those conditions applied under paragraph (1)(B)(iii)) as the Secretary may provide.

“(D) MEDICAID COVERAGE.—In the case of an individual (as determined by the Secretary) who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)).

“(E) DISCONTINUANCE OF MA–PD ELECTION DURING FIRST YEAR OF ELIGIBILITY.—In the case of a part D eligible individual who discontinues enrollment in an MA–PD plan under the second sentence of section 1851(e)(4) at the time of the election of coverage under such sentence under the original medicare fee-for-service program.

“(4) INFORMATION TO FACILITATE ENROLLMENT.—

“(A) IN GENERAL.—Notwithstanding any other provision of law but subject to subparagraph (B), the Secretary may provide to each PDP sponsor and MA organization such identifying information about part D eligible individuals as the Secretary determines to be necessary to facilitate efficient marketing of prescription drug plans and MA–PD plans to such individuals and enrollment of such individuals in such plans.

“(B) LIMITATION.—

“(i) PROVISION OF INFORMATION.—The Secretary may provide the information under subparagraph (A) only to the extent necessary to carry out such subparagraph.

“(ii) USE OF INFORMATION.—Such information provided by the Secretary to a PDP sponsor or an MA organization may be used by such sponsor or organization only to facilitate marketing of, and enrollment of part D eligible individuals in, prescription drug plans and MA–PD plans.

“(5) REFERENCE TO ENROLLMENT PROCEDURES FOR MA–PD PLANS.—For rules applicable to enrollment, disenrollment, termination, and change of enrollment of part D eligible individuals in MA–PD plans, see section 1851.

“(6) REFERENCE TO PENALTIES FOR LATE ENROLLMENT.—Section 1860D–13(b) imposes a late enrollment penalty for part D eligible individuals who—

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“(A) enroll in a prescription drug plan or an MA-PD plan after the initial enrollment period described in paragraph (2); and

“(B) fail to maintain continuous creditable prescription drug coverage during the period of non-enrollment.

“(c) PROVIDING INFORMATION TO BENEFICIARIES.—

“(1) ACTIVITIES.—The Secretary shall conduct activities that are designed to broadly disseminate information to part D eligible individuals (and prospective part D eligible individuals) regarding the coverage provided under this part. Such activities shall ensure that such information is first made available at least 30 days prior to the initial enrollment period described in subsection (b)(2)(A).

“(2) REQUIREMENTS.—The activities described in paragraph (1) shall—

“(A) be similar to the activities performed by the Secretary under section 1851(d), including dissemination (including through the toll-free telephone number 1-800-MEDICARE) of comparative information for prescription drug plans and MA-PD plans; and

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

“(3) COMPARATIVE INFORMATION.—

“(A) IN GENERAL.—Subject to subparagraph (B), the comparative information referred to in paragraph (2)(A) shall include a comparison of the following with respect to qualified prescription drug coverage:

“(i) BENEFITS.—The benefits provided under the plan.

“(ii) MONTHLY BENEFICIARY PREMIUM.—The monthly beneficiary premium under the plan.

“(iii) QUALITY AND PERFORMANCE.—The quality and performance under the plan.

“(iv) BENEFICIARY COST-SHARING.—The cost-sharing required of part D eligible individuals under the plan.

“(v) CONSUMER SATISFACTION SURVEYS.—The results of consumer satisfaction surveys regarding the plan conducted pursuant to section 1860D-4(d).

“(B) EXCEPTION FOR UNAVAILABILITY OF INFORMATION.—The Secretary is not required to provide comparative information under clauses (iii) and (v) of subparagraph (A) with respect to a plan—

“(i) for the first plan year in which it is offered;

and

“(ii) for the next plan year if it is impracticable or the information is otherwise unavailable.

“(4) INFORMATION ON LATE ENROLLMENT PENALTY.—The information disseminated under paragraph (1) shall include information concerning the methodology for determining the late enrollment penalty under section 1860D-13(b).

“PRESCRIPTION DRUG BENEFITS

“SEC. 1860D-2. (a) REQUIREMENTS.—

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

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“(A) STANDARD PRESCRIPTION DRUG COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Standard prescription drug coverage (as defined in subsection (b)) and access to negotiated prices under subsection (d).

“(B) ALTERNATIVE PRESCRIPTION DRUG COVERAGE WITH AT LEAST ACTUARIALLY EQUIVALENT BENEFITS AND ACCESS TO NEGOTIATED PRICES.—Coverage of covered part D drugs which meets the alternative prescription drug coverage requirements of subsection (c) and access to negotiated prices under subsection (d), but only if the benefit design of such coverage is approved by the Secretary, as provided under subsection (c).

“(2) PERMITTING SUPPLEMENTAL PRESCRIPTION DRUG COVERAGE.—

“(A) IN GENERAL.—Subject to subparagraph (B), qualified prescription drug coverage may include supplemental prescription drug coverage consisting of either or both of the following:

“(i) CERTAIN REDUCTIONS IN COST-SHARING.—

“(I) IN GENERAL.—A reduction in the annual deductible, a reduction in the coinsurance percentage, or an increase in the initial coverage limit with respect to covered part D drugs, or any combination thereof, insofar as such a reduction or increase increases the actuarial value of benefits above the actuarial value of basic prescription drug coverage.

“(II) CONSTRUCTION.—Nothing in this paragraph shall be construed as affecting the application of subsection (c)(3).

“(ii) OPTIONAL DRUGS.—Coverage of any product that would be a covered part D drug but for the application of subsection (e)(2)(A).

“(B) REQUIREMENT.—A PDP sponsor may not offer a prescription drug plan that provides supplemental prescription drug coverage pursuant to subparagraph (A) in an area unless the sponsor also offers a prescription drug plan in the area that only provides basic prescription drug coverage.

“(3) BASIC PRESCRIPTION DRUG COVERAGE.—For purposes of this part and part C, the term ‘basic prescription drug coverage’ means either of the following:

“(A) Coverage that meets the requirements of paragraph (1)(A).

“(B) Coverage that meets the requirements of paragraph (1)(B) but does not have any supplemental prescription drug coverage described in paragraph (2)(A).

“(4) 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.

“(5) CONSTRUCTION.—Nothing in this subsection shall be construed as changing the computation of incurred costs under subsection (b)(4).

“(b) STANDARD PRESCRIPTION DRUG COVERAGE.—For purposes of this part and part C, the term ‘standard prescription drug coverage’ means coverage of covered part D drugs that meets the following requirements:

“(1) DEDUCTIBLE.—

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

“(i) for 2006, that is equal to \$250; or

“(ii) for a subsequent year, that is equal to the amount specified under this paragraph for the previous year increased by the percentage specified in paragraph (6) for the year involved.

“(B) ROUNDING.—Any amount determined under subparagraph (A)(ii) that is not a multiple of \$5 shall be rounded to the nearest multiple of \$5.

“(2) BENEFIT STRUCTURE.—

“(A) 25 PERCENT COINSURANCE.—The coverage has coinsurance (for costs above the annual deductible specified in paragraph (1) and up to the initial coverage limit under paragraph (3)) that is—

“(i) equal to 25 percent; or

“(ii) actuarially equivalent (using processes and methods established under section 1860D–11(c)) to an average expected payment of 25 percent of such costs.

“(B) USE OF TIERS.—Nothing in this part shall be construed as preventing a PDP sponsor or an MA organization from applying tiered copayments under a plan, so long as such tiered copayments are consistent with subparagraph (A)(ii).

“(3) INITIAL COVERAGE LIMIT.—

“(A) IN GENERAL.—Except as provided in paragraph (4), the coverage has an initial coverage limit on the maximum costs that may be recognized for payment purposes (including the annual deductible)—

“(i) for 2006, that is equal to \$2,250; or

“(ii) for a subsequent year, that is equal to the amount specified in this paragraph for the previous year, increased by the annual percentage increase described in paragraph (6) for the year involved.

“(B) ROUNDING.—Any amount determined under subparagraph (A)(ii) that is not a multiple of \$10 shall be rounded to the nearest multiple of \$10.

“(4) PROTECTION AGAINST HIGH OUT-OF-POCKET EXPENDITURES.—

“(A) IN GENERAL.—

“(i) IN GENERAL.—The coverage provides benefits, after the part D eligible individual has incurred costs (as described in subparagraph (C)) for covered part D drugs in a year equal to the annual out-of-pocket threshold specified in subparagraph (B), with cost-sharing that is equal to the greater of—

“(I) a copayment of \$2 for a generic drug or a preferred drug that is a multiple source drug (as defined in section 1927(k)(7)(A)(i)) and \$5 for any other drug; or

“(II) coinsurance that is equal to 5 percent.

“(ii) ADJUSTMENT OF AMOUNT.—For a year after 2006, the dollar amounts specified in clause (i)(I) shall be equal to the dollar amounts specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (6)

for the year involved. Any amount established under this clause that is not a multiple of a 5 cents shall be rounded to the nearest multiple of 5 cents.

“(B) ANNUAL OUT-OF-POCKET THRESHOLD.—

“(i) IN GENERAL.—For purposes of this part, the ‘annual out-of-pocket threshold’ specified in this subparagraph—

“(I) for 2006, is equal to \$3,600; 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 (6) for the year involved.

“(ii) ROUNDING.—Any amount determined under clause (i)(II) that is not a multiple of \$50 shall be rounded to the nearest multiple of \$50.

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

“(i) incurred costs shall only include costs incurred with respect to covered part D drugs for the annual deductible described in paragraph (1), for cost-sharing described in paragraph (2), and for amounts for which benefits are not provided because of the application of the initial coverage limit described in paragraph (3), but does not include any costs incurred for covered part D drugs which are not included (or treated as being included) in the plan’s formulary; and

“(ii) such costs shall be treated as incurred only if they are paid by the part D eligible individual (or by another person, such as a family member, on behalf of the individual), under section 1860D–14, or under a State Pharmaceutical Assistance Program and the part D eligible individual (or other person) is not reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement (other than under such section or such a Program) for such costs.

“(D) INFORMATION REGARDING THIRD-PARTY REIMBURSEMENT.—

“(i) PROCEDURES FOR EXCHANGING INFORMATION.—

In order to accurately apply the requirements of subparagraph (C)(ii), the Secretary is authorized to establish procedures, in coordination with the Secretary of the Treasury and the Secretary of Labor—

“(I) for determining whether costs for part D eligible individuals are being reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement; and

“(II) for alerting the PDP sponsors and MA organizations that offer the prescription drug plans and MA–PD plans in which such individuals are enrolled about such reimbursement arrangements.

“(ii) AUTHORITY TO REQUEST INFORMATION FROM ENROLLEES.—A PDP sponsor or an MA organization may periodically ask part D eligible individuals enrolled in a prescription drug plan or an MA–PD plan offered by the sponsor or organization whether such individuals have or expect to receive such third-

party reimbursement. A material misrepresentation of the information described in the preceding sentence by an individual (as defined in standards set by the Secretary and determined through a process established by the Secretary) shall constitute grounds for termination of enrollment in any plan under section 1851(g)(3)(B) (and as applied under this part under section 1860D–1(b)(1)(B)(v)) for a period specified by the Secretary.

“(5) CONSTRUCTION.—Nothing in this part shall be construed as preventing a PDP sponsor or an MA organization offering an MA–PD plan from reducing to zero the cost-sharing otherwise applicable to preferred or generic drugs.

“(6) ANNUAL PERCENTAGE INCREASE.—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 part D drugs in the United States for part D eligible individuals, as determined by the Secretary for the 12-month period ending in July of the previous year using such methods as the Secretary shall specify.

“(c) ALTERNATIVE PRESCRIPTION DRUG COVERAGE REQUIREMENTS.—A prescription drug plan or an MA–PD plan may provide a different prescription drug benefit design from standard prescription drug coverage so long as the Secretary determines (consistent with section 1860D–11(c)) that the following requirements are met and the plan applies for, and receives, the approval of the Secretary 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 is at least equal to the actuarial value of standard prescription drug coverage.

“(B) ASSURING EQUIVALENT UNSUBSIDIZED VALUE OF COVERAGE.—The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard prescription drug coverage. For purposes of this subparagraph, the unsubsidized value of coverage is the amount by which the actuarial value of the coverage exceeds the actuarial value of the subsidy payments under section 1860D–15 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, to provide for the payment, with respect to costs incurred that are equal to the initial coverage limit under subsection (b)(3) for the year, of an amount equal to at least the product of—

“(i) the amount by which the initial coverage limit described in subsection (b)(3) for the year exceeds the deductible described in subsection (b)(1) for the year; and

“(ii) 100 percent minus the coinsurance percentage specified in subsection (b)(2)(A)(i).

“(2) MAXIMUM REQUIRED DEDUCTIBLE.—The deductible under the coverage shall not exceed the deductible amount specified under subsection (b)(1) for the year.

“(3) SAME PROTECTION AGAINST HIGH OUT-OF-POCKET EXPENDITURES.—The coverage provides the coverage required under subsection (b)(4).

“(d) ACCESS TO NEGOTIATED PRICES.—

“(1) ACCESS.—

“(A) IN GENERAL.—Under qualified prescription drug coverage offered by a PDP sponsor offering a prescription drug plan or an MA organization offering an MA–PD plan, the sponsor or organization shall provide enrollees with access to negotiated prices used for payment for covered part D drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of a deductible or other cost-sharing or an initial coverage limit (described in subsection (b)(3)).

“(B) NEGOTIATED PRICES.—For purposes of this part, negotiated prices shall take into account negotiated price concessions, such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations, for covered part D drugs, and include any dispensing fees for such drugs.

“(C) MEDICAID-RELATED PROVISIONS.—The prices negotiated by a prescription drug plan, by an MA–PD plan with respect to covered part D drugs, or by a qualified retiree prescription drug plan (as defined in section 1860D–22(a)(2)) with respect to such drugs on behalf of part D eligible individuals, 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.—A PDP sponsor offering a prescription drug plan or an MA organization offering an MA–PD plan shall disclose to the Secretary (in a manner specified by the Secretary) the aggregate negotiated price concessions described in paragraph (1)(B) made available to the sponsor or organization by a manufacturer which are passed through in the form of lower subsidies, lower monthly beneficiary prescription drug premiums, and lower prices through pharmacies and other dispensers. The provisions of section 1927(b)(3)(D) apply to information disclosed to the Secretary under this paragraph.

“(3) AUDITS.—To protect against fraud and abuse and to ensure proper disclosures and accounting under this part and in accordance with section 1857(d)(2)(B) (as applied under section 1860D–12(b)(3)(C)), the Secretary may conduct periodic audits, directly or through contracts, of the financial statements and records of PDP sponsors with respect to prescription drug plans and MA organizations with respect to MA–PD plans.

“(e) COVERED PART D DRUG DEFINED.—

“(1) IN GENERAL.—Except as provided in this subsection, for purposes of this part, the term ‘covered part D drug’ means—

“(A) a drug that may be dispensed only upon a prescription and that is described in subparagraph (A)(i), (A)(ii), or (A)(iii) 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 medical supplies

associated with the injection of insulin (as defined in regulations of the Secretary), and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered part D 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) of such section (relating to smoking cessation agents), or under section 1927(d)(3).

“(B) MEDICARE COVERED DRUGS.—A drug prescribed for a part D eligible individual that would otherwise be a covered part D drug under this part shall not be so considered if payment for such drug as so prescribed and dispensed or administered with respect to that individual is available (or would be available but for the application of a deductible) under part A or B for that individual.

“(3) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A prescription drug plan or an MA–PD plan may exclude from qualified prescription drug coverage any covered part D drug—

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

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

Such exclusions are determinations subject to reconsideration and appeal pursuant to subsections (g) and (h), respectively, of section 1860D–4.

“ACCESS TO A CHOICE OF QUALIFIED PRESCRIPTION DRUG COVERAGE

“SEC. 1860D–3. (a) ASSURING ACCESS TO A CHOICE OF COVERAGE.—

“(1) CHOICE OF AT LEAST TWO PLANS IN EACH AREA.—The Secretary shall ensure that each part D eligible individual has available, consistent with paragraph (2), a choice of enrollment in at least 2 qualifying plans (as defined in paragraph (3)) in the area in which the individual resides, at least one of which is a prescription drug plan. In any such case in which such plans are not available, the part D eligible individual shall be given the opportunity to enroll in a fallback prescription drug plan.

“(2) REQUIREMENT FOR DIFFERENT PLAN SPONSORS.—The requirement in paragraph (1) is not satisfied with respect to an area if only one entity offers all the qualifying plans in the area.

“(3) QUALIFYING PLAN DEFINED.—For purposes of this section, the term ‘qualifying plan’ means—

“(A) a prescription drug plan; or

“(B) an MA–PD plan described in section 1851(a)(2)(A)(i) that provides—

“(i) basic prescription drug coverage; or

“(ii) qualified prescription drug coverage that provides supplemental prescription drug coverage so long as there is no MA monthly supplemental beneficiary premium applied under the plan, due to the application

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of a credit against such premium of a rebate under section 1854(b)(1)(C).

“(b) FLEXIBILITY IN RISK ASSUMED AND APPLICATION OF FALL-BACK PLAN.—In order to ensure access pursuant to subsection (a) in an area—

“(1) the Secretary may approve limited risk plans under section 1860D–11(f) for the area; and

“(2) only if such access is still not provided in the area after applying paragraph (1), the Secretary shall provide for the offering of a fallback prescription drug plan for that area under section 1860D–11(g).

“BENEFICIARY PROTECTIONS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE

“SEC. 1860D–4. (a) DISSEMINATION OF INFORMATION.—

“(1) GENERAL INFORMATION.—

“(A) APPLICATION OF MA 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, insofar as the Secretary determines appropriate with respect to benefits provided under this part, and including the information described in subparagraph (B).

“(B) DRUG SPECIFIC INFORMATION.—The information described in this subparagraph is information concerning the following:

“(i) Access to specific covered part D drugs, including access through pharmacy networks.

“(ii) How any formulary (including any tiered formulary structure) used by the sponsor functions, including a description of how a part D eligible individual may obtain information on the formulary consistent with paragraph (3).

“(iii) Beneficiary cost-sharing requirements and how a part D eligible individual may obtain information on such requirements, including tiered or other copayment level applicable to each drug (or class of drugs), consistent with paragraph (3).

“(iv) The medication therapy management program required under subsection (c).

“(2) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of a part D eligible individual who is eligible to enroll in a prescription drug plan, the PDP sponsor offering such plan shall provide information similar (as determined by the Secretary) to the information described in subparagraphs (A), (B), and (C) of section 1852(c)(2) to such individual.

“(3) PROVISION OF SPECIFIC INFORMATION.—

“(A) RESPONSE TO BENEFICIARY QUESTIONS.—Each PDP sponsor offering a prescription drug plan shall have a mechanism for providing specific information on a timely basis to enrollees upon request. Such mechanism shall include access to information through the use of a toll-free telephone number and, upon request, the provision of such information in writing.

“(B) AVAILABILITY OF INFORMATION ON CHANGES IN FORMULARY THROUGH THE INTERNET.—A PDP sponsor offering a prescription drug plan shall make available on a timely basis through an Internet website information on specific changes in the formulary under the plan (including changes to tiered or preferred status of covered part D drugs).

“(4) CLAIMS INFORMATION.—A PDP sponsor offering a prescription drug plan must furnish to each enrollee in a form easily understandable to such enrollees—

“(A) an explanation of benefits (in accordance with section 1806(a) or in a comparable manner); and

“(B) when prescription drug benefits are provided under this part, a notice of the benefits in relation to—

“(i) the initial coverage limit for the current year;

and

“(ii) the annual out-of-pocket threshold for the current year.

Notices under subparagraph (B) need not be provided more often than as specified by the Secretary and notices under subparagraph (B)(ii) shall take into account the application of section 1860D–2(b)(4)(C) to the extent practicable, as specified by the Secretary.

“(b) ACCESS TO COVERED PART D DRUGS.—

“(1) ASSURING PHARMACY ACCESS.—

“(A) PARTICIPATION OF ANY WILLING PHARMACY.—A prescription drug plan shall permit the participation of any pharmacy that meets the terms and conditions under the plan.

“(B) DISCOUNTS ALLOWED FOR NETWORK PHARMACIES.—For covered part D drugs dispensed through in-network pharmacies, a prescription drug plan may, notwithstanding subparagraph (A), reduce coinsurance or copayments for part D eligible individuals enrolled in the plan below the level otherwise required. In no case shall such a reduction result in an increase in payments made by the Secretary under section 1860D–15 to a plan.

“(C) CONVENIENT ACCESS FOR NETWORK PHARMACIES.—

“(i) 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 (consistent with rules established by the Secretary).

“(ii) APPLICATION OF TRICARE STANDARDS.—The Secretary shall establish rules for convenient access to in-network pharmacies under this subparagraph that are no less favorable to enrollees than the rules for convenient access to pharmacies included in the statement of work of solicitation (#MDA906–03–R–0002) of the Department of Defense under the TRICARE Retail Pharmacy (TRRx) as of March 13, 2003.

“(iii) ADEQUATE EMERGENCY ACCESS.—Such rules shall include adequate emergency access for enrollees.

“(iv) CONVENIENT ACCESS IN LONG-TERM CARE FACILITIES.—Such rules may include standards with respect to access for enrollees who are residing in

long-term care facilities and for pharmacies operated by the Indian Health Service, Indian tribes and tribal organizations, and urban Indian organizations (as defined in section 4 of the Indian Health Care Improvement Act).

“(D) LEVEL PLAYING FIELD.—Such a sponsor shall permit enrollees to receive benefits (which may include a 90-day supply of drugs or biologicals) through a pharmacy (other than a mail order pharmacy), with any differential in charge paid by such enrollees.

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

“(2) 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 enrollee to assure access to negotiated prices under section 1860D–2(d).

“(B) STANDARDS.—

“(i) IN GENERAL.—The Secretary shall provide for the development, adoption, or recognition of standards relating to a standardized format for the card or other technology required under subparagraph (A). Such standards shall be compatible with part C of title XI and may be based on standards developed by an appropriate standard setting organization.

“(ii) CONSULTATION.—In developing the standards under clause (i), the Secretary shall consult with the National Council for Prescription Drug Programs and other standard setting organizations determined appropriate by the Secretary.

“(iii) IMPLEMENTATION.—The Secretary shall develop, adopt, or recognize the standards under clause (i) by such date as the Secretary determines shall be sufficient to ensure that PDP sponsors utilize such standards beginning January 1, 2006.

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

“(A) DEVELOPMENT AND REVISION BY A PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—

“(i) IN GENERAL.—The formulary must be developed and reviewed by a pharmacy and therapeutic committee. A majority of the members of such committee shall consist of individuals who are practicing physicians or practicing pharmacists (or both).

“(ii) INCLUSION OF INDEPENDENT EXPERTS.—Such committee shall include at least one practicing physician and at least one practicing pharmacist, each of whom—

“(I) is independent and free of conflict with respect to the sponsor and plan; and

“(II) has expertise in the care of elderly or disabled persons.

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

“(i) base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and on such other information as the committee determines to be appropriate; and

“(ii) take into account whether including in the formulary (or in a tier in such formulary) particular covered part D drugs has therapeutic advantages in terms of safety and efficacy.

“(C) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES AND CLASSES.—

“(i) IN GENERAL.—The formulary must include drugs within each therapeutic category and class of covered part D drugs, although not necessarily all drugs within such categories and classes.

“(ii) MODEL GUIDELINES.—The Secretary shall request the United States Pharmacopeia to develop, in consultation with pharmaceutical benefit managers and other interested parties, a list of categories and classes that may be used by prescription drug plans under this paragraph and to revise such classification from time to time to reflect changes in therapeutic uses of covered part D drugs and the additions of new covered part D drugs.

“(iii) LIMITATION ON CHANGES IN THERAPEUTIC CLASSIFICATION.—The PDP sponsor of a prescription drug plan may not change the therapeutic categories and classes in a formulary other than at the beginning of each plan year except as the Secretary may permit to take into account new therapeutic uses and newly approved covered part D drugs.

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

“(E) NOTICE BEFORE REMOVING DRUG FROM FORMULARY OR CHANGING PREFERRED OR TIER STATUS OF DRUG.—Any removal of a covered part D drug from a formulary and any change in the preferred or tiered cost-sharing status of such a drug shall take effect only after appropriate notice is made available (such as under subsection (a)(3)) to the Secretary, affected enrollees, physicians, pharmacies, and pharmacists.

“(F) PERIODIC EVALUATION OF PROTOCOLS.—In connection with the formulary, the sponsor of a prescription drug plan shall provide for the periodic evaluation and analysis of treatment protocols and procedures.

The requirements of this paragraph may be met by a PDP sponsor directly or through arrangements with another entity.

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

“(1) IN GENERAL.—The PDP sponsor shall have in place, directly or through appropriate arrangements, with respect to covered part D drugs, the following:

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“(A) A cost-effective drug utilization management program, including incentives to reduce costs when medically appropriate, such as through the use of multiple source drugs (as defined in section 1927(k)(7)(A)(i)).

“(B) Quality assurance measures and systems to reduce medication errors and adverse drug interactions and improve medication use.

“(C) A medication therapy management program described in paragraph (2).

“(D) A program to control fraud, abuse, and waste. Nothing in this section shall be construed as impairing a PDP sponsor from utilizing cost management tools (including differential payments) under all methods of operation.

“(2) MEDICATION THERAPY MANAGEMENT PROGRAM.—

“(A) DESCRIPTION.—

“(i) IN GENERAL.—A medication therapy management program described in this paragraph is a program of drug therapy management that may be furnished by a pharmacist and that is designed to assure, with respect to targeted beneficiaries described in clause (ii), that covered part D drugs under the prescription drug plan are appropriately used to optimize therapeutic outcomes through improved medication use, and to reduce the risk of adverse events, including adverse drug interactions. Such a program may distinguish between services in ambulatory and institutional settings.

“(ii) TARGETED BENEFICIARIES DESCRIBED.—Targeted beneficiaries described in this clause are part D eligible individuals who—

“(I) have multiple chronic diseases (such as diabetes, asthma, hypertension, hyperlipidemia, and congestive heart failure);

“(II) are taking multiple covered part D drugs; and

“(III) are identified as likely to incur annual costs for covered part D drugs that exceed a level specified by the Secretary.

“(B) ELEMENTS.—Such program may include elements that promote—

“(i) enhanced enrollee understanding to promote the appropriate use of medications by enrollees and to reduce the risk of potential adverse events associated with medications, through beneficiary education, counseling, and other appropriate means;

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

“(iii) detection of adverse drug events and patterns of overuse and underuse of prescription drugs.

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

“(D) COORDINATION WITH CARE MANAGEMENT PLANS.—The Secretary shall establish guidelines for the coordination of any medication therapy management program under this paragraph with respect to a targeted beneficiary with any care management plan established with respect to such beneficiary under a chronic care improvement program under section 1807.

“(E) CONSIDERATIONS IN PHARMACY FEES.—The PDP sponsor of a prescription drug plan shall take into account, in establishing fees for pharmacists and others providing services under such plan, the resources used, and time required to, implement the medication therapy management program under this paragraph. Each such sponsor shall disclose to the Secretary upon request the amount of any such management or dispensing fees. The provisions of section 1927(b)(3)(D) apply to information disclosed under this subparagraph.

“(d) CONSUMER SATISFACTION SURVEYS.—In order to provide for comparative information under section 1860D–1(c)(3)(A)(v), the Secretary shall conduct consumer satisfaction surveys with respect to PDP sponsors and prescription drug plans in a manner similar to the manner such surveys are conducted for MA organizations and MA plans under part C.

“(e) ELECTRONIC PRESCRIPTION PROGRAM.—

“(1) APPLICATION OF STANDARDS.—As of such date as the Secretary may specify, but not later than 1 year after the date of promulgation of final standards under paragraph (4)(D), prescriptions and other information described in paragraph (2)(A) for covered part D drugs prescribed for part D eligible individuals that are transmitted electronically shall be transmitted only in accordance with such standards under an electronic prescription drug program that meets the requirements of paragraph (2).

“(2) PROGRAM REQUIREMENTS.—Consistent with uniform standards established under paragraph (3)—

“(A) PROVISION OF INFORMATION TO PRESCRIBING HEALTH CARE PROFESSIONAL AND DISPENSING PHARMACIES AND PHARMACISTS.—An electronic prescription drug program shall provide for the electronic transmittal to the prescribing health care professional and to the dispensing pharmacy and pharmacist of the prescription and information on eligibility and benefits (including the drugs included in the applicable formulary, any tiered formulary structure, and any requirements for prior authorization) and of the following information with respect to the prescribing and dispensing of a covered part D drug:

“(i) Information on the drug being prescribed or dispensed and other drugs listed on the medication history, including information on drug-drug interactions, warnings or cautions, and, when indicated, dosage adjustments.

“(ii) Information on the availability of lower cost, therapeutically appropriate alternatives (if any) for the drug prescribed.

“(B) APPLICATION TO MEDICAL HISTORY INFORMATION.—Effective on and after such date as the Secretary specifies and after the establishment of appropriate standards to

carry out this subparagraph, the program shall provide for the electronic transmittal in a manner similar to the manner under subparagraph (A) of information that relates to the medical history concerning the individual and related to a covered part D drug being prescribed or dispensed, upon request of the professional or pharmacist involved.

“(C) LIMITATIONS.—Information shall only be disclosed under subparagraph (A) or (B) if the disclosure of such information is permitted under the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

“(D) TIMING.—To the extent feasible, the information exchanged under this paragraph shall be on an interactive, real-time basis.

“(3) STANDARDS.—

“(A) IN GENERAL.—The Secretary shall provide consistent with this subsection for the promulgation of uniform standards relating to the requirements for electronic prescription drug programs under paragraph (2).

“(B) OBJECTIVES.—Such standards shall be consistent with the objectives of improving—

“(i) patient safety;

“(ii) the quality of care provided to patients; and

“(iii) efficiencies, including cost savings, in the delivery of care.

“(C) DESIGN CRITERIA.—Such standards shall—

“(i) be designed so that, to the extent practicable, the standards do not impose an undue administrative burden on prescribing health care professionals and dispensing pharmacies and pharmacists;

“(ii) be compatible with standards established under part C of title XI, standards established under subsection (b)(2)(B)(i), and with general health information technology standards; and

“(iii) be designed so that they permit electronic exchange of drug labeling and drug listing information maintained by the Food and Drug Administration and the National Library of Medicine.

“(D) PERMITTING USE OF APPROPRIATE MESSAGING.—Such standards shall allow for the messaging of information only if it relates to the appropriate prescribing of drugs, including quality assurance measures and systems referred to in subsection (c)(1)(B).

“(E) PERMITTING PATIENT DESIGNATION OF DISPENSING PHARMACY.—

“(i) IN GENERAL.—Consistent with clause (ii), such standards shall permit a part D eligible individual to designate a particular pharmacy to dispense a prescribed drug.

“(ii) NO CHANGE IN BENEFITS.—Clause (i) shall not be construed as affecting—

“(I) the access required to be provided to pharmacies by a prescription drug plan; or

“(II) the application of any differences in benefits or payments under such a plan based on the pharmacy dispensing a covered part D drug.

“(4) DEVELOPMENT, PROMULGATION, AND MODIFICATION OF STANDARDS.—

“(A) INITIAL STANDARDS.—Not later than September 1, 2005, the Secretary shall develop, adopt, recognize, or modify initial uniform standards relating to the requirements for electronic prescription drug programs described in paragraph (2) taking into consideration the recommendations (if any) from the National Committee on Vital and Health Statistics (as established under section 306(k) of the Public Health Service Act (42 U.S.C. 242k(k))) under subparagraph (B).

“(B) ROLE OF NCVHS.—The National Committee on Vital and Health Statistics shall develop recommendations for uniform standards relating to such requirements in consultation with the following:

“(i) Standard setting organizations (as defined in section 1171(8))

“(ii) Practicing physicians.

“(iii) Hospitals.

“(iv) Pharmacies.

“(v) Practicing pharmacists.

“(vi) Pharmacy benefit managers.

“(vii) State boards of pharmacy.

“(viii) State boards of medicine.

“(ix) Experts on electronic prescribing.

“(x) Other appropriate Federal agencies.

“(C) PILOT PROJECT TO TEST INITIAL STANDARDS.—

“(i) IN GENERAL.—During the 1-year period that begins on January 1, 2006, the Secretary shall conduct a pilot project to test the initial standards developed under subparagraph (A) prior to the promulgation of the final uniform standards under subparagraph (D) in order to provide for the efficient implementation of the requirements described in paragraph (2).

“(ii) EXCEPTION.—Pilot testing of standards is not required under clause (i) where there already is adequate industry experience with such standards, as determined by the Secretary after consultation with effected standard setting organizations and industry users.

“(iii) VOLUNTARY PARTICIPATION OF PHYSICIANS AND PHARMACIES.—In order to conduct the pilot project under clause (i), the Secretary shall enter into agreements with physicians, physician groups, pharmacies, hospitals, PDP sponsors, MA organizations, and other appropriate entities under which health care professionals electronically transmit prescriptions to dispensing pharmacies and pharmacists in accordance with such standards.

“(iv) EVALUATION AND REPORT.—

“(I) EVALUATION.—The Secretary shall conduct an evaluation of the pilot project conducted under clause (i).

“(II) REPORT TO CONGRESS.—Not later than April 1, 2007, the Secretary shall submit to Congress a report on the evaluation conducted under subclause (I).

“(D) FINAL STANDARDS.—Based upon the evaluation of the pilot project under subparagraph (C)(iv)(I) and not later than April 1, 2008, the Secretary shall promulgate uniform standards relating to the requirements described in paragraph (2).

“(5) RELATION TO STATE LAWS.—The standards promulgated under this subsection shall supersede any State law or regulation that—

“(A) is contrary to the standards or restricts the ability to carry out this part; and

“(B) pertains to the electronic transmission of medication history and of information on eligibility, benefits, and prescriptions with respect to covered part D drugs under this part.

“(6) ESTABLISHMENT OF SAFE HARBOR.—The Secretary, in consultation with the Attorney General, shall promulgate regulations that provide for a safe harbor from sanctions under paragraphs (1) and (2) of section 1128B(b) and an exception to the prohibition under subsection (a)(1) of section 1877 with respect to the provision of nonmonetary remuneration (in the form of hardware, software, or information technology and training services) necessary and used solely to receive and transmit electronic prescription information in accordance with the standards promulgated under this subsection—

“(A) in the case of a hospital, by the hospital to members of its medical staff;

“(B) in the case of a group practice (as defined in section 1877(h)(4)), by the practice to prescribing health care professionals who are members of such practice; and

“(C) in the case of a PDP sponsor or MA organization, by the sponsor or organization to pharmacists and pharmacies participating in the network of such sponsor or organization, and to prescribing health care professionals.

“(f) GRIEVANCE MECHANISM.—Each PDP sponsor shall provide meaningful procedures for hearing and resolving grievances between the sponsor (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).

“(g) COVERAGE DETERMINATIONS AND RECONSIDERATIONS.—

“(1) 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 an MA organization with respect to benefits it offers under an MA plan under part C.

“(2) REQUEST FOR A DETERMINATION FOR THE TREATMENT OF TIERED FORMULARY DRUG.—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, a part D eligible individual who is enrolled in the

plan may request an exception to the tiered cost-sharing structure. Under such an exception, a nonpreferred drug could be covered under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual or both. A PDP sponsor shall have an exceptions process under this paragraph consistent with guidelines established by the Secretary for making a determination with respect to such a request. Denial of such an exception shall be treated as a coverage denial for purposes of applying subsection (h).

“(h) 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 benefits (including a determination related to the application of tiered cost-sharing described in subsection (g)(2)) in a manner similar (as determined by the Secretary) to the manner such requirements apply to an MA organization with respect to benefits under the original medicare fee-for-service program option it offers under an MA plan under part C. In applying this paragraph only the part D eligible individual shall be entitled to bring such an appeal.

“(2) LIMITATION IN CASES ON NONFORMULARY DETERMINATIONS.—A part D eligible individual who is enrolled in a prescription drug plan offered by a PDP sponsor may appeal under paragraph (1) a determination not to provide for coverage of a covered part D drug that is not on the formulary under the plan only if the prescribing physician determines that all covered part D drugs on any tier of the formulary for treatment of the same condition would not be as effective for the individual as the nonformulary drug, would have adverse effects for the individual, or both.

“(3) TREATMENT OF NONFORMULARY DETERMINATIONS.—If a PDP sponsor determines that a plan provides coverage for a covered part D drug that is not on the formulary of the plan, the drug shall be treated as being included on the formulary for purposes of section 1860D–2(b)(4)(C)(i).

“(i) PRIVACY, CONFIDENTIALITY, AND ACCURACY OF ENROLLEE RECORDS.—The provisions of section 1852(h) shall apply to a PDP sponsor and prescription drug plan in the same manner as it applies to an MA organization and an MA plan.

“(j) TREATMENT OF ACCREDITATION.—Subparagraph (A) of section 1852(e)(4) (relating to treatment of accreditation) shall apply to a PDP sponsor under this part with respect to the following requirements, in the same manner as it applies to an MA organization with respect to the requirements in subparagraph (B) (other than clause (vii) thereof) of such section:

“(1) Subsection (b) of this section (relating to access to covered part D drugs).

“(2) Subsection (c) of this section (including quality assurance and medication therapy management).

“(3) Subsection (i) of this section (relating to confidentiality and accuracy of enrollee records).

“(k) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—

“(1) IN GENERAL.—A PDP sponsor offering a prescription drug plan shall provide that each pharmacy that dispenses

a covered part D drug shall inform an enrollee of any differential between the price of the drug to the enrollee and the price of the lowest priced generic covered part D drug under the plan that is therapeutically equivalent and bioequivalent and available at such pharmacy.

“(2) TIMING OF NOTICE.—

“(A) IN GENERAL.—Subject to subparagraph (B), the information under paragraph (1) shall be provided at the time of purchase of the drug involved, or, in the case of dispensing by mail order, at the time of delivery of such drug.

“(B) WAIVER.—The Secretary may waive subparagraph (A) in such circumstances as the Secretary may specify.

“Subpart 2—Prescription Drug Plans; PDP Sponsors; Financing

“PDP REGIONS; SUBMISSION OF BIDS; PLAN APPROVAL

“SEC. 1860D–11. (a) ESTABLISHMENT OF PDP REGIONS; SERVICE AREAS.—

“(1) COVERAGE OF ENTIRE PDP REGION.—The service area for a prescription drug plan shall consist of an entire PDP region established under paragraph (2).

“(2) ESTABLISHMENT OF PDP REGIONS.—

“(A) IN GENERAL.—The Secretary shall establish, and may revise, PDP regions in a manner that is consistent with the requirements for the establishment and revision of MA regions under subparagraphs (B) and (C) of section 1858(a)(2).

“(B) RELATION TO MA REGIONS.—To the extent practicable, PDP regions shall be the same as MA regions under section 1858(a)(2). The Secretary may establish PDP regions which are not the same as MA regions if the Secretary determines that the establishment of different regions under this part would improve access to benefits under this part.

“(C) AUTHORITY FOR TERRITORIES.—The Secretary shall establish, and may revise, PDP regions for areas in States that are not within the 50 States or the District of Columbia.

“(3) NATIONAL PLAN.—Nothing in this subsection shall be construed as preventing a prescription drug plan from being offered in more than one PDP region (including all PDP regions).

“(b) SUBMISSION OF BIDS, PREMIUMS, AND RELATED INFORMATION.—

“(1) IN GENERAL.—A PDP sponsor shall submit to the Secretary information described in paragraph (2) with respect to each prescription drug plan it offers. Such information shall be submitted at the same time and in a similar manner to the manner in which information described in paragraph (6) of section 1854(a) is submitted by an MA organization under paragraph (1) of such section.

“(2) INFORMATION DESCRIBED.—The information described in this paragraph is information on the following:

“(A) COVERAGE PROVIDED.—The prescription drug coverage provided under the plan, including the deductible and other cost-sharing.

“(B) ACTUARIAL VALUE.—The actuarial value of the qualified prescription drug coverage in the region for a part D eligible individual with a national average risk profile for the factors described in section 1860D–15(c)(1)(A) (as specified by the Secretary).

“(C) BID.—Information on the bid, including an actuarial certification of—

“(i) the basis for the actuarial value described in subparagraph (B) assumed in such bid;

“(ii) the portion of such bid attributable to basic prescription drug coverage and, if applicable, the portion of such bid attributable to supplemental benefits;

“(iii) assumptions regarding the reinsurance subsidy payments provided under section 1860D–15(b) subtracted from the actuarial value to produce such bid; and

“(iv) administrative expenses assumed in the bid.

“(D) SERVICE AREA.—The service area for the plan.

“(E) LEVEL OF RISK ASSUMED.—

“(i) IN GENERAL.—Whether the PDP sponsor requires a modification of risk level under clause (ii) and, if so, the extent of such modification. Any such modification shall apply with respect to all prescription drug plans offered by a PDP sponsor in a PDP region. This subparagraph shall not apply to an MA–PD plan.

“(ii) RISK LEVELS DESCRIBED.—A modification of risk level under this clause may consist of one or more of the following:

“(I) INCREASE IN FEDERAL PERCENTAGE ASSUMED IN INITIAL RISK CORRIDOR.—An equal percentage point increase in the percents applied under subparagraphs (B)(i), (B)(ii)(I), (C)(i), and (C)(ii)(I) of section 1860D–15(e)(2). In no case shall the application of previous sentence prevent the application of a higher percentage under section 1869D–15(e)(2)(B)(iii).

“(II) INCREASE IN FEDERAL PERCENTAGE ASSUMED IN SECOND RISK CORRIDOR.—An equal percentage point increase in the percents applied under subparagraphs (B)(ii)(II) and (C)(ii)(II) of section 1860D–15(e)(2).

“(III) DECREASE IN SIZE OF RISK CORRIDORS.—A decrease in the threshold risk percentages specified in section 1860D–15(e)(3)(C).

“(F) ADDITIONAL INFORMATION.—Such other information as the Secretary may require to carry out this part.

“(3) PAPERWORK REDUCTION FOR OFFERING OF PRESCRIPTION DRUG PLANS NATIONALLY OR IN MULTI-REGION AREAS.—The Secretary shall establish requirements for information submission under this subsection in a manner that promotes the offering of such plans in more than one PDP region (including all regions) through the filing of consolidated information.

“(c) ACTUARIAL VALUATION.—

“(1) PROCESSES.—For purposes of this part, the Secretary shall establish processes and methods for determining the actuarial valuation of prescription drug coverage, including—

“(A) an actuarial valuation of standard prescription drug coverage under section 1860D–2(b);

“(B) actuarial valuations relating to alternative prescription drug coverage under section 1860D–2(c)(1);

“(C) an actuarial valuation of the reinsurance subsidy payments under section 1860D–15(b);

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

“(E) applying the same methodology for determinations of actuarial valuations under subparagraphs (A) and (B).

“(2) ACCOUNTING FOR DRUG UTILIZATION.—Such processes and methods for determining actuarial valuation shall take into account the effect that providing alternative prescription drug coverage (rather than standard prescription drug coverage) has on drug utilization.

“(3) RESPONSIBILITIES.—

“(A) PLAN RESPONSIBILITIES.—PDP sponsors and MA organizations are responsible for the preparation and submission of actuarial valuations required under this part for prescription drug plans and MA–PD plans they offer.

“(B) USE OF OUTSIDE ACTUARIES.—Under the processes and methods established under paragraph (1), PDP sponsors offering prescription drug plans and MA organizations offering MA–PD plans may use actuarial opinions certified by independent, qualified actuaries to establish actuarial values.

“(d) REVIEW OF INFORMATION AND NEGOTIATION.—

“(1) REVIEW OF INFORMATION.—The Secretary shall review the information filed under subsection (b) for the purpose of conducting negotiations under paragraph (2).

“(2) NEGOTIATION REGARDING TERMS AND CONDITIONS.—Subject to subsection (i), in exercising the authority under paragraph (1), the Secretary—

“(A) has the authority to negotiate the terms and conditions of the proposed bid submitted and other terms and conditions of a proposed plan; and

“(B) has authority similar to the authority of the Director of the Office of Personnel Management with respect to health benefits plans under chapter 89 of title 5, United States Code.

“(e) APPROVAL OF PROPOSED PLANS.—

“(1) IN GENERAL.—After review and negotiation under subsection (d), the Secretary shall approve or disapprove the prescription drug plan.

“(2) REQUIREMENTS FOR APPROVAL.—The Secretary may approve a prescription drug plan only if the following requirements are met:

“(A) COMPLIANCE WITH REQUIREMENTS.—The plan and the PDP sponsor offering the plan comply with the requirements under this part, including the provision of qualified prescription drug coverage.

“(B) ACTUARIAL DETERMINATIONS.—The Secretary determines that the plan and PDP sponsor meet the requirements under this part relating to actuarial determinations, including such requirements under section 1860D–2(c).

“(C) APPLICATION OF FEHBP STANDARD.—

“(i) IN GENERAL.—The Secretary determines that the portion of the bid submitted under subsection (b) that is attributable to basic prescription drug coverage is supported by the actuarial bases provided under such subsection and reasonably and equitably reflects the revenue requirements (as used for purposes of section 1302(8)(C) of the Public Health Service Act) for benefits provided under that plan, less the sum (determined on a monthly per capita basis) of the actuarial value of the reinsurance payments under section 1860D–15(b).

“(ii) SUPPLEMENTAL COVERAGE.—The Secretary determines that the portion of the bid submitted under subsection (b) that is attributable to supplemental prescription drug coverage pursuant to section 1860D–2(a)(2) is supported by the actuarial bases provided under such subsection and reasonably and equitably reflects the revenue requirements (as used for purposes of section 1302(8)(C) of the Public Health Service Act) for such coverage under the plan.

“(D) PLAN DESIGN.—

“(i) IN GENERAL.—The Secretary does not find that the design of the plan and its benefits (including any formulary and tiered formulary structure) are likely to substantially discourage enrollment by certain part D eligible individuals under the plan.

“(ii) USE OF CATEGORIES AND CLASSES IN FORMULARIES.—The Secretary may not find that the design of categories and classes within a formulary violates clause (i) if such categories and classes are consistent with guidelines (if any) for such categories and classes established by the United States Pharmacopeia.

“(f) APPLICATION OF LIMITED RISK PLANS.—

“(1) CONDITIONS FOR APPROVAL OF LIMITED RISK PLANS.—The Secretary may only approve a limited risk plan (as defined in paragraph (4)(A)) for a PDP region if the access requirements under section 1860D–3(a) would not be met for the region but for the approval of such a plan (or a fallback prescription drug plan under subsection (g)).

“(2) RULES.—The following rules shall apply with respect to the approval of a limited risk plan in a PDP region:

“(A) LIMITED EXERCISE OF AUTHORITY.—Only the minimum number of such plans may be approved in order to meet the access requirements under section 1860D–3(a).

“(B) MAXIMIZING ASSUMPTION OF RISK.—The Secretary shall provide priority in approval for those plans bearing the highest level of risk (as computed by the Secretary), but the Secretary may take into account the level of the bids submitted by such plans.

“(C) NO FULL UNDERWRITING FOR LIMITED RISK PLANS.—In no case may the Secretary approve a limited risk plan under which the modification of risk level provides for no (or a de minimis) level of financial risk.

“(3) ACCEPTANCE OF ALL FULL RISK CONTRACTS.—There shall be no limit on the number of full risk plans that are approved under subsection (e).

“(4) RISK-PLANS DEFINED.—For purposes of this subsection:

“(A) LIMITED RISK PLAN.—The term ‘limited risk plan’ means a prescription drug plan that provides basic prescription drug coverage and for which the PDP sponsor includes a modification of risk level described in subparagraph (E) of subsection (b)(2) in its bid submitted for the plan under such subsection. Such term does not include a fallback prescription drug plan.

“(B) FULL RISK PLAN.—The term ‘full risk plan’ means a prescription drug plan that is not a limited risk plan or a fallback prescription drug plan.

“(g) GUARANTEEING ACCESS TO COVERAGE.—

“(1) SOLICITATION OF BIDS.—

“(A) IN GENERAL.—Separate from the bidding process under subsection (b), the Secretary shall provide for a process for the solicitation of bids from eligible fallback entities (as defined in paragraph (2)) for the offering in all fallback service areas (as defined in paragraph (3)) in one or more PDP regions of a fallback prescription drug plan (as defined in paragraph (4)) during the contract period specified in paragraph (5).

“(B) ACCEPTANCE OF BIDS.—

“(i) IN GENERAL.—Except as provided in this subparagraph, the provisions of subsection (e) shall apply with respect to the approval or disapproval of fallback prescription drug plans. The Secretary shall enter into contracts under this subsection with eligible fallback entities for the offering of fallback prescription drug plans so approved in fallback service areas.

“(ii) LIMITATION OF 1 PLAN FOR ALL FALLBACK SERVICE AREAS IN A PDP REGION.—With respect to all fallback service areas in any PDP region for a contract period, the Secretary shall approve the offering of only 1 fallback prescription drug plan.

“(iii) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5))) shall be used to enter into a contract under this subsection. The provisions of subsection (d) of section 1874A shall apply to a contract under this section in the same manner as they apply to a contract under such section.

“(iv) TIMING.—The Secretary shall approve a fallback prescription drug plan for a PDP region in a manner so that, if there are any fallback service areas in the region for a year, the fallback prescription drug plan is offered at the same time as prescription drug plans would otherwise be offered.

“(V) NO NATIONAL FALLBACK PLAN.—The Secretary shall not enter into a contract with a single fallback entity for the offering of fallback plans throughout the United States.

“(2) ELIGIBLE FALLBACK ENTITY.—For purposes of this section, the term ‘eligible fallback entity’ means, with respect

to all fallback service areas in a PDP region for a contract period, an entity that—

“(A) meets the requirements to be a PDP sponsor (or would meet such requirements but for the fact that the entity is not a risk-bearing entity); and

“(B) does not submit a bid under section 1860D–11(b) for any prescription drug plan for any PDP region for the first year of such contract period.

For purposes of subparagraph (B), an entity shall be treated as submitting a bid with respect to a prescription drug plan if the entity is acting as a subcontractor of a PDP sponsor that is offering such a plan. The previous sentence shall not apply to entities that are subcontractors of an MA organization except insofar as such organization is acting as a PDP sponsor with respect to a prescription drug plan.

“(3) FALLBACK SERVICE AREA.—For purposes of this subsection, the term ‘fallback service area’ means, for a PDP region with respect to a year, any area within such region for which the Secretary determines before the beginning of the year that the access requirements of the first sentence of section 1860D–3(a) will not be met for part D eligible individuals residing in the area for the year.

“(4) FALLBACK PRESCRIPTION DRUG PLAN.—For purposes of this part, the term ‘fallback prescription drug plan’ means a prescription drug plan that—

“(A) only offers the standard prescription drug coverage and access to negotiated prices described in section 1860D–2(a)(1)(A) and does not include any supplemental prescription drug coverage; and

“(B) meets such other requirements as the Secretary may specify.

“(5) PAYMENTS UNDER THE CONTRACT.—

“(A) IN GENERAL.—A contract entered into under this subsection shall provide for—

“(i) payment for the actual costs (taking into account negotiated price concessions described in section 1860D–2(d)(1)(B)) of covered part D drugs provided to part D eligible individuals enrolled in a fallback prescription drug plan offered by the entity; and

“(ii) payment of management fees that are tied to performance measures established by the Secretary for the management, administration, and delivery of the benefits under the contract.

“(B) PERFORMANCE MEASURES.—The performance measures established by the Secretary pursuant to subparagraph (A)(ii) shall include at least measures for each of the following:

“(i) COSTS.—The entity contains costs to the Medicare Prescription Drug Account and to part D eligible individuals enrolled in a fallback prescription drug plan offered by the entity through mechanisms such as generic substitution and price discounts.

“(ii) QUALITY PROGRAMS.—The entity provides such enrollees with quality programs that avoid adverse drug reactions and overutilization and reduce medical errors.

“(iii) CUSTOMER SERVICE.—The entity provides timely and accurate delivery of services and pharmacy and beneficiary support services.

“(iv) BENEFIT ADMINISTRATION AND CLAIMS ADJUDICATION.—The entity provides efficient and effective benefit administration and claims adjudication.

“(6) MONTHLY BENEFICIARY PREMIUM.—Except as provided in section 1860D–13(b) (relating to late enrollment penalty) and subject to section 1860D–14 (relating to low-income assistance), the monthly beneficiary premium to be charged under a fallback prescription drug plan offered in all fallback service areas in a PDP region shall be uniform and shall be equal to 25.5 percent of an amount equal to the Secretary’s estimate of the average monthly per capita actuarial cost, including administrative expenses, under the fallback prescription drug plan of providing coverage in the region, as calculated by the Chief Actuary of the Centers for Medicare & Medicaid Services. In calculating such administrative expenses, the Chief Actuary shall use a factor that is based on similar expenses of prescription drug plans that are not fallback prescription drug plans.

“(7) GENERAL CONTRACT TERMS AND CONDITIONS.—

“(A) IN GENERAL.—Except as may be appropriate to carry out this section, the terms and conditions of contracts with eligible fallback entities offering fallback prescription drug plans under this subsection shall be the same as the terms and conditions of contracts under this part for prescription drug plans.

“(B) PERIOD OF CONTRACT.—

“(i) IN GENERAL.—Subject to clause (ii), a contract approved for a fallback prescription drug plan for fallback service areas for a PDP region under this section shall be for a period of 3 years (except as may be renewed after a subsequent bidding process).

“(ii) LIMITATION.—A fallback prescription drug plan may be offered under a contract in an area for a year only if that area is a fallback service area for that year.

“(C) ENTITY NOT PERMITTED TO MARKET OR BRAND FALLBACK PRESCRIPTION DRUG PLANS.—An eligible fallback entity with a contract under this subsection may not engage in any marketing or branding of a fallback prescription drug plan.

“(h) ANNUAL REPORT ON USE OF LIMITED RISK PLANS AND FALLBACK PLANS.—The Secretary shall submit to Congress an annual report that describes instances in which limited risk plans and fallback prescription drug plans were offered under subsections (f) and (g). The Secretary shall include in such report such recommendations as may be appropriate to limit the need for the provision of such plans and to maximize the assumption of financial risk under section subsection (f).

“(i) NONINTERFERENCE.—In order to promote competition under this part and in carrying out this part, the Secretary—

“(1) may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors; and

“(2) may not require a particular formulary or institute a price structure for the reimbursement of covered part D drugs.

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“(j) COORDINATION OF BENEFITS.—A PDP sponsor offering a prescription drug plan shall permit State Pharmaceutical Assistance Programs and Rx plans under sections 1860D–23 and 1860D–24 to coordinate benefits with the plan and, in connection with such coordination with such a Program, not to impose fees that are unrelated to the cost of coordination.

“REQUIREMENTS FOR AND CONTRACTS WITH PRESCRIPTION DRUG PLAN (PDP) SPONSORS

“SEC. 1860D–12. (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 FOR UNSUBSIDIZED COVERAGE.—

“(A) IN GENERAL.—Subject to subparagraph (B), to the extent that the entity is at risk the entity assumes financial risk on a prospective basis for benefits that it offers under a prescription drug plan and that is not covered under section 1860D–15(b).

“(B) REINSURANCE PERMITTED.—The plan sponsor may obtain insurance or make other arrangements for the cost of coverage provided to any enrollee to the extent that the sponsor is at risk for providing such coverage.

“(3) SOLVENCY FOR UNLICENSED SPONSORS.—In the case of a PDP sponsor that is not described in paragraph (1) and for which a waiver has been approved under subsection (c), such sponsor shall meet solvency standards established by the Secretary under subsection (d).

“(b) CONTRACT REQUIREMENTS.—

“(1) IN GENERAL.—The Secretary shall not permit the enrollment under section 1860D–1 in a prescription drug plan offered by a PDP sponsor under this part, and the sponsor shall not be eligible for payments under section 1860D–14 or 1860D–15, unless the Secretary 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) LIMITATION ON ENTITIES OFFERING FALLBACK PRESCRIPTION DRUG PLANS.—The Secretary shall not enter into a contract with a PDP sponsor for the offering of a prescription drug plan (other than a fallback prescription drug plan) in a PDP region for a year if the sponsor—

“(A) submitted a bid under section 1860D–11(g) for such year (as the first year of a contract period under such section) to offer a fallback prescription drug plan in any PDP region;

“(B) offers a fallback prescription drug plan in any PDP region during the year; or

“(C) offered a fallback prescription drug plan in that PDP region during the previous year.

For purposes of this paragraph, an entity shall be treated as submitting a bid with respect to a prescription drug plan or offering a fallback prescription drug plan if the entity is acting as a subcontractor of a PDP sponsor that is offering such a plan. The previous sentence shall not apply to entities that are subcontractors of an MA organization except insofar as such organization is acting as a PDP sponsor with respect to a prescription drug plan.

“(3) INCORPORATION OF CERTAIN MEDICARE ADVANTAGE CONTRACT REQUIREMENTS.—Except as otherwise provided, the following provisions of section 1857 shall apply 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), except that—

“(i) the Secretary may increase the minimum number of enrollees required under such paragraph (1) as the Secretary determines appropriate; and

“(ii) the requirement of such paragraph (1) shall be waived during the first contract year with respect to an organization in a region.

“(B) CONTRACT PERIOD AND EFFECTIVENESS.—Section 1857(c), except that in applying paragraph (4)(B) of such section any reference to payment amounts under section 1853 shall be deemed payment amounts under section 1860D–15.

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

“(D) ADDITIONAL CONTRACT TERMS.—Section 1857(e); except that section 1857(e)(2) shall apply as specified to PDP sponsors and payments under this part to an MA–PD plan shall be treated as expenditures made under part D.

“(E) INTERMEDIATE SANCTIONS.—Section 1857(g) (other than paragraph (1)(F) of such section), except that in applying such section the reference in section 1857(g)(1)(B) to section 1854 is deemed a reference to this part.

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

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

“(1) AUTHORIZING WAIVER.—

“(A) IN GENERAL.—In the case of an entity that seeks to offer a prescription drug plan in a State, the Secretary shall waive the requirement of subsection (a)(1) that the entity be licensed in that State if the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for approval of the application described in paragraph (2) have been met.

“(B) APPLICATION OF REGIONAL PLAN WAIVER RULE.—In addition to the waiver available under subparagraph (A), the provisions of section 1858(d) shall apply to PDP sponsors under this part in a manner similar to the manner in which such provisions apply to MA organizations under part C, except that no application shall be required under paragraph (1)(B) of such section in the case of a State that does not provide a licensing process for such a sponsor.

“(2) GROUNDS FOR APPROVAL.—

“(A) IN GENERAL.—The grounds for approval under this paragraph are—

“(i) subject to subparagraph (B), the grounds for approval described in subparagraphs (B), (C), and (D) of section 1855(a)(2); and

“(ii) the application by a State of any grounds other than those required under Federal law.

“(B) SPECIAL RULES.—In applying subparagraph (A)(i)—

“(i) the ground of approval described in section 1855(a)(2)(B) is deemed to have been met if the State does not have a licensing process in effect with respect to the PDP sponsor; and

“(ii) for plan years beginning before January 1, 2008, if the State does have such a licensing process in effect, such ground for approval described in such section is deemed to have been met upon submission of an application described in such section.

“(3) APPLICATION OF WAIVER PROCEDURES.—With respect to an application for a waiver (or a waiver granted) under paragraph (1)(A) of this subsection, the provisions of subparagraphs (E), (F), and (G) of section 1855(a)(2) shall apply, except that clauses (i) and (ii) of such subparagraph (E) shall not apply in the case of a State that does not have a licensing process described in paragraph (2)(B)(i) in effect.

“(4) REFERENCES TO CERTAIN PROVISIONS.—In applying provisions of section 1855(a)(2) under paragraphs (2) and (3) of 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)(A) of this subsection; and

“(B) any reference to solvency standards shall be treated as a reference to solvency standards established under subsection (d) of this section.

“(d) SOLVENCY STANDARDS FOR NON-LICENSED ENTITIES.—

“(1) ESTABLISHMENT AND PUBLICATION.—The Secretary, in consultation with the National Association of Insurance Commissioners, shall establish and publish, by not later than January 1, 2005, financial solvency and capital adequacy standards for entities described in paragraph (2).

“(2) COMPLIANCE WITH STANDARDS.—A 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 Secretary shall establish certification procedures for such sponsors with respect to such solvency standards in the manner described in section 1855(c)(2).

“(e) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that a PDP sponsor is licensed in accordance with subsection (a)(1) or has a waiver application approved under subsection (c) does not deem the sponsor to meet other requirements imposed under this part for a sponsor.

“(f) PERIODIC REVIEW AND REVISION OF STANDARDS.—

“(1) IN GENERAL.—Subject to paragraph (2), the Secretary may periodically review the standards established under this

section and, based on such review, may revise such standards if the Secretary determines such revision to be appropriate.

“(2) PROHIBITION OF MIDYEAR IMPLEMENTATION OF SIGNIFICANT NEW REGULATORY REQUIREMENTS.—The Secretary may not implement, other than at the beginning of a calendar year, regulations under this section that impose new, significant regulatory requirements on a PDP sponsor or a prescription drug plan.

“(g) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES; RELATION TO STATE LAWS.—The provisions of sections 1854(g) and 1856(b)(3) shall apply with respect to PDP sponsors and prescription drug plans under this part in the same manner as such sections apply to MA organizations and MA plans under part C.

“PREMIUMS; LATE ENROLLMENT PENALTY

“SEC. 1860D–13. (a) MONTHLY BENEFICIARY PREMIUM.—

“(1) COMPUTATION.—

“(A) IN GENERAL.—The monthly beneficiary premium for a prescription drug plan is the base beneficiary premium computed under paragraph (2) as adjusted under this paragraph.

“(B) ADJUSTMENT TO REFLECT DIFFERENCE BETWEEN BID AND NATIONAL AVERAGE BID.—

“(i) ABOVE AVERAGE BID.—If for a month the amount of the standardized bid amount (as defined in paragraph (5)) exceeds the amount of the adjusted national average monthly bid amount (as defined in clause (iii)), the base beneficiary premium for the month shall be increased by the amount of such excess.

“(ii) BELOW AVERAGE BID.—If for a month the amount of the adjusted national average monthly bid amount for the month exceeds the standardized bid amount, the base beneficiary premium for the month shall be decreased by the amount of such excess.

“(iii) ADJUSTED NATIONAL AVERAGE MONTHLY BID AMOUNT DEFINED.—For purposes of this subparagraph, the term ‘adjusted national average monthly bid amount’ means the national average monthly bid amount computed under paragraph (4), as adjusted under section 1860D–15(c)(2).

“(C) INCREASE FOR SUPPLEMENTAL PRESCRIPTION DRUG BENEFITS.—The base beneficiary premium shall be increased by the portion of the PDP approved bid that is attributable to supplemental prescription drug benefits.

“(D) INCREASE FOR LATE ENROLLMENT PENALTY.—The base beneficiary premium shall be increased by the amount of any late enrollment penalty under subsection (b).

“(E) DECREASE FOR LOW-INCOME ASSISTANCE.—The monthly beneficiary premium is subject to decrease in the case of a subsidy eligible individual under section 1860D–14.

“(F) UNIFORM PREMIUM.—Except as provided in subparagraphs (D) and (E), the monthly beneficiary premium for a prescription drug plan in a PDP region is the same for all part D eligible individuals enrolled in the plan.

“(2) BASE BENEFICIARY PREMIUM.—The base beneficiary premium under this paragraph for a prescription drug plan for a month is equal to the product—

“(A) the beneficiary premium percentage (as specified in paragraph (3)); and

“(B) the national average monthly bid amount (computed under paragraph (4)) for the month.

“(3) BENEFICIARY PREMIUM PERCENTAGE.—For purposes of this subsection, the beneficiary premium percentage for any year is the percentage equal to a fraction—

“(A) the numerator of which is 25.5 percent; and

“(B) the denominator of which is 100 percent minus a percentage equal to—

“(i) the total reinsurance payments which the Secretary estimates are payable under section 1860D–15(b) with respect to the coverage year; divided by

“(ii) the sum of—

“(I) the amount estimated under clause (i) for the year; and

“(II) the total payments which the Secretary estimates will be paid to prescription drug plans and MA–PD plans that are attributable to the standardized bid amount during the year, taking into account amounts paid by the Secretary and enrollees.

“(4) COMPUTATION OF NATIONAL AVERAGE MONTHLY BID AMOUNT.—

“(A) IN GENERAL.—For each year (beginning with 2006) the Secretary shall compute a national average monthly bid amount equal to the average of the standardized bid amounts (as defined in paragraph (5)) for each prescription drug plan and for each MA–PD plan described in section 1851(a)(2)(A)(i). Such average does not take into account the bids submitted for MSA plans, MA private fee-for-service plan, and specialized MA plans for special needs individuals, PACE programs under section 1894 (pursuant to section 1860D–21(f)), and under reasonable cost reimbursement contracts under section 1876(h) (pursuant to section 1860D–21(e)).

“(B) WEIGHTED AVERAGE.—

“(i) IN GENERAL.—The monthly national average monthly bid amount computed under subparagraph (A) for a year shall be a weighted average, with the weight for each plan being equal to the average number of part D eligible individuals enrolled in such plan in the reference month (as defined in section 1858(f)(4)).

“(ii) SPECIAL RULE FOR 2006.—For purposes of applying this paragraph for 2006, the Secretary shall establish procedures for determining the weighted average under clause (i) for 2005.

“(5) STANDARDIZED BID AMOUNT DEFINED.—For purposes of this subsection, the term ‘standardized bid amount’ means the following:

“(A) PRESCRIPTION DRUG PLANS.—

“(i) BASIC COVERAGE.—In the case of a prescription drug plan that provides basic prescription drug coverage, the PDP approved bid (as defined in paragraph (6)).

“(ii) SUPPLEMENTAL COVERAGE.—In the case of a prescription drug plan that provides supplemental prescription drug coverage, the portion of the PDP approved bid that is attributable to basic prescription drug coverage.

“(B) MA–PD PLANS.—In the case of an MA–PD plan, the portion of the accepted bid amount that is attributable to basic prescription drug coverage.

“(6) PDP APPROVED BID DEFINED.—For purposes of this part, the term ‘PDP approved bid’ means, with respect to a prescription drug plan, the bid amount approved for the plan under this part.

“(b) LATE ENROLLMENT PENALTY.—

“(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, in the case of a part D eligible individual described in paragraph (2) with respect to a continuous period of eligibility, there shall be an increase in the monthly beneficiary premium established under subsection (a) in an amount determined under paragraph (3).

“(2) INDIVIDUALS SUBJECT TO PENALTY.—A part D eligible individual described in this paragraph is, with respect to a continuous period of eligibility, an individual for whom there is a continuous period of 63 days or longer (all of which in such continuous period of eligibility) beginning on the day after the last date of the individual’s initial enrollment period under section 1860D–1(b)(2) and ending on the date of enrollment under a prescription drug plan or MA–PD plan during all of which the individual was not covered under any creditable prescription drug coverage.

“(3) AMOUNT OF PENALTY.—

“(A) IN GENERAL.—The amount determined under this paragraph for a part D eligible individual for a continuous period of eligibility is the greater of—

“(i) an amount that the Secretary determines is actuarially sound for each uncovered month (as defined in subparagraph (B)) in the same continuous period of eligibility; or

“(ii) 1 percent of the base beneficiary premium (computed under subsection (a)(2)) for each such uncovered month in such period.

“(B) UNCOVERED MONTH DEFINED.—For purposes of this subsection, the term ‘uncovered month’ means, with respect to a part D eligible individual, any month beginning after the end of the initial enrollment period under section 1860D–1(b)(2) unless the individual can demonstrate that the individual had creditable prescription drug coverage (as defined in paragraph (4)) for any portion of such month.

“(4) CREDITABLE PRESCRIPTION DRUG COVERAGE DEFINED.—For purposes of this part, the term ‘creditable prescription drug coverage’ means any of the following coverage, but only if the coverage meets the requirement of paragraph (5):

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“(A) COVERAGE UNDER PRESCRIPTION DRUG PLAN OR MA–PD PLAN.—Coverage under a prescription drug plan or under an MA–PD plan.

“(B) MEDICAID.—Coverage under a medicaid plan under title XIX or under a waiver under section 1115.

“(C) GROUP HEALTH PLAN.—Coverage under a group health plan, including a health benefits plan under chapter 89 of title 5, United States Code (commonly known as the Federal employees health benefits program), and a qualified retiree prescription drug plan (as defined in section 1860D–22(a)(2)).

“(D) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage under a State pharmaceutical assistance program described in section 1860D–23(b)(1).

“(E) VETERANS’ COVERAGE OF PRESCRIPTION DRUGS.—Coverage for veterans, and survivors and dependents of veterans, under chapter 17 of title 38, United States Code.

“(F) PRESCRIPTION DRUG COVERAGE UNDER 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)).

“(G) MILITARY COVERAGE (INCLUDING TRICARE).—Coverage under chapter 55 of title 10, United States Code.

“(H) OTHER COVERAGE.—Such other coverage as the Secretary determines appropriate.

“(5) ACTUARIAL EQUIVALENCE REQUIREMENT.—Coverage meets the requirement of this paragraph only if the coverage is determined (in a manner specified by the Secretary) to provide coverage of the cost of prescription drugs the actuarial value of which (as defined by the Secretary) to the individual equals or exceeds the actuarial value of standard prescription drug coverage (as determined under section 1860D–11(c)).

“(6) PROCEDURES TO DOCUMENT CREDITABLE PRESCRIPTION DRUG COVERAGE.—

“(A) IN GENERAL.—The Secretary shall establish procedures (including the form, manner, and time) for the documentation of creditable prescription drug coverage, including procedures to assist in determining whether coverage meets the requirement of paragraph (5).

“(B) DISCLOSURE BY ENTITIES OFFERING CREDITABLE PRESCRIPTION DRUG COVERAGE.—

“(i) IN GENERAL.—Each entity that offers prescription drug coverage of the type described in subparagraphs (B) through (H) of paragraph (4) shall provide for disclosure, in a form, manner, and time consistent with standards established by the Secretary, to the Secretary and part D eligible individuals of whether the coverage meets the requirement of paragraph (5) or whether such coverage is changed so it no longer meets such requirement.

“(ii) DISCLOSURE OF NON-CREDITABLE COVERAGE.—In the case of such coverage that does not meet such requirement, the disclosure to part D eligible individuals under this subparagraph shall include information regarding the fact that because such coverage does not meet such requirement there are limitations on

the periods in a year in which the individuals may enroll under a prescription drug plan or an MA-PD plan and that any such enrollment is subject to a late enrollment penalty under this subsection.

“(C) WAIVER OF REQUIREMENT.—In the case of a part D eligible individual who was enrolled in prescription drug coverage of the type described in subparagraphs (B) through (H) of paragraph (4) which is not creditable prescription drug coverage because it does not meet the requirement of paragraph (5), the individual may apply to the Secretary to have such coverage treated as creditable prescription drug coverage if the individual establishes that the individual was not adequately informed that such coverage did not meet such requirement.

“(7) CONTINUOUS PERIOD OF ELIGIBILITY.—

“(A) IN GENERAL.—Subject to subparagraph (B), for purposes of this subsection, the term ‘continuous period of eligibility’ means, with respect to a part D eligible individual, the period that begins with the first day on which the individual is eligible to enroll in a prescription drug plan under this part and ends with the individual’s death.

“(B) SEPARATE PERIOD.—Any period during all of which a part D eligible individual is entitled to hospital insurance benefits under part A and—

“(i) which terminated in or before the month preceding the month in which the individual attained age 65; or

“(ii) for which the basis for eligibility for such entitlement changed between section 226(b) and section 226(a), between 226(b) and section 226A, or between section 226A and section 226(a),

shall be a separate continuous period of eligibility with respect to the individual (and each such period which terminates shall be deemed not to have existed for purposes of subsequently applying this paragraph).

“(c) COLLECTION OF MONTHLY BENEFICIARY PREMIUMS.—

“(1) IN GENERAL.—Subject to paragraphs (2) and (3), the provisions of section 1854(d) shall apply to PDP sponsors and premiums (and any late enrollment penalty) under this part in the same manner as they apply to MA organizations and beneficiary premiums under part C, except that any reference to a Trust Fund is deemed for this purpose a reference to the Medicare Prescription Drug Account.

“(2) CREDITING OF LATE ENROLLMENT PENALTY.—

“(A) PORTION ATTRIBUTABLE TO INCREASED ACTUARIAL COSTS.—With respect to late enrollment penalties imposed under subsection (b), the Secretary shall specify the portion of such a penalty that the Secretary estimates is attributable to increased actuarial costs assumed by the PDP sponsor or MA organization (and not taken into account through risk adjustment provided under section 1860D-15(c)(1) or through reinsurance payments under section 1860D-15(b)) as a result of such late enrollment.

“(B) COLLECTION THROUGH WITHHOLDING.—In the case of a late enrollment penalty that is collected from a part D eligible individual in the manner described in section 1854(d)(2)(A), the Secretary shall provide that only the

portion of such penalty estimated under subparagraph (A) shall be paid to the PDP sponsor or MA organization offering the part D plan in which the individual is enrolled.

“(C) COLLECTION BY PLAN.—In the case of a late enrollment penalty that is collected from a part D eligible individual in a manner other than the manner described in section 1854(d)(2)(A), the Secretary shall establish procedures for reducing payments otherwise made to the PDP sponsor or MA organization by an amount equal to the amount of such penalty less the portion of such penalty estimated under subparagraph (A).

“(3) FALLBACK PLANS.—In applying this subsection in the case of a fallback prescription drug plan, paragraph (2) shall not apply and the monthly beneficiary premium shall be collected in the manner specified in section 1854(d)(2)(A) (or such other manner as may be provided under section 1840 in the case of monthly premiums under section 1839).

“PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS

“SEC. 1860D–14. (a) INCOME-RELATED SUBSIDIES FOR INDIVIDUALS WITH INCOME UP TO 150 PERCENT OF POVERTY LINE.—

“(1) INDIVIDUALS WITH INCOME BELOW 135 PERCENT OF POVERTY LINE.—In the case of a subsidy eligible individual (as defined in paragraph (3)) who is determined to have income that is below 135 percent of the poverty line applicable to a family of the size involved and who meets the resources requirement described in paragraph (3)(D) or who is covered under this paragraph under paragraph (3)(B)(i), the individual is entitled under this section to the following:

“(A) FULL PREMIUM SUBSIDY.—An income-related premium subsidy equal to—

“(i) 100 percent of the amount described in subsection (b)(1), but not to exceed the premium amount specified in subsection (b)(2)(B); plus

“(ii) 80 percent of any late enrollment penalties imposed under section 1860D–13(b) for the first 60 months in which such penalties are imposed for that individual, and 100 percent of any such penalties for any subsequent month.

“(B) ELIMINATION OF DEDUCTIBLE.—A reduction in the annual deductible applicable under section 1860D–2(b)(1) to \$0.

“(C) CONTINUATION OF COVERAGE ABOVE THE INITIAL COVERAGE LIMIT.—The continuation of coverage from the initial coverage limit (under paragraph (3) of section 1860D–2(b)) for expenditures incurred through the total amount of expenditures at which benefits are available under paragraph (4) of such section, subject to the reduced cost-sharing described in subparagraph (D).

“(D) REDUCTION IN COST-SHARING BELOW OUT-OF-POCKET THRESHOLD.—

“(i) INSTITUTIONALIZED INDIVIDUALS.—In the case of an individual who is a full-benefit dual eligible individual and who is an institutionalized individual or

couple (as defined in section 1902(q)(1)(B)), the elimination of any beneficiary coinsurance described in section 1860D-2(b)(2) (for all amounts through the total amount of expenditures at which benefits are available under section 1860D-2(b)(4)).

“(ii) LOWEST INCOME DUAL ELIGIBLE INDIVIDUALS.—In the case of an individual not described in clause (i) who is a full-benefit dual eligible individual and whose income does not exceed 100 percent of the poverty line applicable to a family of the size involved, the substitution for the beneficiary coinsurance described in section 1860D-2(b)(2) (for all amounts through the total amount of expenditures at which benefits are available under section 1860D-2(b)(4)) of a copayment amount that does not exceed \$1 for a generic drug or a preferred drug that is a multiple source drug (as defined in section 1927(k)(7)(A)(i)) and \$3 for any other drug, or, if less, the copayment amount applicable to an individual under clause (iii).

“(iii) OTHER INDIVIDUALS.—In the case of an individual not described in clause (i) or (ii), the substitution for the beneficiary coinsurance described in section 1860D-2(b)(2) (for all amounts through the total amount of expenditures at which benefits are available under section 1860D-2(b)(4)) of a copayment amount that does not exceed the copayment amount specified under section 1860D-2(b)(4)(A)(i)(I) for the drug and year involved.

“(E) ELIMINATION OF COST-SHARING ABOVE ANNUAL OUT-OF-POCKET THRESHOLD.—The elimination of any cost-sharing imposed under section 1860D-2(b)(4)(A).

“(2) OTHER INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF POVERTY LINE.—In the case of a subsidy eligible individual who is not described in paragraph (1), the individual is entitled under this section to the following:

“(A) SLIDING SCALE PREMIUM SUBSIDY.—An income-related premium subsidy determined on a linear sliding scale ranging from 100 percent of the amount described in paragraph (1)(A) for individuals with incomes at or below 135 percent of such level to 0 percent of such amount for individuals with incomes at 150 percent of such level.

“(B) REDUCTION OF DEDUCTIBLE.—A reduction in the annual deductible applicable under section 1860D-2(b)(1) to \$50.

“(C) CONTINUATION OF COVERAGE ABOVE THE INITIAL COVERAGE LIMIT.—The continuation of coverage from the initial coverage limit (under paragraph (3) of section 1860D-2(b)) for expenditures incurred through the total amount of expenditures at which benefits are available under paragraph (4) of such section, subject to the reduced coinsurance described in subparagraph (D).

“(D) REDUCTION IN COST-SHARING BELOW OUT-OF-POCKET THRESHOLD.—The substitution for the beneficiary coinsurance described in section 1860D-2(b)(2) (for all amounts above the deductible under subparagraph (B) through the total amount of expenditures at which benefits are available under section 1860D-2(b)(4)) of coinsurance

of ‘15 percent’ instead of coinsurance of ‘25 percent’ in section 1860D–2(b)(2).

“(E) REDUCTION OF COST-SHARING ABOVE ANNUAL OUT-OF-POCKET THRESHOLD.—Subject to subsection (c), the substitution for the cost-sharing imposed under section 1860D–2(b)(4)(A) of a copayment or coinsurance not to exceed the copayment or coinsurance amount specified under section 1860D–2(b)(4)(A)(i)(I) for the drug and year involved.

“(3) DETERMINATION OF ELIGIBILITY.—

“(A) SUBSIDY ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this part, subject to subparagraph (F), the term ‘subsidy eligible individual’ means a part D eligible individual who—

“(i) is enrolled in a prescription drug plan or MA–PD plan;

“(ii) has income below 150 percent of the poverty line applicable to a family of the size involved; and

“(iii) meets the resources requirement described in subparagraph (D) or (E).

“(B) DETERMINATIONS.—

“(i) IN GENERAL.—The determination of whether a part D eligible individual residing in a State is a subsidy eligible individual and whether the individual is described in paragraph (1) shall be determined under the State plan under title XIX for the State under section 1935(a) or by the Commissioner of Social Security. There are authorized to be appropriated to the Social Security Administration such sums as may be necessary for the determination of eligibility under this subparagraph.

“(ii) EFFECTIVE PERIOD.—Determinations under this subparagraph shall be effective beginning with the month in which the individual applies for a determination that the individual is a subsidy eligible individual and shall remain in effect for a period specified by the Secretary, but not to exceed 1 year.

“(iii) REDETERMINATIONS AND APPEALS THROUGH MEDICAID.—Redeterminations and appeals, with respect to eligibility determinations under clause (i) made under a State plan under title XIX, shall be made in accordance with the frequency of, and manner in which, redeterminations and appeals of eligibility are made under such plan for purposes of medical assistance under such title.

“(iv) REDETERMINATIONS AND APPEALS THROUGH COMMISSIONER.—With respect to eligibility determinations under clause (i) made by the Commissioner of Social Security—

“(I) redeterminations shall be made at such time or times as may be provided by the Commissioner; and

“(II) the Commissioner shall establish procedures for appeals of such determinations that are similar to the procedures described in the third sentence of section 1631(c)(1)(A).

“(v) TREATMENT OF MEDICAID BENEFICIARIES.—Subject to subparagraph (F), the Secretary—

“(I) shall provide that part D eligible individuals who are full-benefit dual eligible individuals (as defined in section 1935(c)(6)) or who are recipients of supplemental security income benefits under title XVI shall be treated as subsidy eligible individuals described in paragraph (1); and

“(II) may provide that part D eligible individuals not described in subclause (I) who are determined for purposes of the State plan under title XIX to be eligible for medical assistance under clause (i), (iii), or (iv) of section 1902(a)(10)(E) are treated as being determined to be subsidy eligible individuals described in paragraph (1).

Insofar as the Secretary determines that the eligibility requirements under the State plan for medical assistance referred to in subclause (II) are substantially the same as the requirements for being treated as a subsidy eligible individual described in paragraph (1), the Secretary shall provide for the treatment described in such subclause.

“(C) INCOME DETERMINATIONS.—For purposes of applying this section—

“(i) in the case of a part D eligible individual who is not treated as a subsidy eligible individual under subparagraph (B)(v), income shall be determined in the manner described in section 1905(p)(1)(B), without regard to the application of section 1902(r)(2); and

“(ii) the term ‘poverty line’ has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

Nothing in clause (i) shall be construed to affect the application of section 1902(r)(2) for the determination of eligibility for medical assistance under title XIX.

“(D) RESOURCE STANDARD APPLIED TO FULL LOW-INCOME SUBSIDY TO BE BASED ON THREE TIMES SSI RESOURCE STANDARD.—The resources requirement of this subparagraph is that an individual’s resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed—

“(i) for 2006 three times the maximum amount of resources that an individual may have and obtain benefits under that program; and

“(ii) for a subsequent year the resource limitation established under this clause for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year.

Any resource limitation established under clause (ii) that is not a multiple of \$10 shall be rounded to the nearest multiple of \$10.

“(E) ALTERNATIVE RESOURCE STANDARD.—

“(i) IN GENERAL.—The resources requirement of this subparagraph is that an individual’s resources (as determined under section 1613 for purposes of the

supplemental security income program) do not exceed—

“(I) for 2006, \$10,000 (or \$20,000 in the case of the combined value of the individual’s assets or resources and the assets or resources of the individual’s spouse); and

“(II) for a subsequent year the dollar amounts specified in this subclause (or subclause (I)) for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year.

Any dollar amount established under subclause (II) that is not a multiple of \$10 shall be rounded to the nearest multiple of \$10.

“(ii) USE OF SIMPLIFIED APPLICATION FORM AND PROCESS.—The Secretary, jointly with the Commissioner of Social Security, shall—

“(I) develop a model, simplified application form and process consistent with clause (iii) for the determination and verification of a part D eligible individual’s assets or resources under this subparagraph; and

“(II) provide such form to States.

“(iii) DOCUMENTATION AND SAFEGUARDS.—Under such process—

“(I) the application form shall consist of an attestation under penalty of perjury regarding the level of assets or resources (or combined assets and resources in the case of a married part D eligible individual) and valuations of general classes of assets or resources;

“(II) such form shall be accompanied by copies of recent statements (if any) from financial institutions in support of the application; and

“(III) matters attested to in the application shall be subject to appropriate methods of verification.

“(iv) METHODOLOGY FLEXIBILITY.—The Secretary may permit a State in making eligibility determinations for premium and cost-sharing subsidies under this section to use the same asset or resource methodologies that are used with respect to eligibility for medical assistance for medicare cost-sharing described in section 1905(p) so long as the Secretary determines that the use of such methodologies will not result in any significant differences in the number of individuals determined to be subsidy eligible individuals.

“(F) TREATMENT OF TERRITORIAL RESIDENTS.—In the case of a part D eligible 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 under this section but may be eligible for financial assistance with prescription drug expenses under section 1935(e).

“(4) INDEXING DOLLAR AMOUNTS.—

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“(A) COPAYMENT FOR LOWEST INCOME DUAL ELIGIBLE INDIVIDUALS.—The dollar amounts applied under paragraph (1)(D)(ii)—

“(i) for 2007 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year; or

“(ii) for a subsequent year shall be the dollar amounts specified in this clause (or clause (i)) for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year.

Any amount established under clause (i) or (ii), that is based on an increase of \$1 or \$3, that is not a multiple of 5 cents or 10 cents, respectively, shall be rounded to the nearest multiple of 5 cents or 10 cents, respectively.

“(B) REDUCED DEDUCTIBLE.—The dollar amount applied under paragraph (2)(B)—

“(i) for 2007 shall be the dollar amount specified in such paragraph increased by the annual percentage increase described in section 1860D–2(b)(6) for 2007; or

“(ii) for a subsequent year shall be the dollar amount specified in this clause (or clause (i)) for the previous year increased by the annual percentage increase described in section 1860D–2(b)(6) for the year involved.

Any amount established under clause (i) or (ii) that is not a multiple of \$1 shall be rounded to the nearest multiple of \$1.

“(b) PREMIUM SUBSIDY AMOUNT.—

“(1) IN GENERAL.—The premium subsidy amount described in this subsection for a subsidy eligible individual residing in a PDP region and enrolled in a prescription drug plan or MA–PD plan is the low-income benchmark premium amount (as defined in paragraph (2)) for the PDP region in which the individual resides or, if greater, the amount specified in paragraph (3).

“(2) LOW-INCOME BENCHMARK PREMIUM AMOUNT DEFINED.—

“(A) IN GENERAL.—For purposes of this subsection, the term ‘low-income benchmark premium amount’ means, with respect to a PDP region in which—

“(i) all prescription drug plans are offered by the same PDP sponsor, the weighted average of the amounts described in subparagraph (B)(i) for such plans; or

“(ii) there are prescription drug plans offered by more than one PDP sponsor, the weighted average of amounts described in subparagraph (B) for prescription drug plans and MA–PD plans described in section 1851(a)(2)(A)(i) offered in such region.

“(B) PREMIUM AMOUNTS DESCRIBED.—The premium amounts described in this subparagraph are, in the case of—

“(i) a prescription drug plan that is a basic prescription drug plan, the monthly beneficiary premium for such plan;

“(ii) a prescription drug plan that provides alternative prescription drug coverage the actuarial value of which is greater than that of standard prescription drug coverage, the portion of the monthly beneficiary premium that is attributable to basic prescription drug coverage; and

“(iii) an MA–PD plan, the portion of the MA monthly prescription drug beneficiary premium that is attributable to basic prescription drug benefits (described in section 1852(a)(6)(B)(ii)).

The premium amounts described in this subparagraph do not include any amounts attributable to late enrollment penalties under section 1860D–13(b).

“(3) ACCESS TO 0 PREMIUM PLAN.—In no case shall the premium subsidy amount under this subsection for a PDP region be less than the lowest monthly beneficiary premium for a prescription drug plan that offers basic prescription drug coverage in the region.

“(c) ADMINISTRATION OF SUBSIDY PROGRAM.—

“(1) IN GENERAL.—The Secretary shall provide a process whereby, in the case of a part D eligible individual who is determined to be a subsidy eligible individual and who is enrolled in a prescription drug plan or is enrolled in an MA–PD plan—

“(A) the Secretary provides for a notification of the PDP sponsor or the MA organization offering the plan involved that the individual is eligible for a subsidy and the amount of the subsidy under subsection (a);

“(B) the sponsor or organization involved reduces the premiums or cost-sharing otherwise imposed by the amount of the applicable subsidy and submits to the Secretary information on the amount of such reduction;

“(C) the Secretary periodically and on a timely basis reimburses the sponsor or organization for the amount of such reductions; and

“(D) the Secretary ensures the confidentiality of individually identifiable information.

In applying subparagraph (C), the Secretary shall compute reductions based upon imposition under subsections (a)(1)(D) and (a)(2)(E) of unreduced copayment amounts applied under such subsections.

“(2) USE OF CAPITATED FORM OF PAYMENT.—The reimbursement under this section 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.

“(d) RELATION TO MEDICAID PROGRAM.—For special provisions under the medicaid program relating to medicare prescription drug benefits, see section 1935.

“SUBSIDIES FOR PART D ELIGIBLE INDIVIDUALS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE

“SEC. 1860D–15. (a) SUBSIDY PAYMENT.—In order to reduce premium levels applicable to qualified prescription drug coverage

for part D eligible individuals consistent with an overall subsidy level of 74.5 percent for basic prescription drug coverage, to reduce adverse selection among prescription drug plans and MA–PD plans, and to promote the participation of PDP sponsors under this part and MA organizations under part C, the Secretary shall provide for payment to a PDP sponsor that offers a prescription drug plan and an MA organization that offers an MA–PD plan of the following subsidies in accordance with this section:

“(1) DIRECT SUBSIDY.—A direct subsidy for each part D eligible individual enrolled in a prescription drug plan or MA–PD plan for a month equal to—

“(A) the amount of the plan’s standardized bid amount (as defined in section 1860D–13(a)(5)), adjusted under subsection (c)(1), reduced by

“(B) the base beneficiary premium (as computed under paragraph (2) of section 1860D–13(a) and as adjusted under paragraph (1)(B) of such section).

“(2) SUBSIDY THROUGH REINSURANCE.—The reinsurance payment amount (as defined in subsection (b)).

This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this section.

“(b) REINSURANCE PAYMENT AMOUNT.—

“(1) IN GENERAL.—The reinsurance payment amount under this subsection for a part D eligible individual enrolled in a prescription drug plan or MA–PD plan for a coverage year is an amount equal to 80 percent of the allowable reinsurance costs (as specified in paragraph (2)) attributable to that portion of gross covered prescription drug costs as specified in paragraph (3) incurred in the coverage year after such individual has incurred costs that exceed the annual out-of-pocket threshold specified in section 1860D–2(b)(4)(B).

“(2) ALLOWABLE REINSURANCE COSTS.—For purposes of this section, the term ‘allowable reinsurance costs’ means, with respect to gross covered prescription drug costs under a prescription drug plan offered by a PDP sponsor or an MA–PD plan offered by an MA organization, the part of such costs that are actually paid (net of discounts, chargebacks, and average percentage rebates) by the sponsor or organization or by (or on behalf of) an enrollee 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 basic prescription drug coverage, or, in the case of a plan providing supplemental prescription drug coverage, if such coverage were standard prescription drug coverage.

“(3) GROSS COVERED PRESCRIPTION DRUG COSTS.—For purposes of this section, the term ‘gross covered prescription drug costs’ means, with respect to a part D eligible individual enrolled in a prescription drug plan or MA–PD plan during a coverage year, the costs incurred under the plan, not including administrative costs, but including costs directly related to the dispensing of covered part D drugs during the year and costs relating to the deductible. Such costs shall be determined whether they are paid by the individual or under the plan, regardless of whether the coverage under the plan exceeds basic prescription drug coverage.

“(4) COVERAGE YEAR DEFINED.—For purposes of this section, the term ‘coverage year’ means a calendar year in which covered part D drugs are dispensed if the claim for such drugs (and payment on such claim) is made not later than such period after the end of such year as the Secretary specifies.

“(c) ADJUSTMENTS RELATING TO BIDS.—

“(1) HEALTH STATUS RISK ADJUSTMENT.—

“(A) ESTABLISHMENT OF RISK ADJUSTORS.—The Secretary shall establish an appropriate methodology for adjusting the standardized bid amount under subsection (a)(1)(A) to take into account variation in costs for basic prescription drug coverage among prescription drug plans and MA–PD plans based on the differences in actuarial risk of different enrollees being served. Any such risk adjustment shall be designed in a manner so as not to result in a change in the aggregate amounts payable to such plans under subsection (a)(1) and through that portion of the monthly beneficiary prescription drug premiums described in subsection (a)(1)(B) and MA monthly prescription drug beneficiary premiums.

“(B) CONSIDERATIONS.—In establishing the methodology under subparagraph (A), the Secretary may take into account the similar methodologies used under section 1853(a)(3) to adjust payments to MA organizations for benefits under the original medicare fee-for-service program option.

“(C) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require—

“(i) PDP sponsors to submit data regarding drug claims that can be linked at the individual level to part A and part B data and such other information as the Secretary determines necessary; and

“(ii) MA organizations that offer MA–PD plans to submit data regarding drug claims that can be linked at the individual level to other data that such organizations are required to submit to the Secretary and such other information as the Secretary determines necessary.

“(D) PUBLICATION.—At the time of publication of risk adjustment factors under section 1853(b)(1)(B)(i)(II), the Secretary shall publish the risk adjusters established under this paragraph for the succeeding year.

“(2) GEOGRAPHIC ADJUSTMENT.—

“(A) IN GENERAL.—Subject to subparagraph (B), for purposes of section 1860D–13(a)(1)(B)(iii), the Secretary shall establish an appropriate methodology for adjusting the national average monthly bid amount (computed under section 1860D–13(a)(4)) to take into account differences in prices for covered part D drugs among PDP regions.

“(B) DE MINIMIS RULE.—If the Secretary determines that the price variations described in subparagraph (A) among PDP regions are de minimis, the Secretary shall not provide for adjustment under this paragraph.

“(C) BUDGET NEUTRAL ADJUSTMENT.—Any adjustment under this paragraph shall be applied in a manner so as to not result in a change in the aggregate payments

made under this part that would have been made if the Secretary had not applied such adjustment.

“(d) PAYMENT METHODS.—

“(1) IN GENERAL.—Payments under this section shall be based on such a method as the Secretary determines. The Secretary may establish a payment method by which interim payments of amounts under this section are made during a year based on the Secretary’s best estimate of amounts that will be payable after obtaining all of the information.

“(2) REQUIREMENT FOR PROVISION OF INFORMATION.—

“(A) REQUIREMENT.—Payments under this section to a PDP sponsor or MA organization are conditioned upon the furnishing to the Secretary, in a form and manner specified by the Secretary, of such information as may be required to carry out this section.

“(B) RESTRICTION ON USE OF INFORMATION.—Information disclosed or obtained pursuant to subparagraph (A) may be used by officers, employees, and contractors of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this section.

“(3) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Medicare Prescription Drug Account.

“(4) APPLICATION OF ENROLLEE ADJUSTMENT.—The provisions of section 1853(a)(2) shall apply to payments to PDP sponsors under this section in the same manner as they apply to payments to MA organizations under section 1853(a).

“(e) PORTION OF TOTAL PAYMENTS TO A SPONSOR OR ORGANIZATION SUBJECT TO RISK (APPLICATION OF RISK CORRIDORS).—

“(1) COMPUTATION OF ADJUSTED ALLOWABLE RISK CORRIDOR COSTS.—

“(A) IN GENERAL.—For purposes of this subsection, the term ‘adjusted allowable risk corridor costs’ means, for a plan for a coverage year (as defined in subsection (b)(4))—

“(i) the allowable risk corridor costs (as defined in subparagraph (B)) for the plan for the year, reduced by

“(ii) the sum of (I) the total reinsurance payments made under subsection (b) to the sponsor of the plan for the year, and (II) the total subsidy payments made under section 1860D–14 to the sponsor of the plan for the year.

“(B) ALLOWABLE RISK CORRIDOR COSTS.—For purposes of this subsection, the term ‘allowable risk corridor costs’ means, with respect to a prescription drug plan offered by a PDP sponsor or an MA–PD plan offered by an MA organization, the part of costs (not including administrative costs, but including costs directly related to the dispensing of covered part D drugs during the year) incurred by the sponsor or organization under the plan that are actually paid (net of discounts, chargebacks, and average percentage rebates) by the sponsor or organization 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 basic prescription drug coverage, or, in the case of a plan providing supplemental prescription drug coverage, if such coverage were basic

prescription drug coverage taking into account the adjustment under section 1860D–11(c)(2). In computing allowable costs under this paragraph, the Secretary shall compute such costs based upon imposition under paragraphs (1)(D) and (2)(E) of section 1860D–14(a) of the maximum amount of copayments permitted under such paragraphs.

“(2) ADJUSTMENT OF PAYMENT.—

“(A) NO ADJUSTMENT IF ADJUSTED ALLOWABLE RISK CORRIDOR COSTS WITHIN RISK CORRIDOR.—If the adjusted allowable risk corridor costs (as defined in paragraph (1)) for the plan for the year are at least equal to the first threshold lower limit of the risk corridor (specified in paragraph (3)(A)(i)), but not greater than the first threshold upper limit of the risk corridor (specified in paragraph (3)(A)(iii)) for the plan for the year, then no payment adjustment shall be made under this subsection.

“(B) INCREASE IN PAYMENT IF ADJUSTED ALLOWABLE RISK CORRIDOR COSTS ABOVE UPPER LIMIT OF RISK CORRIDOR.—

“(i) COSTS BETWEEN FIRST AND SECOND THRESHOLD UPPER LIMITS.—If the adjusted allowable risk corridor costs for the plan for the year are greater than the first threshold upper limit, but not greater than the second threshold upper limit, of the risk corridor for the plan for the year, the Secretary shall increase the total of the payments made to the sponsor or organization offering the plan for the year under this section by an amount equal to 50 percent (or, for 2006 and 2007, 75 percent or 90 percent if the conditions described in clause (iii) are met for the year) of the difference between such adjusted allowable risk corridor costs and the first threshold upper limit of the risk corridor.

“(ii) COSTS ABOVE SECOND THRESHOLD UPPER LIMITS.—If the adjusted allowable risk corridor costs for the plan for the year are greater than the second threshold upper limit of the risk corridor for the plan for the year, the Secretary shall increase the total of the payments made to the sponsor or organization offering the plan for the year under this section by an amount equal to the sum of—

“(I) 50 percent (or, for 2006 and 2007, 75 percent or 90 percent if the conditions described in clause (iii) are met for the year) of the difference between the second threshold upper limit and the first threshold upper limit; and

“(II) 80 percent of the difference between such adjusted allowable risk corridor costs and the second threshold upper limit of the risk corridor.

“(iii) CONDITIONS FOR APPLICATION OF HIGHER PERCENTAGE FOR 2006 AND 2007.—The conditions described in this clause are met for 2006 or 2007 if the Secretary determines with respect to such year that—

“(I) at least 60 percent of prescription drug plans and MA–PD plans to which this subsection applies have adjusted allowable risk corridor costs

for the plan for the year that are more than the first threshold upper limit of the risk corridor for the plan for the year; and

“(II) such plans represent at least 60 percent of part D eligible individuals enrolled in any prescription drug plan or MA–PD plan.

“(C) REDUCTION IN PAYMENT IF ADJUSTED ALLOWABLE RISK CORRIDOR COSTS BELOW LOWER LIMIT OF RISK CORRIDOR.—

“(i) COSTS BETWEEN FIRST AND SECOND THRESHOLD LOWER LIMITS.—If the adjusted allowable risk corridor costs for the plan for the year are less than the first threshold lower limit, but not less than the second threshold lower limit, of the risk corridor for the plan for the year, the Secretary shall reduce the total of the payments made to the sponsor or organization offering the plan for the year under this section by an amount (or otherwise recover from the sponsor or organization an amount) equal to 50 percent (or, for 2006 and 2007, 75 percent) of the difference between the first threshold lower limit of the risk corridor and such adjusted allowable risk corridor costs.

“(ii) COSTS BELOW SECOND THRESHOLD LOWER LIMIT.—If the adjusted allowable risk corridor costs for the plan for the year are less the second threshold lower limit of the risk corridor for the plan for the year, the Secretary shall reduce the total of the payments made to the sponsor or organization offering the plan for the year under this section by an amount (or otherwise recover from the sponsor or organization an amount) equal to the sum of—

“(I) 50 percent (or, for 2006 and 2007, 75 percent) of the difference between the first threshold lower limit and the second threshold lower limit; and

“(II) 80 percent of the difference between the second threshold upper limit of the risk corridor and such adjusted allowable risk corridor costs.

“(3) ESTABLISHMENT OF RISK CORRIDORS.—

“(A) IN GENERAL.—For each plan year the Secretary shall establish a risk corridor for each prescription drug plan and each MA–PD plan. The risk corridor for a plan for a year shall be equal to a range as follows:

“(i) FIRST THRESHOLD LOWER LIMIT.—The first threshold lower limit of such corridor shall be equal to—

“(I) the target amount described in subparagraph (B) for the plan; minus

“(II) an amount equal to the first threshold risk percentage for the plan (as determined under subparagraph (C)(i)) of such target amount.

“(ii) SECOND THRESHOLD LOWER LIMIT.—The second threshold lower limit of such corridor shall be equal to—

“(I) the target amount described in subparagraph (B) for the plan; minus

“(II) an amount equal to the second threshold risk percentage for the plan (as determined under subparagraph (C)(ii)) of such target amount.

“(iii) FIRST THRESHOLD UPPER LIMIT.—The first threshold upper limit of such corridor shall be equal to the sum of—

“(I) such target amount; and

“(II) the amount described in clause (i)(II).

“(iv) SECOND THRESHOLD UPPER LIMIT.—The second threshold upper limit of such corridor shall be equal to the sum of—

“(I) such target amount; and

“(II) the amount described in clause (ii)(II).

“(B) TARGET AMOUNT DESCRIBED.—The target amount described in this paragraph is, with respect to a prescription drug plan or an MA–PD plan in a year, the total amount of payments paid to the PDP sponsor or MA–PD organization for the plan for the year, taking into account amounts paid by the Secretary and enrollees, based upon the standardized bid amount (as defined in section 1860D–13(a)(5) and as risk adjusted under subsection (c)(1)), reduced by the total amount of administrative expenses for the year assumed in such standardized bid.

“(C) FIRST AND SECOND THRESHOLD RISK PERCENTAGE DEFINED.—

“(i) FIRST THRESHOLD RISK PERCENTAGE.—Subject to clause (iii), for purposes of this section, the first threshold risk percentage is—

“(I) for 2006 and 2007, and 2.5 percent;

“(II) for 2008 through 2011, 5 percent; and

“(III) for 2012 and subsequent years, a percentage established by the Secretary, but in no case less than 5 percent.

“(ii) SECOND THRESHOLD RISK PERCENTAGE.—Subject to clause (iii), for purposes of this section, the second threshold risk percentage is—

“(I) for 2006 and 2007, 5 percent;

“(II) for 2008 through 2011, 10 percent; and

“(III) for 2012 and subsequent years, a percentage established by the Secretary that is greater than the percent established for the year under clause (i)(III), but in no case less than 10 percent.

“(iii) REDUCTION OF RISK PERCENTAGE TO ENSURE 2 PLANS IN AN AREA.—Pursuant to section 1860D–11(b)(2)(E)(ii), a PDP sponsor may submit a bid that requests a decrease in the applicable first or second threshold risk percentages or an increase in the percents applied under paragraph (2).

“(4) PLANS AT RISK FOR ENTIRE AMOUNT OF SUPPLEMENTAL PRESCRIPTION DRUG COVERAGE.—A PDP sponsor and MA organization that offers a plan that provides supplemental prescription drug benefits shall be at full financial risk for the provision of such supplemental benefits.

“(5) NO EFFECT ON MONTHLY PREMIUM.—No adjustment in payments made by reason of this subsection shall affect

the monthly beneficiary premium or the MA monthly prescription drug beneficiary premium.

“(f) DISCLOSURE OF INFORMATION.—

“(1) IN GENERAL.—Each contract under this part and under part C shall provide that—

“(A) the PDP sponsor offering a prescription drug plan or an MA organization offering an MA–PD plan shall provide the Secretary with such information as the Secretary determines is necessary to carry out this section; and

“(B) the Secretary shall have the right in accordance with section 1857(d)(2)(B) (as applied under section 1860D–12(b)(3)(C)) to inspect and audit any books and records of a PDP sponsor or MA organization that pertain to the information regarding costs provided to the Secretary under subparagraph (A).

“(2) RESTRICTION ON USE OF INFORMATION.—Information disclosed or obtained pursuant to the provisions of this section may be used by officers, employees, and contractors of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this section.

“(g) PAYMENT FOR FALLBACK PRESCRIPTION DRUG PLANS.—In lieu of the amounts otherwise payable under this section to a PDP sponsor offering a fallback prescription drug plan (as defined in section 1860D–3(c)(4)), the amount payable shall be the amounts determined under the contract for such plan pursuant to section 1860D–11(g)(5).

“MEDICARE PRESCRIPTION DRUG ACCOUNT IN THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

“SEC. 1860D–16. (a) ESTABLISHMENT AND OPERATION OF ACCOUNT.—

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

“(2) FUNDING.—The Account shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), accrued interest on balances in the Account, and such amounts as may be deposited in, or appropriated to, such Account as provided in this part.

“(3) SEPARATE FROM REST OF TRUST FUND.—Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund, but shall be invested, and such investments redeemed, in the same manner as all other funds and investments within such Trust Fund.

“(b) PAYMENTS FROM ACCOUNT.—

“(1) IN GENERAL.—The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary certifies are necessary to make payments to operate the program under this part, including—

“(A) payments under section 1860D–14 (relating to low-income subsidy payments);

“(B) payments under section 1860D–15 (relating to subsidy payments and payments for fallback plans);

“(C) payments to sponsors of qualified retiree prescription drug plans under section 1860D–22(a); and

“(D) 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 Account to the Grants to States for Medicaid account amounts the Secretary certifies are attributable to increases in payment resulting from the application of section 1935(b).

“(3) PAYMENTS OF PREMIUMS WITHHELD.—The Managing Trustee shall make payment to the PDP sponsor or MA organization involved of the premiums (and the portion of late enrollment penalties) that are collected in the manner described in section 1854(d)(2)(A) and that are payable under a prescription drug plan or MA–PD plan offered by such sponsor or organization.

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

“(c) DEPOSITS INTO ACCOUNT.—

“(1) LOW-INCOME TRANSFER.—Amounts paid under section 1935(c) (and any amounts collected or offset under paragraph (1)(C) of such section) are deposited into the Account.

“(2) AMOUNTS WITHHELD.—Pursuant to sections 1860D–13(c) and 1854(d) (as applied under this part), amounts that are withheld (and allocated) to the Account are deposited into the Account.

“(3) 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 Account, an amount equivalent to the amount of payments made from the Account under subsection (b) plus such amounts as the Managing Trustee certifies is necessary to maintain an appropriate contingency margin, reduced by the amounts deposited under paragraph (1) or subsection (a)(2).

“(4) INITIAL FUNDING AND RESERVE.—In order to assure prompt payment of benefits provided under this part and the administrative expenses thereunder during the early months of the program established by this part and to provide an initial contingency reserve, there are authorized to be appropriated to the Account, out of any moneys in the Treasury not otherwise appropriated, such amount as the Secretary certifies are required, but not to exceed 10 percent of the estimated total expenditures from such Account in 2006.

“(5) TRANSFER OF ANY REMAINING BALANCE FROM TRANSITIONAL ASSISTANCE ACCOUNT.—Any balance in the Transitional Assistance Account that is transferred under section 1860D–31(k)(5) shall be deposited into the Account.

“Subpart 3—Application to Medicare Advantage Program and Treatment of Employer-Sponsored Programs and Other Prescription Drug Plans

“APPLICATION TO MEDICARE ADVANTAGE PROGRAM AND RELATED MANAGED CARE PROGRAMS

“SEC. 1860D–21. (a) SPECIAL RULES RELATING TO OFFERING OF QUALIFIED PRESCRIPTION DRUG COVERAGE.—

“(1) IN GENERAL.—An MA organization on and after January 1, 2006—

“(A) may not offer an MA plan described in section 1851(a)(2)(A) in an area unless either that plan (or another MA plan offered by the organization in that same service area) includes required prescription drug coverage (as defined in paragraph (2)); and

“(B) may not offer prescription drug coverage (other than that required under parts A and B) to an enrollee—

“(i) under an MSA plan; or

“(ii) under another MA plan unless such drug coverage under such other plan provides qualified prescription drug coverage and unless the requirements of this section with respect to such coverage are met.

“(2) QUALIFYING COVERAGE.—For purposes of paragraph (1)(A), the term ‘required coverage’ means with respect to an MA–PD plan—

“(A) basic prescription drug coverage; or

“(B) qualified prescription drug coverage that provides supplemental prescription drug coverage, so long as there is no MA monthly supplemental beneficiary premium applied under the plan (due to the application of a credit against such premium of a rebate under section 1854(b)(1)(C)).

“(b) APPLICATION OF DEFAULT ENROLLMENT RULES.—

“(1) SEAMLESS CONTINUATION.—In applying section 1851(c)(3)(A)(ii), an individual who is enrolled in a health benefits plan shall not be considered to have been deemed to make an election into an MA–PD plan unless such health benefits plan provides any prescription drug coverage.

“(2) MA CONTINUATION.—In applying section 1851(c)(3)(B), an individual who is enrolled in an MA plan shall not be considered to have been deemed to make an election into an MA–PD plan unless—

“(A) for purposes of the election as of January 1, 2006, the MA plan provided as of December 31, 2005, any prescription drug coverage; or

“(B) for periods after January 1, 2006, such MA plan is an MA–PD plan.

“(3) DISCONTINUANCE OF MA–PD ELECTION DURING FIRST YEAR OF ELIGIBILITY.—In applying the second sentence of section 1851(e)(4) in the case of an individual who is electing to discontinue enrollment in an MA–PD plan, the individual shall be permitted to enroll in a prescription drug plan under part D at the time of the election of coverage under the original medicare fee-for-service program.

“(4) RULES REGARDING ENROLLEES IN MA PLANS NOT PROVIDING QUALIFIED PRESCRIPTION DRUG COVERAGE.—In the case

of an individual who is enrolled in an MA plan (other than an MSA plan) that does not provide qualified prescription drug coverage, if the organization offering such coverage discontinues the offering with respect to the individual of all MA plans that do not provide such coverage—

“(i) the individual is deemed to have elected the original medicare fee-for-service program option, unless the individual affirmatively elects to enroll in an MA-PD plan; and

“(ii) in the case of such a deemed election, the disenrollment shall be treated as an involuntary termination of the MA plan described in subparagraph (B)(ii) of section 1882(s)(3) for purposes of applying such section.

The information disclosed under section 1852(c)(1) for individuals who are enrolled in such an MA plan shall include information regarding such rules.

“(c) APPLICATION OF PART D RULES FOR PRESCRIPTION DRUG COVERAGE.—With respect to the offering of qualified prescription drug coverage by an MA organization under this part on and after January 1, 2006—

“(1) IN GENERAL.—Except as otherwise provided, the provisions of this part shall apply under part C with respect to prescription drug coverage provided under MA-PD plans in lieu of the other provisions of part C that would apply to such coverage under such plans.

“(2) WAIVER.—The Secretary shall waive the provisions referred to in paragraph (1) to the extent the Secretary determines that such provisions duplicate, or are in conflict with, provisions otherwise applicable to the organization or plan under part C or as may be necessary in order to improve coordination of this part with the benefits under this part.

“(3) TREATMENT OF MA OWNED AND OPERATED PHARMACIES.—The Secretary may waive the requirement of section 1860D-4(b)(1)(C) in the case of an MA-PD plan that provides access (other than mail order) to qualified prescription drug coverage through pharmacies owned and operated by the MA organization, if the Secretary determines that the organization’s pharmacy network is sufficient to provide comparable access for enrollees under the plan.

“(d) SPECIAL RULES FOR PRIVATE FEE-FOR-SERVICE PLANS THAT OFFER PRESCRIPTION DRUG COVERAGE.—With respect to an MA plan described in section 1851(a)(2)(C) that offers qualified prescription drug coverage, on and after January 1, 2006, the following rules apply:

“(1) REQUIREMENTS REGARDING NEGOTIATED PRICES.—Subsections (a)(1) and (d)(1) of section 1860D-2 and section 1860D-4(b)(2)(A) shall not be construed to require the plan to provide negotiated prices (described in subsection (d)(1)(B) of such section), but shall apply to the extent the plan does so.

“(2) MODIFICATION OF PHARMACY ACCESS STANDARD AND DISCLOSURE REQUIREMENT.—If the plan provides coverage for drugs purchased from all pharmacies, without charging additional cost-sharing, and without regard to whether they are participating pharmacies in a network or have entered into contracts or agreements with pharmacies to provide drugs to

enrollees covered by the plan, subsections (b)(1)(C) and (k) of section 1860D–4 shall not apply to the plan.

“(3) DRUG UTILIZATION MANAGEMENT PROGRAM AND MEDICATION THERAPY MANAGEMENT PROGRAM NOT REQUIRED.—The requirements of subparagraphs (A) and (C) of section 1860D–4(c)(1) shall not apply to the plan.

“(4) APPLICATION OF REINSURANCE.—The Secretary shall determine the amount of reinsurance payments under section 1860D–15(b) using a methodology that—

“(A) bases such amount on the Secretary’s estimate of the amount of such payments that would be payable if the plan were an MA–PD plan described in section 1851(a)(2)(A)(i) and the previous provisions of this subsection did not apply; and

“(B) takes into account the average reinsurance payments made under section 1860D–15(b) for populations of similar risk under MA–PD plans described in such section.

“(5) EXEMPTION FROM RISK CORRIDOR PROVISIONS.—The provisions of section 1860D–15(e) shall not apply.

“(6) EXEMPTION FROM NEGOTIATIONS.—Subsections (d) and (e)(2)(C) of section 1860D–11 shall not apply and the provisions of section 1854(a)(5)(B) prohibiting the review, approval, or disapproval of amounts described in such section shall apply to the proposed bid and terms and conditions described in section 1860D–11(d).

“(7) TREATMENT OF INCURRED COSTS WITHOUT REGARD TO FORMULARY.—The exclusion of costs incurred for covered part D drugs which are not included (or treated as being included) in a plan’s formulary under section 1860D–2(b)(4)(B)(i) shall not apply insofar as the plan does not utilize a formulary.

“(e) APPLICATION TO REASONABLE COST REIMBURSEMENT CONTRACTORS.—

“(1) IN GENERAL.—Subject to paragraphs (2) and (3) and rules established by the Secretary, in the case of an organization that is providing benefits under a reasonable cost reimbursement contract under section 1876(h) and that elects to provide qualified prescription drug coverage to a part D eligible individual who is enrolled under such a contract, the provisions of this part (and related provisions of part C) shall apply to the provision of such coverage to such enrollee in the same manner as such provisions apply to the provision of such coverage under an MA–PD local plan described in section 1851(a)(2)(A)(i) and coverage under such a contract that so provides qualified prescription drug coverage shall be deemed to be an MA–PD local plan.

“(2) LIMITATION ON ENROLLMENT.—In applying paragraph (1), the organization may not enroll part D eligible individuals who are not enrolled under the reasonable cost reimbursement contract involved.

“(3) BIDS NOT INCLUDED IN DETERMINING NATIONAL AVERAGE MONTHLY BID AMOUNT.—The bid of an organization offering prescription drug coverage under this subsection shall not be taken into account in computing the national average monthly bid amount and low-income benchmark premium amount under this part.

“(f) APPLICATION TO PACE.—

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“(1) IN GENERAL.—Subject to paragraphs (2) and (3) and rules established by the Secretary, in the case of a PACE program under section 1894 that elects to provide qualified prescription drug coverage to a part D eligible individual who is enrolled under such program, the provisions of this part (and related provisions of part C) shall apply to the provision of such coverage to such enrollee in a manner that is similar to the manner in which such provisions apply to the provision of such coverage under an MA–PD local plan described in section 1851(a)(2)(A)(ii) and a PACE program that so provides such coverage may be deemed to be an MA–PD local plan.

“(2) LIMITATION ON ENROLLMENT.—In applying paragraph (1), the organization may not enroll part D eligible individuals who are not enrolled under the PACE program involved.

“(3) BIDS NOT INCLUDED IN DETERMINING STANDARDIZED BID AMOUNT.—The bid of an organization offering prescription drug coverage under this subsection is not be taken into account in computing any average benchmark bid amount and low-income benchmark premium amount under this part.

“SPECIAL RULES FOR EMPLOYER-SPONSORED PROGRAMS

“SEC. 1860D–22. (a) SUBSIDY PAYMENT.—

“(1) IN GENERAL.—The Secretary shall provide in accordance with this subsection for payment to the sponsor of a qualified retiree prescription drug plan (as defined in paragraph (2)) of a special subsidy payment equal to the amount specified in paragraph (3) for each qualified covered retiree under the plan (as defined in paragraph (4)). This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this section.

“(2) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN DEFINED.—For purposes of this subsection, the term ‘qualified retiree prescription drug plan’ means employment-based retiree health coverage (as defined in subsection (c)(1)) if, with respect to a part D eligible individual who is a participant or beneficiary under such coverage, the following requirements are met:

“(A) ATTESTATION OF ACTUARIAL EQUIVALENCE TO STANDARD COVERAGE.—The sponsor of the plan provides the Secretary, annually or at such other time as the Secretary may require, with an attestation that the actuarial value of prescription drug coverage under the plan (as determined using the processes and methods described in section 1860D–11(c)) is at least equal to the actuarial value of standard prescription drug coverage.

“(B) AUDITS.—The sponsor of the plan, or an administrator of the plan designated by the sponsor, shall maintain (and afford the Secretary access to) such records as the Secretary may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage and the accuracy of payments made under this section. The provisions of section 1860D–2(d)(3) shall apply to such information under this section (including such actuarial value and attestation) in a manner similar to the manner in which they apply to financial records of PDP sponsors and MA organizations.

“(C) PROVISION OF DISCLOSURE REGARDING PRESCRIPTION DRUG COVERAGE.—The sponsor of the plan shall provide for disclosure of information regarding prescription drug coverage in accordance with section 1860D–13(b)(6)(B).

“(3) EMPLOYER AND UNION SPECIAL SUBSIDY AMOUNTS.—

“(A) IN GENERAL.—For purposes of this subsection, the special subsidy payment amount under this paragraph for a qualifying covered retiree for a coverage year enrolled with the sponsor of a qualified retiree prescription drug plan is, for the portion of the retiree’s gross covered retiree plan-related prescription drug costs (as defined in subparagraph (C)(ii)) for such year that exceeds the cost threshold amount specified in subparagraph (B) and does not exceed the cost limit under such subparagraph, an amount equal to 28 percent of the allowable retiree costs (as defined in subparagraph (C)(i)) attributable to such gross covered prescription drug costs.

“(B) COST THRESHOLD AND COST LIMIT APPLICABLE.—

“(i) IN GENERAL.—Subject to clause (ii)—

“(I) the cost threshold under this subparagraph is equal to \$250 for plan years that end in 2006; and

“(II) the cost limit under this subparagraph is equal to \$5,000 for plan years that end in 2006.

“(ii) INDEXING.—The cost threshold and cost limit amounts specified in subclauses (I) and (II) of clause (i) for a plan year that ends after 2006 shall be adjusted in the same manner as the annual deductible and the annual out-of-pocket threshold, respectively, are annually adjusted under paragraphs (1) and (4)(B) of section 1860D–2(b).

“(C) DEFINITIONS.—For purposes of this paragraph:

“(i) ALLOWABLE RETIREE COSTS.—The term ‘allowable retiree costs’ means, with respect to gross covered prescription drug costs under a qualified retiree prescription drug plan by a plan sponsor, the part of such costs that are actually paid (net of discounts, chargebacks, and average percentage rebates) by the sponsor or by or on behalf of a qualifying covered retiree under the plan.

“(ii) GROSS COVERED RETIREE PLAN-RELATED PRESCRIPTION DRUG COSTS.—For purposes of this section, the term ‘gross covered retiree plan-related prescription drug costs’ means, with respect to a qualifying covered retiree enrolled in a qualified retiree prescription drug plan during a coverage year, the costs incurred under the plan, not including administrative costs, but including costs directly related to the dispensing of covered part D drugs during the year. Such costs shall be determined whether they are paid by the retiree or under the plan.

“(iii) COVERAGE YEAR.—The term ‘coverage year’ has the meaning given such term in section 1860D–15(b)(4).

“(4) QUALIFYING COVERED RETIREE DEFINED.—For purposes of this subsection, the term ‘qualifying covered retiree’ means a part D eligible individual who is not enrolled in a prescription

drug plan or an MA-PD plan but is covered under a qualified retiree prescription drug plan.

“(5) PAYMENT METHODS, INCLUDING PROVISION OF NECESSARY INFORMATION.—The provisions of section 1860D–15(d) (including paragraph (2), relating to requirement for provision of information) shall apply to payments under this subsection in a manner similar to the manner in which they apply to payment under section 1860D–15(b).

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

“(A) precluding a part D eligible individual who is covered under employment-based retiree health coverage from enrolling in a prescription drug plan or in an MA-PD plan;

“(B) precluding such employment-based retiree health coverage or an employer or other person from paying all or any portion of any premium required for coverage under a prescription drug plan or MA-PD plan on behalf of such an individual;

“(C) preventing such employment-based retiree health coverage from providing coverage—

“(i) that is better than standard prescription drug coverage to retirees who are covered under a qualified retiree prescription drug plan; or

“(ii) that is supplemental to the benefits provided under a prescription drug plan or an MA-PD plan, including benefits to retirees who are not covered under a qualified retiree prescription drug plan but who are enrolled in such a prescription drug plan or MA-PD plan; or

“(D) preventing employers to provide for flexibility in benefit design and pharmacy access provisions, without regard to the requirements for basic prescription drug coverage, so long as the actuarial equivalence requirement of paragraph (2)(A) is met.

“(b) APPLICATION OF MA WAIVER AUTHORITY.—The provisions of section 1857(i) shall apply with respect to prescription drug plans in relation to employment-based retiree health coverage in a manner similar to the manner in which they apply to an MA plan in relation to employers, including authorizing the establishment of separate premium amounts for enrollees in a prescription drug plan by reason of such coverage and limitations on enrollment to part D eligible individuals enrolled under such coverage.

“(c) DEFINITIONS.—For purposes of this section:

“(1) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term ‘employment-based retiree health coverage’ means health insurance or other coverage of health care costs (whether provided by voluntary insurance coverage or pursuant to statutory or contractual obligation) for part D eligible individuals (or for such individuals and their spouses and dependents) under a group health plan based on their status as retired participants in such plan.

“(2) SPONSOR.—The term ‘sponsor’ means a plan sponsor, as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974, in relation to a group health plan, except that, in the case of a plan maintained jointly by one employer and an employee organization and with respect

to which the employer is the primary source of financing, such term means such employer.

“(3) GROUP HEALTH PLAN.—The term ‘group health plan’ includes such a plan as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 and also includes the following:

“(A) FEDERAL AND STATE GOVERNMENTAL PLANS.—Such a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing, including a health benefits plan offered under chapter 89 of title 5, United States Code.

“(B) COLLECTIVELY BARGAINED PLANS.—Such a plan established or maintained under or pursuant to one or more collective bargaining agreements.

“(C) CHURCH PLANS.—Such a plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 of the Internal Revenue Code of 1986.

“STATE PHARMACEUTICAL ASSISTANCE PROGRAMS

“SEC. 1860D–23. (a) REQUIREMENTS FOR BENEFIT COORDINATION.—

“(1) IN GENERAL.—Before July 1, 2005, the Secretary shall establish consistent with this section requirements for prescription drug plans to ensure the effective coordination between a part D plan (as defined in paragraph (5)) and a State Pharmaceutical Assistance Program (as defined in subsection (b)) with respect to—

“(A) payment of premiums and coverage; and

“(B) payment for supplemental prescription drug benefits,

for part D eligible individuals enrolled under both types of plans.

“(2) COORDINATION ELEMENTS.—The requirements under paragraph (1) shall include requirements relating to coordination of each of the following:

“(A) Enrollment file sharing.

“(B) The processing of claims, including electronic processing.

“(C) Claims payment.

“(D) Claims reconciliation reports.

“(E) Application of the protection against high out-of-pocket expenditures under section 1860D–2(b)(4).

“(F) Other administrative processes specified by the Secretary.

Such requirements shall be consistent with applicable law to safeguard the privacy of any individually identifiable beneficiary information.

“(3) USE OF LUMP SUM PER CAPITA METHOD.—Such requirements shall include a method for the application by a part D plan of specified funding amounts from a State Pharmaceutical Assistance Program for enrolled individuals for supplemental prescription drug benefits.

“(4) CONSULTATION.—In establishing requirements under this subsection, the Secretary shall consult with State Pharmaceutical Assistance Programs, MA organizations, States, pharmaceutical benefit managers, employers, representatives of part D eligible individuals, the data processing experts, pharmacists, pharmaceutical manufacturers, and other experts.

“(5) PART D PLAN DEFINED.—For purposes of this section and section 1860D–24, the term ‘part D plan’ means a prescription drug plan and an MA–PD plan.

“(b) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—For purposes of this part, the term ‘State Pharmaceutical Assistance Program’ means a State program—

“(1) which provides financial assistance for the purchase or provision of supplemental prescription drug coverage or benefits on behalf of part D eligible individuals;

“(2) which, in determining eligibility and the amount of assistance to part D eligible individuals under the Program, provides assistance to such individuals in all part D plans and does not discriminate based upon the part D plan in which the individual is enrolled; and

“(3) which satisfies the requirements of subsections (a) and (c).

“(c) RELATION TO OTHER PROVISIONS.—

“(1) MEDICARE AS PRIMARY PAYOR.—The requirements of this section shall not change or affect the primary payor status of a part D plan.

“(2) USE OF A SINGLE CARD.—A card that is issued under section 1860D–4(b)(2)(A) for use under a part D plan may also be used in connection with coverage of benefits provided under a State Pharmaceutical Assistance Program and, in such case, may contain an emblem or symbol indicating such connection.

“(3) OTHER PROVISIONS.—The provisions of section 1860D–24(c) shall apply to the requirements under this section.

“(4) SPECIAL TREATMENT UNDER OUT-OF-POCKET RULE.—In applying section 1860D–2(b)(4)(C)(ii), expenses incurred under a State Pharmaceutical Assistance Program may be counted toward the annual out-of-pocket threshold.

“(5) CONSTRUCTION.—Nothing in this section shall be construed as requiring a State Pharmaceutical Assistance Program to coordinate or provide financial assistance with respect to any part D plan.

“(d) FACILITATION OF TRANSITION AND COORDINATION WITH STATE PHARMACEUTICAL ASSISTANCE PROGRAMS.—

“(1) TRANSITIONAL GRANT PROGRAM.—The Secretary shall provide payments to State Pharmaceutical Assistance Programs with an application approved under this subsection.

“(2) USE OF FUNDS.—Payments under this section may be used by a Program for any of the following:

“(A) Educating part D eligible individuals enrolled in the Program about the prescription drug coverage available through part D plans under this part.

“(B) Providing technical assistance, phone support, and counseling for such enrollees to facilitate selection and enrollment in such plans.

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“(C) Other activities designed to promote the effective coordination of enrollment, coverage, and payment between such Program and such plans.

“(3) ALLOCATION OF FUNDS.—Of the amount appropriated to carry out this subsection for a fiscal year, the Secretary shall allocate payments among Programs that have applications approved under paragraph (4) for such fiscal year in proportion to the number of enrollees enrolled in each such Program as of October 1, 2003.

“(4) APPLICATION.—No payments may be made under this subsection except pursuant to an application that is submitted and approved in a time, manner, and form specified by the Secretary.

“(5) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated for each of fiscal years 2005 and 2006, \$62,500,000 to carry out this subsection.

“COORDINATION REQUIREMENTS FOR PLANS PROVIDING PRESCRIPTION
DRUG COVERAGE

“SEC. 1860D–24. (a) APPLICATION OF BENEFIT COORDINATION
REQUIREMENTS TO ADDITIONAL PLANS.—

“(1) IN GENERAL.—The Secretary shall apply the coordination requirements established under section 1860D–23(a) to Rx plans described in subsection (b) in the same manner as such requirements apply to a State Pharmaceutical Assistance Program.

“(2) APPLICATION TO TREATMENT OF CERTAIN OUT-OF-POCKET EXPENDITURES.—To the extent specified by the Secretary, the requirements referred to in paragraph (1) shall apply to procedures established under section 1860D–2(b)(4)(D).

“(3) USER FEES.—

“(A) IN GENERAL.—The Secretary may impose user fees for the transmittal of information necessary for benefit coordination under section 1860D–2(b)(4)(D) in a manner similar to the manner in which user fees are imposed under section 1842(h)(3)(B), except that the Secretary may retain a portion of such fees to defray the Secretary’s costs in carrying out procedures under section 1860D–2(b)(4)(D).

“(B) APPLICATION.—A user fee may not be imposed under subparagraph (A) with respect to a State Pharmaceutical Assistance Program.

“(b) RX PLAN.—An Rx plan described in this subsection is any of the following:

“(1) MEDICAID PROGRAMS.—A State plan under title XIX, including such a plan operating under a waiver under section 1115, if it meets the requirements of section 1860D–23(b)(2).

“(2) GROUP HEALTH PLANS.—An employer group health plan.

“(3) FEHBP.—The Federal employees health benefits plan under chapter 89 of title 5, United States Code.

“(4) MILITARY COVERAGE (INCLUDING TRICARE).—Coverage under chapter 55 of title 10, United States Code.

“(5) OTHER PRESCRIPTION DRUG COVERAGE.—Such other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of prescription

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drug coverage on behalf of part D eligible individuals as the Secretary may specify.

“(c) RELATION TO OTHER PROVISIONS.—

“(1) USE OF COST MANAGEMENT TOOLS.—The requirements of this section shall not impair or prevent a PDP sponsor or MA organization from applying cost management tools (including differential payments) under all methods of operation.

“(2) NO AFFECT ON TREATMENT OF CERTAIN OUT-OF-POCKET EXPENDITURES.—The requirements of this section shall not affect the application of the procedures established under section 1860D–2(b)(4)(D).

“Subpart 4—Medicare Prescription Drug Discount Card and Transitional Assistance Program

“MEDICARE PRESCRIPTION DRUG DISCOUNT CARD AND TRANSITIONAL ASSISTANCE PROGRAM

“SEC. 1860D–31. (a) ESTABLISHMENT OF PROGRAM.—

“(1) IN GENERAL.—The Secretary shall establish a program under this section—

“(A) to endorse prescription drug discount card programs that meet the requirements of this section in order to provide access to prescription drug discounts through prescription drug card sponsors for discount card eligible individuals throughout the United States; and

“(B) to provide for transitional assistance for transitional assistance eligible individuals enrolled in such endorsed programs.

“(2) PERIOD OF OPERATION.—

“(A) IMPLEMENTATION DEADLINE.—The Secretary shall implement the program under this section so that discount cards and transitional assistance are first available by not later than 6 months after the date of the enactment of this section.

“(B) EXPEDITING IMPLEMENTATION.—The Secretary shall promulgate regulations to carry out the program under this section which may be effective and final immediately on an interim basis as of the date of publication of the interim final regulation. If the Secretary provides for an interim final regulation, the Secretary shall provide for a period of public comments on such regulation after the date of publication. The Secretary may change or revise such regulation after completion of the period of public comment.

“(C) TERMINATION AND TRANSITION.—

“(i) IN GENERAL.—Subject to clause (ii)—

“(I) the program under this section shall not apply to covered discount card drugs dispensed after December 31, 2005; and

“(II) transitional assistance shall be available after such date to the extent the assistance relates to drugs dispensed on or before such date.

“(ii) TRANSITION.—In the case of an individual who is enrolled in an endorsed discount card program as

of December 31, 2005, during the individual's transition period (if any) under clause (iii), in accordance with transition rules specified by the Secretary—

“(I) such endorsed program may continue to apply to covered discount card drugs dispensed to the individual under the program during such transition period;

“(II) no annual enrollment fee shall be applicable during the transition period;

“(III) during such period the individual may not change the endorsed program plan in which the individual is enrolled; and

“(IV) the balance of any transitional assistance remaining on January 1, 2006, shall remain available for drugs dispensed during the individual's transition period.

“(iii) TRANSITION PERIOD.—The transition period under this clause for an individual is the period beginning on January 1, 2006, and ending in the case of an individual who—

“(I) is enrolled in a prescription drug plan or an MA-PD plan before the last date of the initial enrollment period under section 1860D-1(b)(2)(A), on the effective date of the individual's coverage under such part; or

“(II) is not so enrolled, on the last day of such initial period.

“(3) VOLUNTARY NATURE OF PROGRAM.—Nothing in this section shall be construed as requiring a discount card eligible individual to enroll in an endorsed discount card program under this section.

“(4) GLOSSARY AND DEFINITIONS OF TERMS.—For purposes of this section:

“(A) COVERED DISCOUNT CARD DRUG.—The term ‘covered discount card drug’ has the meaning given the term ‘covered part D drug’ in section 1860D-2(e).

“(B) DISCOUNT CARD ELIGIBLE INDIVIDUAL.—The term ‘discount card eligible individual’ is defined in subsection (b)(1)(A).

“(C) ENDORSED DISCOUNT CARD PROGRAM; ENDORSED PROGRAM.—The terms ‘endorsed discount card program’ and ‘endorsed program’ mean a prescription drug discount card program that is endorsed (and for which the sponsor has a contract with the Secretary) under this section.

“(D) NEGOTIATED PRICE.—Negotiated prices are described in subsection (e)(1)(A)(ii).

“(E) PRESCRIPTION DRUG CARD SPONSOR; SPONSOR.—The terms ‘prescription drug card sponsor’ and ‘sponsor’ are defined in subsection (h)(1)(A).

“(F) STATE.—The term ‘State’ has the meaning given such term for purposes of title XIX.

“(G) TRANSITIONAL ASSISTANCE ELIGIBLE INDIVIDUAL.—The term ‘transitional assistance eligible individual’ is defined in subsection (b)(2).

“(b) ELIGIBILITY FOR DISCOUNT CARD AND FOR TRANSITIONAL ASSISTANCE.—For purposes of this section:

“(1) DISCOUNT CARD ELIGIBLE INDIVIDUAL.—

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“(A) IN GENERAL.—The term ‘discount card eligible individual’ means an individual who—

“(i) is entitled to benefits, or enrolled, under part A or enrolled under part B; and

“(ii) subject to paragraph (4), is not an individual described in subparagraph (B).

“(B) INDIVIDUAL DESCRIBED.—An individual described in this subparagraph is an individual described in subparagraph (A)(i) who is enrolled under title XIX (or under a waiver under section 1115 of the requirements of such title) and is entitled to any medical assistance for outpatient prescribed drugs described in section 1905(a)(12).

“(2) TRANSITIONAL ASSISTANCE ELIGIBLE INDIVIDUAL.—

“(A) IN GENERAL.—Subject to subparagraph (B), the term ‘transitional assistance eligible individual’ means a discount card eligible individual who resides in one of the 50 States or the District of Columbia and whose income (as determined under subsection (f)(1)(B)) is not more than 135 percent of the poverty line (as defined in section 673(2) of the Community Services Block Grant Act, 42 U.S.C. 9902(2), including any revision required by such section) applicable to the family size involved (as determined under subsection (f)(1)(B)).

“(B) EXCLUSION OF INDIVIDUALS WITH CERTAIN PRESCRIPTION DRUG COVERAGE.—Such term does not include an individual who has coverage of, or assistance for, covered discount card drugs under any of the following:

“(i) A group health plan or health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act), other than coverage under a plan under part C and other than coverage consisting only of excepted benefits (as defined in such section).

“(ii) Chapter 55 of title 10, United States Code (relating to medical and dental care for members of the uniformed services).

“(iii) A plan under chapter 89 of title 5, United States Code (relating to the Federal employees’ health benefits program).

“(3) SPECIAL TRANSITIONAL ASSISTANCE ELIGIBLE INDIVIDUAL.—The term ‘special transitional assistance eligible individual’ means a transitional assistance eligible individual whose income (as determined under subsection (f)(1)(B)) is not more than 100 percent of the poverty line (as defined in section 673(2) of the Community Services Block Grant Act, 42 U.S.C. 9902(2), including any revision required by such section) applicable to the family size involved (as determined under subsection (f)(1)(B)).

“(4) TREATMENT OF MEDICAID MEDICALLY NEEDY.—For purposes of this section, the Secretary shall provide for appropriate rules for the treatment of medically needy individuals described in section 1902(a)(10)(C) as discount card eligible individuals and as transitional assistance eligible individuals.

“(c) ENROLLMENT AND ENROLLMENT FEES.—

“(1) ENROLLMENT PROCESS.—The Secretary shall establish a process through which a discount card eligible individual

is enrolled and disenrolled in an endorsed discount card program under this section consistent with the following:

“(A) CONTINUOUS OPEN ENROLLMENT.—Subject to the succeeding provisions of this paragraph and subsection (h)(9), a discount card eligible individual who is not enrolled in an endorsed discount card program and is residing in a State may enroll in any such endorsed program—

“(i) that serves residents of the State; and

“(ii) at any time beginning on the initial enrollment date, specified by the Secretary, and before January 1, 2006.

“(B) USE OF STANDARD ENROLLMENT FORM.—An enrollment in an endorsed program shall only be effected through completion of a standard enrollment form specified by the Secretary. Each sponsor of an endorsed program shall transmit to the Secretary (in a form and manner specified by the Secretary) information on individuals who complete such enrollment forms and, to the extent provided under subsection (f), information regarding certification as a transitional assistance eligible individual.

“(C) ENROLLMENT ONLY IN ONE PROGRAM.—

“(i) IN GENERAL.—Subject to clauses (ii) and (iii), a discount card eligible individual may be enrolled in only one endorsed discount card program under this section.

“(ii) CHANGE IN ENDORSED PROGRAM PERMITTED FOR 2005.—The Secretary shall establish a process, similar to (and coordinated with) the process for annual, coordinated elections under section 1851(e)(3) during 2004, under which an individual enrolled in an endorsed discount card program may change the endorsed program in which the individual is enrolled for 2005.

“(iii) ADDITIONAL EXCEPTIONS.—The Secretary shall permit an individual to change the endorsed discount card program in which the individual is enrolled in the case of an individual who changes residence to be outside the service area of such program and in such other exceptional cases as the Secretary may provide (taking into account the circumstances for special election periods under section 1851(e)(4)). Under the previous sentence, the Secretary may consider a change in residential setting (such as placement in a nursing facility) or enrollment in or disenrollment from a plan under part C through which the individual was enrolled in an endorsed program to be an exceptional circumstance.

“(D) DISENROLLMENT.—

“(i) VOLUNTARY.—An individual may voluntarily disenroll from an endorsed discount card program at any time. In the case of such a voluntary disenrollment, the individual may not enroll in another endorsed program, except under such exceptional circumstances as the Secretary may recognize under subparagraph (C)(iii) or during the annual coordinated enrollment period provided under subparagraph (C)(ii).

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“(ii) INVOLUNTARY.—An individual who is enrolled in an endorsed discount card program and not a transitional assistance eligible individual may be disenrolled by the sponsor of the program if the individual fails to pay any annual enrollment fee required under the program.

“(E) APPLICATION TO CERTAIN ENROLLEES.—In the case of a discount card eligible individual who is enrolled in a plan described in section 1851(a)(2)(A) or under a reasonable cost reimbursement contract under section 1876(h) that is offered by an organization that also is a prescription discount card sponsor that offers an endorsed discount card program under which the individual may be enrolled and that has made an election to apply the special rules under subsection (h)(9)(B) for such an endorsed program, the individual may only enroll in such an endorsed discount card program offered by that sponsor.

“(2) ENROLLMENT FEES.—

“(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, a prescription drug card sponsor may charge an annual enrollment fee for each discount card eligible individual enrolled in an endorsed discount card program offered by such sponsor. The annual enrollment fee for either 2004 or 2005 shall not be prorated for portions of a year. There shall be no annual enrollment fee for a year after 2005.

“(B) AMOUNT.—No annual enrollment fee charged under subparagraph (A) may exceed \$30.

“(C) UNIFORM ENROLLMENT FEE.—A prescription drug card sponsor shall ensure that the annual enrollment fee (if any) for an endorsed discount card program is the same for all discount card eligible individuals enrolled in the program and residing in the State.

“(D) COLLECTION.—The annual enrollment fee (if any) charged for enrollment in an endorsed program shall be collected by the sponsor of the program.

“(E) PAYMENT OF FEE FOR TRANSITIONAL ASSISTANCE ELIGIBLE INDIVIDUALS.—Under subsection (g)(1)(A), the annual enrollment fee (if any) otherwise charged under this paragraph with respect to a transitional assistance eligible individual shall be paid by the Secretary on behalf of such individual.

“(F) OPTIONAL PAYMENT OF FEE BY STATE.—

“(i) IN GENERAL.—The Secretary shall establish an arrangement under which a State may provide for payment of some or all of the enrollment fee for some or all enrollees who are not transitional assistance eligible individuals in the State, as specified by the State under the arrangement. Insofar as such a payment arrangement is made with respect to an enrollee, the amount of the enrollment fee shall be paid directly by the State to the sponsor.

“(ii) NO FEDERAL MATCHING AVAILABLE UNDER MEDICAID OR SCHIP.—Expenditures made by a State for enrollment fees described in clause (i) shall not be treated as State expenditures for purposes of Federal matching payments under title XIX or XXI.

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“(G) RULES IN CASE OF CHANGES IN PROGRAM ENROLLMENT DURING A YEAR.—The Secretary shall provide special rules in the case of payment of an annual enrollment fee for a discount card eligible individual who changes the endorsed program in which the individual is enrolled during a year.

“(3) ISSUANCE OF DISCOUNT CARD.—Each prescription drug card sponsor of an endorsed discount card program shall issue, in a standard format specified by the Secretary, to each discount card eligible individual enrolled in such program a card that establishes proof of enrollment and that can be used in a coordinated manner to identify the sponsor, program, and individual for purposes of the program under this section.

“(4) PERIOD OF ACCESS.—In the case of a discount card eligible individual who enrolls in an endorsed program, access to negotiated prices and transitional assistance, if any, under such endorsed program shall take effect on such date as the Secretary shall specify.

“(d) PROVISION OF INFORMATION ON ENROLLMENT AND PROGRAM FEATURES.—

“(1) SECRETARIAL RESPONSIBILITIES.—

“(A) IN GENERAL.—The Secretary shall provide for activities under this subsection to broadly disseminate information to discount card eligible individuals (and prospective eligible individuals) regarding—

“(i) enrollment in endorsed discount card programs; and

“(ii) the features of the program under this section, including the availability of transitional assistance.

“(B) 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—

“(i) compares the annual enrollment fee and other features of such programs, which may include comparative prices for covered discount card drugs; and

“(ii) includes educational materials on the variability of discounts on prices of covered discount card drugs under an endorsed program.

The dissemination of information under clause (i) shall, to the extent practicable, be coordinated with the dissemination of educational information on other medicare options.

“(C) SPECIAL RULE FOR INITIAL ENROLLMENT DATE UNDER THE PROGRAM.—To the extent practicable, the Secretary shall ensure, through the activities described in subparagraphs (A) and (B), that discount card eligible individuals are provided with such information at least 30 days prior to the initial enrollment date specified under subsection (c)(1)(A)(ii).

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

“(2) PRESCRIPTION DRUG CARD SPONSOR RESPONSIBILITIES.—

“(A) IN GENERAL.—Each prescription drug card sponsor that offers an endorsed discount card program shall make available to discount card eligible individuals (through the Internet and otherwise) information that the Secretary identifies as being necessary to promote informed choice among endorsed discount card programs by such individuals, including information on enrollment fees and negotiated prices for covered discount card drugs charged to such individuals.

“(B) RESPONSE TO ENROLLEE QUESTIONS.—Each sponsor offering an endorsed discount card program shall have a mechanism (including a toll-free telephone number) for providing upon request specific information (such as negotiated prices and the amount of transitional assistance remaining available through the program) to discount card eligible individuals enrolled in the program. The sponsor shall inform transitional assistance eligible individuals enrolled in the program of the availability of such toll-free telephone number to provide information on the amount of available transitional assistance.

“(C) INFORMATION ON BALANCE OF TRANSITIONAL ASSISTANCE AVAILABLE AT POINT-OF-SALE.—Each sponsor offering an endorsed discount card program shall have a mechanism so that information on the amount of transitional assistance remaining under subsection (g)(1)(B) is available (electronically or by telephone) at the point-of-sale of covered discount card drugs.

“(3) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—

“(A) IN GENERAL.—A prescription drug card sponsor offering an endorsed discount card program shall provide that each pharmacy that dispenses a covered discount card drug shall inform a discount card eligible individual enrolled in the program of any differential between the price of the drug to the enrollee and the price of the lowest priced generic covered discount card drug under the program that is therapeutically equivalent and bioequivalent and available at such pharmacy.

“(B) TIMING OF NOTICE.—

“(i) IN GENERAL.—Subject to clause (ii), the information under subparagraph (A) shall be provided at the time of purchase of the drug involved, or, in the case of dispensing by mail order, at the time of delivery of such drug.

“(ii) WAIVER.—The Secretary may waive clause (i) in such circumstances as the Secretary may specify.

“(e) DISCOUNT CARD FEATURES.—

“(1) SAVINGS TO ENROLLEES THROUGH NEGOTIATED PRICES.—

“(A) ACCESS TO NEGOTIATED PRICES.—

“(i) IN GENERAL.—Each prescription drug card sponsor that offers an endorsed discount card program shall provide each discount card eligible individual enrolled in the program with access to negotiated prices.

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“(ii) NEGOTIATED PRICES.—For purposes of this section, negotiated prices shall take into account negotiated price concessions, such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations, for covered discount card drugs, and include any dispensing fees for such drugs.

“(B) ENSURING PHARMACY ACCESS.—Each prescription drug card sponsor offering an endorsed discount card program shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than solely by mail order) drugs directly to enrollees to ensure convenient access to covered discount card drugs at negotiated prices (consistent with rules established by the Secretary). The Secretary shall establish convenient access rules under this clause that are no less favorable to enrollees than the standards for convenient access to pharmacies included in the statement of work of solicitation (#MDA906–03–R–0002) of the Department of Defense under the TRICARE Retail Pharmacy (TRRx) as of March 13, 2003.

“(C) PROHIBITION ON CHARGES FOR REQUIRED SERVICES.—

“(i) IN GENERAL.—Subject to clause (ii), a prescription drug card sponsor (and any pharmacy contracting with such sponsor for the provision of covered discount card drugs to individuals enrolled in such sponsor’s endorsed discount card program) may not charge an enrollee any amount for any items and services required to be provided by the sponsor under this section.

“(ii) CONSTRUCTION.—Nothing in clause (i) shall be construed to prevent—

“(I) the sponsor from charging the annual enrollment fee (except in the case of a transitional assistance eligible individual); and

“(II) the pharmacy dispensing the covered discount card drug, from imposing a charge (consistent with the negotiated price) for the covered discount card drug dispensed, reduced by the amount of any transitional assistance made available.

“(D) INAPPLICABILITY OF MEDICAID BEST PRICE RULES.—

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

“(2) REDUCTION OF MEDICATION ERRORS AND ADVERSE DRUG INTERACTIONS.—Each endorsed discount card program shall implement a system to reduce the likelihood of medication errors and adverse drug interactions and to improve medication use.

“(f) ELIGIBILITY PROCEDURES FOR ENDORSED PROGRAMS AND TRANSITIONAL ASSISTANCE.—

“(1) DETERMINATIONS.—

“(A) PROCEDURES.—The determination of whether an individual is a discount card eligible individual or a transitional assistance eligible individual or a special transitional assistance eligible individual (as defined in subsection (b)) shall be determined under procedures specified by the Secretary consistent with this subsection.

“(B) INCOME AND FAMILY SIZE DETERMINATIONS.—For purposes of this section, the Secretary shall define the terms ‘income’ and ‘family size’ and shall specify the methods and period for which they are determined. If under such methods income or family size is determined based on the income or family size for prior periods of time, the Secretary shall permit (whether through a process of reconsideration or otherwise) an individual whose income or family size has changed to elect to have eligibility for transitional assistance determined based on income or family size for a more recent period.

“(2) USE OF SELF-CERTIFICATION FOR TRANSITIONAL ASSISTANCE.—

“(A) IN GENERAL.—Under the procedures specified under paragraph (1)(A) an individual who wishes to be treated as a transitional assistance eligible individual or a special transitional assistance eligible individual under this section (or another qualified person on such individual’s behalf) shall certify on the enrollment form under subsection (c)(1)(B) (or similar form specified by the Secretary), through a simplified means specified by the Secretary and under penalty of perjury or similar sanction for false statements, as to the amount of the individual’s income, family size, and individual’s prescription drug coverage (if any) insofar as they relate to eligibility to be a transitional assistance eligible individual or a special transitional assistance eligible individual. Such certification shall be deemed as consent to verification of respective eligibility under paragraph (3). A certification under this paragraph may be provided before, on, or after the time of enrollment under an endorsed program.

“(B) TREATMENT OF SELF-CERTIFICATION.—The Secretary shall treat a certification under subparagraph (A) that is verified under paragraph (3) as a determination that the individual involved is a transitional assistance eligible individual or special transitional assistance eligible individual (as the case may be) for the entire period of the enrollment of the individual in any endorsed program.

“(3) VERIFICATION.—

“(A) IN GENERAL.—The Secretary shall establish methods (which may include the use of sampling) and the use of information described in subparagraph (B)) to verify eligibility for individuals who seek to enroll in an endorsed program and for individuals who provide a certification under paragraph (2).

“(B) INFORMATION DESCRIBED.—The information described in this subparagraph is as follows:

“(i) MEDICAID-RELATED INFORMATION.—Information on eligibility under title XIX and provided to the Secretary under arrangements between the Secretary

and States in order to verify the eligibility of individuals who seek to enroll in an endorsed program and of individuals who provide certification under paragraph (2).

“(ii) SOCIAL SECURITY INFORMATION.—Financial information made available to the Secretary under arrangements between the Secretary and the Commissioner of Social Security in order to verify the eligibility of individuals who provide such certification.

“(iii) INFORMATION FROM SECRETARY OF THE TREASURY.—Financial information made available to the Secretary under section 6103(l)(19) of the Internal Revenue Code of 1986 in order to verify the eligibility of individuals who provide such certification.

“(C) VERIFICATION IN CASES OF MEDICAID ENROLLEES.—

“(i) IN GENERAL.—Nothing in this section shall be construed as preventing the Secretary from finding that a discount card eligible individual meets the income requirements under subsection (b)(2)(A) if the individual is within a category of discount card eligible individuals who are enrolled under title XIX (such as qualified medicare beneficiaries (QMBs), specified low-income medicare beneficiaries (SLMBs), and certain qualified individuals (QI-1s)).

“(ii) AVAILABILITY OF INFORMATION FOR VERIFICATION PURPOSES.—As a condition of provision of Federal financial participation to a State that is one of the 50 States or the District of Columbia under title XIX, for purposes of carrying out this section, the State shall provide the information it submits to the Secretary relating to such title in a manner specified by the Secretary that permits the Secretary to identify individuals who are described in subsection (b)(1)(B) or are transitional assistance eligible individuals or special transitional assistance eligible individuals.

“(4) RECONSIDERATION.—

“(A) IN GENERAL.—The Secretary shall establish a process under which a discount card eligible individual, who is determined through the certification and verification methods under paragraphs (2) and (3) not to be a transitional assistance eligible individual or a special transitional assistance eligible individual, may request a reconsideration of the determination.

“(B) CONTRACT AUTHORITY.—The Secretary may enter into a contract to perform the reconsiderations requested under subparagraph (A).

“(C) COMMUNICATION OF RESULTS.—Under the process under subparagraph (A) the results of such reconsideration shall be communicated to the individual and the prescription drug card sponsor involved.

“(g) TRANSITIONAL ASSISTANCE.—

“(1) PROVISION OF TRANSITIONAL ASSISTANCE.—An individual who is a transitional assistance eligible individual (as determined under this section) and who is enrolled with an endorsed program is entitled—

“(A) to have payment made of any annual enrollment fee charged under subsection (c)(2) for enrollment under the program; and

“(B) to have payment made, up to the amount specified in paragraph (2), under such endorsed program of 90 percent (or 95 percent in the case of a special transitional assistance eligible individual) of the costs incurred for covered discount card drugs obtained through the program taking into account the negotiated price (if any) for the drug under the program.

“(2) LIMITATION ON DOLLAR AMOUNT.—

“(A) IN GENERAL.—Subject to subparagraph (B), the amount specified in this paragraph for a transitional assistance eligible individual—

“(i) for costs incurred during 2004, is \$600; or

“(ii) for costs incurred during 2005, is—

“(I) \$600, plus

“(II) except as provided in subparagraph (E), the amount by which the amount available under this paragraph for 2004 for that individual exceeds the amount of payment made under paragraph (1)(B) for that individual for costs incurred during 2004.

“(B) PRORATION.—

“(i) IN GENERAL.—In the case of an individual not described in clause (ii) with respect to a year, the Secretary may prorate the amount specified in subparagraph (A) for the balance of the year involved in a manner specified by the Secretary.

“(ii) INDIVIDUAL DESCRIBED.—An individual described in this clause is a transitional assistance eligible individual who—

“(I) with respect to 2004, enrolls in an endorsed program, and provides a certification under subsection (f)(2), before the initial implementation date of the program under this section; and

“(II) with respect to 2005, is enrolled in an endorsed program, and has provided such a certification, before February 1, 2005.

“(C) ACCOUNTING FOR AVAILABLE BALANCES IN CASES OF CHANGES IN PROGRAM ENROLLMENT.—In the case of a transitional assistance eligible individual who changes the endorsed discount card program in which the individual is enrolled under this section, the Secretary shall provide a process under which the Secretary provides to the sponsor of the endorsed program in which the individual enrolls information concerning the balance of amounts available on behalf of the individual under this paragraph.

“(D) LIMITATION ON USE OF FUNDS.—Pursuant to subsection (a)(2)(C), no assistance shall be provided under paragraph (1)(B) with respect to covered discount card drugs dispensed after December 31, 2005.

“(E) NO ROLLOVER PERMITTED IN CASE OF VOLUNTARY DISENROLLMENT.—Except in such exceptional cases as the Secretary may provide, in the case of a transitional assistance eligible individual who voluntarily disenrolls from

an endorsed plan, the provisions of subclause (II) of subparagraph (A)(ii) shall not apply.

“(3) PAYMENT.—The Secretary shall provide a method for the reimbursement of prescription drug card sponsors for assistance provided under this subsection.

“(4) COVERAGE OF COINSURANCE.—

“(A) WAIVER PERMITTED BY PHARMACY.—Nothing in this section shall be construed as precluding a pharmacy from reducing or waiving the application of coinsurance imposed under paragraph (1)(B) in accordance with section 1128B(b)(3)(G).

“(B) OPTIONAL PAYMENT OF COINSURANCE BY STATE.—

“(i) IN GENERAL.—The Secretary shall establish an arrangement under which a State may provide for payment of some or all of the coinsurance under paragraph (1)(B) for some or all enrollees in the State, as specified by the State under the arrangement. Insofar as such a payment arrangement is made with respect to an enrollee, the amount of the coinsurance shall be paid directly by the State to the pharmacy involved.

“(ii) NO FEDERAL MATCHING AVAILABLE UNDER MEDICAID OR SCHIP.—Expenditures made by a State for coinsurance described in clause (i) shall not be treated as State expenditures for purposes of Federal matching payments under title XIX or XXI.

“(iii) NOT TREATED AS MEDICARE COST-SHARING.—Coinsurance described in paragraph (1)(B) shall not be treated as coinsurance under this title for purposes of section 1905(p)(3)(B).

“(C) TREATMENT OF COINSURANCE.—The amount of any coinsurance imposed under paragraph (1)(B), whether paid or waived under this paragraph, shall not be taken into account in applying the limitation in dollar amount under paragraph (2).

“(5) ENSURING ACCESS TO TRANSITIONAL ASSISTANCE FOR QUALIFIED RESIDENTS OF LONG-TERM CARE FACILITIES AND AMERICAN INDIANS.—

“(A) RESIDENTS OF LONG-TERM CARE FACILITIES.—The Secretary shall establish procedures and may waive requirements of this section as necessary to negotiate arrangements with sponsors to provide arrangements with pharmacies that support long-term care facilities in order to ensure access to transitional assistance for transitional assistance eligible individuals who reside in long-term care facilities.

“(B) AMERICAN INDIANS.—The Secretary shall establish procedures and may waive requirements of this section to ensure that, for purposes of providing transitional assistance, pharmacies operated by the Indian Health Service, Indian tribes and tribal organizations, and urban Indian organizations (as defined in section 4 of the Indian Health Care Improvement Act) have the opportunity to participate in the pharmacy networks of at least two endorsed programs in each of the 50 States and the District of Columbia where such a pharmacy operates.

“(6) NO IMPACT ON BENEFITS UNDER OTHER PROGRAMS.—The availability of negotiated prices or transitional assistance under this section shall not be treated as benefits or otherwise taken into account in determining an individual’s eligibility for, or the amount of benefits under, any other Federal program.

“(7) DISREGARD FOR PURPOSES OF PART C.—Nonuniformity of benefits resulting from the implementation of this section (including the provision or nonprovision of transitional assistance and the payment or waiver of any enrollment fee under this section) shall not be taken into account in applying section 1854(f).

“(h) QUALIFICATION OF PRESCRIPTION DRUG CARD SPONSORS AND ENDORSEMENT OF DISCOUNT CARD PROGRAMS; BENEFICIARY PROTECTIONS.—

“(1) PRESCRIPTION DRUG CARD SPONSOR AND QUALIFICATIONS.—

“(A) PRESCRIPTION DRUG CARD SPONSOR AND SPONSOR DEFINED.—For purposes of this section, the terms ‘prescription drug card sponsor’ and ‘sponsor’ mean any nongovernmental entity that the Secretary determines to be appropriate to offer an endorsed discount card program under this section, which may include—

“(i) a pharmaceutical benefit management company;

“(ii) a wholesale or retail pharmacy delivery system;

“(iii) an insurer (including an insurer that offers medicare supplemental policies under section 1882);

“(iv) an organization offering a plan under part C; or

“(v) any combination of the entities described in clauses (i) through (iv).

“(B) ADMINISTRATIVE QUALIFICATIONS.—Each endorsed discount card program shall be operated directly, or through arrangements with an affiliated organization (or organizations), by one or more entities that have demonstrated experience and expertise in operating such a program or a similar program and that meets such business stability and integrity requirements as the Secretary may specify.

“(C) ACCOUNTING FOR TRANSITIONAL ASSISTANCE.—The sponsor of an endorsed discount card program shall have arrangements satisfactory to the Secretary to account for the assistance provided under subsection (g) on behalf of transitional assistance eligible individuals.

“(2) APPLICATIONS FOR PROGRAM ENDORSEMENT.—

“(A) SUBMISSION.—Each prescription drug card sponsor that seeks endorsement of a prescription drug discount card program under this section shall submit to the Secretary, at such time and in such manner as the Secretary may specify, an application containing such information as the Secretary may require.

“(B) APPROVAL; COMPLIANCE WITH APPLICABLE REQUIREMENTS.—The Secretary shall review the application submitted under subparagraph (A) and shall determine whether to endorse the prescription drug discount card

program. The Secretary may not endorse such a program unless—

“(i) the program and prescription drug card sponsor offering the program comply with the applicable requirements under this section; and

“(ii) the sponsor has entered into a contract with the Secretary to carry out such requirements.

“(C) TERMINATION OF ENDORSEMENT AND CONTRACTS.—

An endorsement of an endorsed program and a contract under subparagraph (B) shall be for the duration of the program under this section (including any transition applicable under subsection (a)(2)(C)(ii)), except that the Secretary may, with notice and for cause (as defined by the Secretary), terminate such endorsement and contract.

“(D) ENSURING CHOICE OF PROGRAMS.—

“(i) IN GENERAL.—The Secretary shall ensure that there is available to each discount card eligible individual a choice of at least 2 endorsed programs (each offered by a different sponsor).

“(ii) LIMITATION ON NUMBER.—The Secretary may limit (but not below 2) the number of sponsors in a State that are awarded contracts under this paragraph.

“(3) SERVICE AREA ENCOMPASSING ENTIRE STATES.—Except as provided in paragraph (9), if a prescription drug card sponsor that offers an endorsed program enrolls in the program individuals residing in any part of a State, the sponsor must permit any discount card eligible individual residing in any portion of the State to enroll in the program.

“(4) SAVINGS TO MEDICARE BENEFICIARIES.—Each prescription drug card sponsor that offers an endorsed discount card program shall pass on to discount card eligible individuals enrolled in the program negotiated prices on covered discount card drugs, including discounts negotiated with pharmacies and manufacturers, to the extent disclosed under subsection (i)(1).

“(5) GRIEVANCE MECHANISM.—Each prescription drug card sponsor shall provide meaningful procedures for hearing and resolving grievances between the sponsor (including any entity or individual through which the sponsor carries out the endorsed discount card program) and enrollees in endorsed discount card programs of the sponsor under this section in a manner similar to that required under section 1852(f).

“(6) CONFIDENTIALITY OF ENROLLEE RECORDS.—

“(A) IN GENERAL.—For purposes of the program under this section, the operations of an endorsed program are covered functions and a prescription drug card sponsor is a covered entity for purposes of applying part C of title XI and all regulatory provisions promulgated thereunder, including regulations (relating to privacy) adopted pursuant to the authority of the Secretary under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).

“(B) WAIVER AUTHORITY.—In order to promote participation of sponsors in the program under this section, the Secretary may waive such relevant portions of regulations relating to privacy referred to in subparagraph (A), for

such appropriate, limited period of time, as the Secretary specifies.

“(7) LIMITATION ON PROVISION AND MARKETING OF PRODUCTS AND SERVICES.—The sponsor of an endorsed discount card program—

“(A) may provide under the program—

“(i) a product or service only if the product or service is directly related to a covered discount card drug; or

“(ii) a discount price for nonprescription drugs; and

“(B) may, to the extent otherwise permitted under paragraph (6) (relating to application of HIPAA requirements), market a product or service under the program only if the product or service is directly related to—

“(i) a covered discount card drug; or

“(ii) a drug described in subparagraph (A)(ii) and the marketing consists of information on the discounted price made available for the drug involved.

“(8) ADDITIONAL PROTECTIONS.—Each endorsed discount card program shall meet such additional requirements as the Secretary identifies to protect and promote the interest of discount card eligible individuals, including requirements that ensure that discount card eligible individuals enrolled in endorsed discount card programs are not charged more than the lower of the price based on negotiated prices or the usual and customary price.

“(9) SPECIAL RULES FOR CERTAIN ORGANIZATIONS.—

“(A) IN GENERAL.—In the case of an organization that is offering a plan under part C or enrollment under a reasonable cost reimbursement contract under section 1876(h) that is seeking to be a prescription drug card sponsor under this section, the organization may elect to apply the special rules under subparagraph (B) with respect to enrollees in any plan described in section 1851(a)(2)(A) that it offers or under such contract and an endorsed discount card program it offers, but only if it limits enrollment under such program to individuals enrolled in such plan or under such contract.

“(B) SPECIAL RULES.—The special rules under this subparagraph are as follows:

“(i) LIMITATION ON ENROLLMENT.—The sponsor limits enrollment under this section under the endorsed discount card program to discount card eligible individuals who are enrolled in the part C plan involved or under the reasonable cost reimbursement contract involved and is not required nor permitted to enroll other individuals under such program.

“(ii) PHARMACY ACCESS.—Pharmacy access requirements under subsection (e)(1)(B) are deemed to be met if the access is made available through a pharmacy network (and not only through mail order) and the network used by the sponsor is approved by the Secretary.

“(iii) SPONSOR REQUIREMENTS.—The Secretary may waive the application of such requirements for a sponsor as the Secretary determines to be duplicative

or to conflict with a requirement of the organization under part C or section 1876 (as the case may be) or to be necessary in order to improve coordination of this section with the benefits under such part or section.

“(i) DISCLOSURE AND OVERSIGHT.—

“(1) DISCLOSURE.—Each prescription drug card sponsor offering an endorsed discount card program shall disclose to the Secretary (in a manner specified by the Secretary) information relating to program performance, use of prescription drugs by discount card eligible individuals enrolled in the program, the extent to which negotiated price concessions described in subsection (e)(1)(A)(ii) made available to the entity by a manufacturer are passed through to enrollees through pharmacies or otherwise, and such other information as the Secretary may specify. The provisions of section 1927(b)(3)(D) shall apply to drug pricing data reported under the previous sentence (other than data in aggregate form).

“(2) OVERSIGHT; AUDIT AND INSPECTION AUTHORITY.—The Secretary shall provide appropriate oversight to ensure compliance of endorsed discount card programs and their sponsors with the requirements of this section. The Secretary shall have the right to audit and inspect any books and records of a prescription discount card sponsor (and of any affiliated organization referred to in subsection (h)(1)(B)) that pertain to the endorsed discount card program under this section, including amounts payable to the sponsor under this section.

“(3) SANCTIONS FOR ABUSIVE PRACTICES.—The Secretary may implement intermediate sanctions or may revoke the endorsement of a program offered by a sponsor under this section if the Secretary determines that the sponsor or the program no longer meets the applicable requirements of this section or that the sponsor has engaged in false or misleading marketing practices. The Secretary may impose a civil money penalty in an amount not to exceed \$10,000 for conduct that a party knows or should know is a violation of this section. The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

“(j) TREATMENT OF TERRITORIES.—

“(1) IN GENERAL.—The Secretary may waive any provision of this section (including subsection (h)(2)(D)) in the case of a resident of a State (other than the 50 States and the District of Columbia) insofar as the Secretary determines it is necessary to secure access to negotiated prices for discount card eligible individuals (or, at the option of the Secretary, individuals described in subsection (b)(1)(A)(i)).

“(2) TRANSITIONAL ASSISTANCE.—

“(A) IN GENERAL.—In the case of a State, other than the 50 States and the District of Columbia, if the State establishes a plan described in subparagraph (B) (for providing transitional assistance with respect to the provision of prescription drugs to some or all individuals residing in the State who are described in subparagraph (B)(i)), the Secretary shall pay to the State for the entire period

of the operation of this section an amount equal to the amount allotted to the State under subparagraph (C).

“(B) PLAN.—The plan described in this subparagraph is a plan that—

“(i) provides transitional assistance with respect to the provision of covered discount card drugs to some or all individuals who are entitled to benefits under part A or enrolled under part B, who reside in the State, and who have income below 135 percent of the poverty line; and

“(ii) assures that amounts received by the State under this paragraph are used only for such assistance.

“(C) ALLOTMENT LIMIT.—The amount described in this subparagraph for a State is equal to \$35,000,000 multiplied by the ratio (as estimated by the Secretary) of—

“(i) the number of individuals who are entitled to benefits under part A or enrolled under part B and who reside in the State (as determined by the Secretary as of July 1, 2003), to

“(ii) the sum of such numbers for all States to which this paragraph applies.

“(D) CONTINUED AVAILABILITY OF FUNDS.—Amounts made available to a State under this paragraph which are not used under this paragraph shall be added to the amount available to that State for purposes of carrying out section 1935(e).

“(k) FUNDING.—

“(1) ESTABLISHMENT OF TRANSITIONAL ASSISTANCE ACCOUNT.—

“(A) IN GENERAL.—There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1841 an account to be known as the ‘Transitional Assistance Account’ (in this subsection referred to as the ‘Account’).

“(B) FUNDS.—The Account shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), accrued interest on balances in the Account, and such amounts as may be deposited in, or appropriated to, the Account as provided in this subsection.

“(C) SEPARATE FROM REST OF TRUST FUND.—Funds provided under this subsection to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund, but shall be invested, and such investments redeemed, in the same manner as all other funds and investments within such Trust Fund.

“(2) PAYMENTS FROM ACCOUNT.—

“(A) IN GENERAL.—The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary certifies are necessary to make payments for transitional assistance provided under subsections (g) and (j)(2).

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

“(3) APPROPRIATIONS TO COVER BENEFITS.—There are appropriated to the Account in a fiscal year, out of any moneys in the Treasury not otherwise appropriated, an amount equal to the payments made from the Account in the year.

“(4) FOR ADMINISTRATIVE EXPENSES.—There are authorized to be appropriated to the Secretary such sums as may be necessary to carry out the Secretary’s responsibilities under this section.

“(5) TRANSFER OF ANY REMAINING BALANCE TO MEDICARE PRESCRIPTION DRUG ACCOUNT.—Any balance remaining in the Account after the Secretary determines that funds in the Account are no longer necessary to carry out the program under this section shall be transferred and deposited into the Medicare Prescription Drug Account under section 1860D–16.

“(6) CONSTRUCTION.—Nothing in this section shall be construed as authorizing the Secretary to provide for payment (other than payment of an enrollment fee on behalf of a transitional assistance eligible individual under subsection (g)(1)(A)) to a sponsor for administrative expenses incurred by the sponsor in carrying out this section (including in administering the transitional assistance provisions of subsections (f) and (g)).

“Subpart 5—Definitions and Miscellaneous Provisions

“DEFINITIONS; TREATMENT OF REFERENCES TO PROVISIONS IN PART C

“SEC. 1860D–41. (a) DEFINITIONS.—For purposes of this part:

“(1) BASIC PRESCRIPTION DRUG COVERAGE.—The term ‘basic prescription drug coverage’ is defined in section 1860D–2(a)(3).

“(2) COVERED PART D DRUG.—The term ‘covered part D drug’ is defined in section 1860D–2(e).

“(3) CREDITABLE PRESCRIPTION DRUG COVERAGE.—The term ‘creditable prescription drug coverage’ has the meaning given such term in section 1860D–13(b)(4).

“(4) PART D ELIGIBLE INDIVIDUAL.—The term ‘part D eligible individual’ has the meaning given such term in section 1860D–1(a)(4)(A).

“(5) FALLBACK PRESCRIPTION DRUG PLAN.—The term ‘fallback prescription drug plan’ has the meaning given such term in section 1860D–11(g)(4).

“(6) INITIAL COVERAGE LIMIT.—The term ‘initial coverage limit’ means such limit as established under section 1860D–2(b)(3), or, in the case of coverage that is not standard prescription drug coverage, the comparable limit (if any) established under the coverage.

“(7) INSURANCE RISK.—The term ‘insurance risk’ means, with respect to a participating pharmacy, risk of the type commonly assumed only by insurers licensed by a State and does not include payment variations designed to reflect performance-based measures of activities within the control of the pharmacy, such as formulary compliance and generic drug substitution.

“(8) MA PLAN.—The term ‘MA plan’ has the meaning given such term in section 1860D–1(a)(4)(B).

“(9) MA–PD PLAN.—The term ‘MA–PD plan’ has the meaning given such term in section 1860D–1(a)(4)(C).

“(10) MEDICARE PRESCRIPTION DRUG ACCOUNT.—The term ‘Medicare Prescription Drug Account’ means the Account created under section 1860D–16(a).

“(11) PDP APPROVED BID.—The term ‘PDP approved bid’ has the meaning given such term in section 1860D–13(a)(6).

“(12) PDP REGION.—The term ‘PDP region’ means such a region as provided under section 1860D–11(a)(2).

“(13) PDP SPONSOR.—The term ‘PDP sponsor’ means a nongovernmental entity that is certified under this part as meeting the requirements and standards of this part for such a sponsor.

“(14) PRESCRIPTION DRUG PLAN.—The term ‘prescription drug plan’ means prescription drug coverage that is offered—

“(A) under a policy, contract, or plan that has been approved under section 1860D–11(e); and

“(B) by a PDP sponsor pursuant to, and in accordance with, a contract between the Secretary and the sponsor under section 1860D–12(b).

“(15) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term ‘qualified prescription drug coverage’ is defined in section 1860D–2(a)(1).

“(16) STANDARD PRESCRIPTION DRUG COVERAGE.—The term ‘standard prescription drug coverage’ is defined in section 1860D–2(b).

“(17) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—The term ‘State Pharmaceutical Assistance Program’ has the meaning given such term in section 1860D–23(b).

“(18) SUBSIDY ELIGIBLE INDIVIDUAL.—The term ‘subsidy eligible individual’ has the meaning given such term in section 1860D–14(a)(3)(A).

“(b) APPLICATION OF PART C 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 an MA plan included a reference to a prescription drug plan;

“(2) any reference to an MA organization or 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–12(b);

“(4) any reference to part C included a reference to this part; and

“(5) any reference to an election period under section 1851 were a reference to an enrollment period under section 1860D–1.

“MISCELLANEOUS PROVISIONS

“SEC. 1860D–42. (a) ACCESS TO COVERAGE IN TERRITORIES.—The Secretary may waive such requirements of this part, including section 1860D–3(a)(1), insofar as the Secretary determines it is necessary to secure access to qualified prescription drug coverage for part D eligible individuals residing in a State (other than the 50 States and the District of Columbia).

“(b) APPLICATION OF DEMONSTRATION AUTHORITY.—The provisions of section 402 of the Social Security Amendments of 1967 (Public Law 90–248) shall apply with respect to this part and

part C in the same manner it applies with respect to parts A and B, except that any reference with respect to a Trust Fund in relation to an experiment or demonstration project relating to prescription drug coverage under this part shall be deemed a reference to the Medicare Prescription Drug Account within the Federal Supplementary Medical Insurance Trust Fund.”

(b) SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this title and title II.

(c) STUDY ON TRANSITIONING PART B PRESCRIPTION DRUG COVERAGE.—Not later than January 1, 2005, the Secretary shall submit a report to Congress that makes recommendations regarding methods for providing benefits under subpart 1 of part D of title XVIII of the Social Security Act for outpatient prescription drugs for which benefits are provided under part B of such title.

(d) REPORT ON PROGRESS IN IMPLEMENTATION OF PRESCRIPTION DRUG BENEFIT.—Not later than March 1, 2005, the Secretary shall submit a report to Congress on the progress that has been made in implementing the prescription drug benefit under this title. The Secretary shall include in the report specific steps that have been taken, and that need to be taken, to ensure a timely start of the program on January 1, 2006. The report shall include recommendations regarding an appropriate transition from the program under section 1860D–31 of the Social Security Act to prescription drug benefits under subpart 1 of part D of title XVIII of such Act.

(e) ADDITIONAL CONFORMING CHANGES.—

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

(2) CONFORMING AMENDMENT PERMITTING WAIVER OF COST-SHARING.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

(A) by striking “and” at the end of subparagraph (E);

(B) by striking the period at the end of subparagraph

(F) and inserting “; and”; and

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

“(G) the waiver or reduction by pharmacies (including pharmacies of the Indian Health Service, Indian tribes, tribal organizations, and urban Indian organizations) of any cost-sharing imposed under part D of title XVIII, if the conditions described in clauses (i) through (iii) of section 1128A(i)(6)(A) are met with respect to the waiver or reduction (except that, in the case of such a waiver or reduction on behalf of a subsidy eligible individual (as defined in section 1860D–14(a)(3)), section 1128A(i)(6)(A) shall be applied without regard to clauses (ii) and (iii) of that section).”

(3) MEDICARE PRESCRIPTION DRUG ACCOUNT.—

(A) Section 201(g) (42 U.S.C. 401(g)) is amended—

(i) in paragraph (1)(B)(i)(V), by inserting “(and, of such portion, the portion of such costs which should

have been borne by the Medicare Prescription Drug Account in such Trust Fund)” after “Trust Fund”; and

(ii) in paragraph (1)(B)(ii)(III), by inserting “(and, of such portion, the portion of such costs which should have been borne by the Medicare Prescription Drug Account in such Trust Fund)” after “Trust Fund”.

(B) Section 201(i)(1) (42 U.S.C. 401(i)(1)) is amended by inserting “(and for the Medicare Prescription Drug Account and the Transitional Assistance Account in such Trust Fund)” after “Federal Supplementary Medical Insurance Trust Fund”.

(C) Section 1841 (42 U.S.C. 1395t) is amended—

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

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

(II) by inserting before the period the following: “, and such amounts as may be deposited in, or appropriated to, the Medicare Prescription Drug Account established by section 1860D–16”;

(ii) in subsection (g), by adding at the end the following: “The payments provided for under part D, other than under section 1860D–31(k)(2), shall be made from the Medicare Prescription Drug Account in the Trust Fund.”;

(iii) in subsection (h), by inserting “or pursuant to section 1860D–13(c)(1) or 1854(d)(2)(A) (in which case payments shall be made in appropriate part from the Medicare Prescription Drug Account in the Trust Fund)” after “1840(d)”; and

(iv) in subsection (i), by inserting after “and section 1842(g)” the following: “and pursuant to sections 1860D–13(c)(1) and 1854(d)(2)(A) (in which case payments shall be made in appropriate part from the Medicare Prescription Drug Account in the Trust Fund)”.

(D) Section 1853(f) (42 U.S.C. 1395w–23(f)) is amended—

(i) in the heading by striking “TRUST FUND” and inserting “TRUST FUNDS”; and

(ii) by inserting after the first sentence the following: “Payments to MA organizations for statutory drug benefits provided under this title are made from the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.”.

(4) APPLICATION OF CONFIDENTIALITY FOR DRUG PRICING DATA.—Section 1927(b)(3)(D) (42 U.S.C. 1396r–8(b)(3)(D)) is amended by adding after and below clause (iii) the following: “The previous sentence shall also apply to information disclosed under section 1860D–2(d)(2) or 1860D–4(c)(2)(E).”.

(5) CLARIFICATION OF TREATMENT OF PART A ENROLLEES.—Section 1818(a) (42 U.S.C. 1395i–2(a)) is amended by adding at the end the following: “Except as otherwise provided, any reference to an individual entitled to benefits under this part includes an individual entitled to benefits under this part pursuant to an enrollment under this section or section 1818A.”.

(6) DISCLOSURE.—Section 6103(l)(7)(D)(ii) of the Internal Revenue Code of 1986 is amended by inserting “or subsidies

provided under section 1860D–14 of such Act” after “Social Security Act”.

(7) EXTENSION OF STUDY AUTHORITY.—Section 1875(b) (42 U.S.C. 1395ll(b)) is amended by striking “the insurance programs under parts A and B” and inserting “this title”.

(8) CONFORMING AMENDMENTS RELATING TO FACILITATION OF ELECTRONIC PRESCRIBING.—

(A) Section 1128B(b)(3)(C) (42 U.S.C. 1320a–7b(b)(3)(C)) is amended by inserting “or in regulations under section 1860D–3(e)(6)” after “1987”.

(B) Section 1877(b) (42 U.S.C. 1395nn(b)) is amended by adding at the end the following new paragraph:

“(5) ELECTRONIC PRESCRIBING.—An exception established by regulation under section 1860D–3(e)(6).”.

(9) OTHER CHANGES.—Section 1927(g)(1)(B)(i) (42 U.S.C. 1396r–8(g)(1)(B)(i)) is amended—

- (A) by adding “and” at the end of subclause (II); and
- (B) by striking subclause (IV).

SEC. 102. MEDICARE ADVANTAGE CONFORMING AMENDMENTS.

(a) CONFORMING AMENDMENTS TO ENROLLMENT PROCESS.—

(1) EXTENDING OPEN ENROLLMENT PERIODS.—Section 1851(e) (42 U.S.C. 1395w–21(e)) is amended—

(A) in paragraph (2), by striking “2004” and “2005” and inserting “2005” and “2006” each place it appears; and

(B) in paragraph (4), by striking “2005” and inserting “2006” each place it appears.

(2) ESTABLISHMENT OF SPECIAL ANNUAL, COORDINATED ELECTION PERIOD FOR 6 MONTHS BEGINNING NOVEMBER 15, 2005.—Section 1851(e)(3)(B) (42 U.S.C. 1395w–21(e)(3)(B)) is amended to read as follows:

“(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term ‘annual, coordinated election period’ means—

“(i) with respect to a year before 2002, the month of November before such year;

“(ii) with respect to 2002, 2003, 2004, and 2005, the period beginning on November 15 and ending on December 31 of the year before such year;

“(iii) with respect to 2006, the period beginning on November 15, 2005, and ending on May 15, 2006; and

“(iv) with respect to 2007 and succeeding years, the period beginning on November 15 and ending on December 31 of the year before such year.”.

(3) SPECIAL INFORMATION CAMPAIGN.—Section 1851(e)(3) (42 U.S.C. 1395w–21(e)(3)) is amended—

(A) in subparagraph (C), by inserting “and during the period described in subparagraph (B)(iii)” after “(beginning with 1999)”; and

(B) in subparagraph (D)—

(i) in the heading by striking “CAMPAIGN IN 1998” and inserting “CAMPAIGNS”; and

(ii) by adding at the end the following: “During the period described in subparagraph (B)(iii), the Secretary shall provide for an educational and publicity

campaign to inform MA eligible individuals about the availability of MA plans (including MA-PD plans) offered in different areas and the election process provided under this section.”

(4) COORDINATING INITIAL ENROLLMENT PERIODS.—Section 1851(e)(1) (42 U.S.C. 1395w-21(e)(1)) is amended by adding at the end the following new sentence: “If any portion of an individual’s initial enrollment period under part B occurs after the end of the annual, coordinated election period described in paragraph (3)(B)(iii), the initial enrollment period under this part shall further extend through the end of the individual’s initial enrollment period under part B.”

(5) COORDINATION OF EFFECTIVENESS OF ELECTIONS DURING ANNUAL COORDINATED ELECTION PERIOD FOR 2006.—Section 1851(f)(3) (42 U.S.C. 1395w-21(f)(3)) is amended by inserting “, other than the period described in clause (iii) of such subsection” after “subsection (e)(3)(B)”.

(6) LIMITATION ON ONE-CHANGE RULE TO SAME TYPE OF PLAN.—Section 1851(e)(2) (42 U.S.C. 1395w-21(e)(2)) is amended—

(A) in subparagraph (B)(i), by inserting “, subparagraph (C)(iii),” after “clause (ii)”;

(B) in subparagraph (C)(i), by striking “clause (ii)” and inserting “clauses (ii) and (iii)”;

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

“(iii) LIMITATION ON EXERCISE OF RIGHT WITH RESPECT TO PRESCRIPTION DRUG COVERAGE.—Effective for plan years beginning on or after January 1, 2006, in applying clause (i) (and clause (i) of subparagraph (B)) in the case of an individual who—

“(I) is enrolled in an MA plan that does provide qualified prescription drug coverage, the individual may exercise the right under such clause only with respect to coverage under the original fee-for-service plan or coverage under another MA plan that does not provide such coverage and may not exercise such right to obtain coverage under an MA-PD plan or under a prescription drug plan under part D; or

“(II) is enrolled in an MA-PD plan, the individual may exercise the right under such clause only with respect to coverage under another MA-PD plan (and not an MA plan that does not provide qualified prescription drug coverage) or under the original fee-for-service plan and coverage under a prescription drug plan under part D.”

(b) PROMOTION OF E-PRESCRIBING BY MA PLANS.—Section 1852(j) (42 U.S.C. 1395w-22(j)) is amended by adding at the end the following new paragraph:

“(7) PROMOTION OF E-PRESCRIBING BY MA PLANS.—

“(A) IN GENERAL.—An MA-PD plan may provide for a separate payment or otherwise provide for a differential payment for a participating physician that prescribes covered part D drugs in accordance with an electronic prescription drug program that meets standards established under section 1860D-4(e).

“(B) CONSIDERATIONS.—Such payment may take into consideration the costs of the physician in implementing such a program and may also be increased for those participating physicians who significantly increase—

“(i) formulary compliance;

“(ii) lower cost, therapeutically equivalent alternatives;

“(iii) reductions in adverse drug interactions; and

“(iv) efficiencies in filing prescriptions through reduced administrative costs.

“(C) STRUCTURE.—Additional or increased payments under this subsection may be structured in the same manner as medication therapy management fees are structured under section 1860D–4(c)(2)(E).”.

(c) OTHER CONFORMING AMENDMENTS.—

(1) Section 1851(a)(1) (42 U.S.C. 1395w–21(a)(1)) is amended—

(A) by inserting “(other than qualified prescription drug benefits)” after “benefits”;

(B) by striking the period at the end of subparagraph (B) and inserting a comma; and

(C) by adding after and below subparagraph (B) the following:

“and may elect qualified prescription drug coverage in accordance with section 1860D–1.”.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply on and after January 1, 2006.

SEC. 103. MEDICAID AMENDMENTS.

(a) DETERMINATIONS OF ELIGIBILITY FOR LOW-INCOME SUBSIDIES.—

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

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

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

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

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

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

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

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

“SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

“SEC. 1935. (a) REQUIREMENTS RELATING TO MEDICARE PRESCRIPTION DRUG LOW-INCOME SUBSIDIES AND MEDICARE TRANSITIONAL PRESCRIPTION DRUG ASSISTANCE.—As a condition of its State plan under this title under section 1902(a)(66) and receipt of any Federal financial assistance under section 1903(a), a State shall do the following:

“(1) INFORMATION FOR TRANSITIONAL PRESCRIPTION DRUG ASSISTANCE VERIFICATION.—The State shall provide the Secretary with information to carry out section 1860D–31(f)(3)(B)(i).

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“(2) ELIGIBILITY DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—The State shall—

“(A) make determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D–14;

“(B) inform the Secretary of such determinations in cases in which such eligibility is established; and

“(C) otherwise provide the Secretary with such information as may be required to carry out part D, other than subpart 4, of title XVIII (including section 1860D–14).

“(3) SCREENING FOR ELIGIBILITY, AND ENROLLMENT OF, BENEFICIARIES FOR MEDICARE COST-SHARING.—As part of making an eligibility determination required under paragraph (2) for an individual, the State shall make a determination of the individual’s eligibility for medical assistance for any medicare cost-sharing described in section 1905(p)(3) and, if the individual is eligible for any such medicare cost-sharing, offer enrollment to the individual under the State plan (or under a waiver of such plan).

“(b) REGULAR FEDERAL SUBSIDY OF ADMINISTRATIVE COSTS.—The amounts expended by a State in carrying out subsection (a) are expenditures reimbursable under the appropriate paragraph of section 1903(a).”

(b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID RESPONSIBILITY FOR PREMIUM AND COST-SHARING SUBSIDIES FOR DUALY ELIGIBLE INDIVIDUALS.—Section 1935, as inserted by subsection (a)(2), is amended by adding at the end the following new subsection:

“(c) FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION DRUG COSTS FOR DUALY ELIGIBLE INDIVIDUALS.—

“(1) PHASED-DOWN STATE CONTRIBUTION.—

“(A) IN GENERAL.—Each of the 50 States and the District of Columbia for each month beginning with January 2006 shall provide for payment under this subsection to the Secretary of the product of—

“(i) the amount computed under paragraph (2)(A) for the State and month;

“(ii) the total number of full-benefit dual eligible individuals (as defined in paragraph (6)) for such State and month; and

“(iii) the factor for the month specified in paragraph (5).

“(B) FORM AND MANNER OF PAYMENT.—Payment under subparagraph (A) shall be made in a manner specified by the Secretary that is similar to the manner in which State payments are made under an agreement entered into under section 1843, except that all such payments shall be deposited into the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.

“(C) COMPLIANCE.—If a State fails to pay to the Secretary an amount required under subparagraph (A), interest shall accrue on such amount at the rate provided under section 1903(d)(5). The amount so owed and applicable interest shall be immediately offset against amounts otherwise payable to the State under section

1903(a), in accordance with the Federal Claims Collection Act of 1996 and applicable regulations.

“(D) DATA MATCH.—The Secretary shall perform such periodic data matches as may be necessary to identify and compute the number of full-benefit dual eligible individuals for purposes of computing the amount under subparagraph (A).

“(2) AMOUNT.—

“(A) IN GENERAL.—The amount computed under this paragraph for a State described in paragraph (1) and for a month in a year is equal to—

“(i) $\frac{1}{12}$ of the product of—

“(I) the base year State medicaid per capita expenditures for covered part D drugs for full-benefit dual eligible individuals (as computed under paragraph (3)); and

“(II) a proportion equal to 100 percent minus the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State for the fiscal year in which the month occurs; and

“(ii) increased for each year (beginning with 2004 up to and including the year involved) by the applicable growth factor specified in paragraph (4) for that year.

“(B) NOTICE.—The Secretary shall notify each State described in paragraph (1) not later than October 15 before the beginning of each year (beginning with 2006) of the amount computed under subparagraph (A) for the State for that year.

“(3) BASE YEAR STATE MEDICAID PER CAPITA EXPENDITURES FOR COVERED PART D DRUGS FOR FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—

“(A) IN GENERAL.—For purposes of paragraph (2)(A), the ‘base year State medicaid per capita expenditures for covered part D drugs for full-benefit dual eligible individuals’ for a State is equal to the weighted average (as weighted under subparagraph (C)) of—

“(i) the gross per capita medicaid expenditures for prescription drugs for 2003, determined under subparagraph (B); and

“(ii) the estimated actuarial value of prescription drug benefits provided under a capitated managed care plan per full-benefit dual eligible individual for 2003, as determined using such data as the Secretary determines appropriate.

“(B) GROSS PER CAPITA MEDICAID EXPENDITURES FOR PRESCRIPTION DRUGS.—

“(i) IN GENERAL.—The gross per capita medicaid expenditures for prescription drugs for 2003 under this subparagraph is equal to the expenditures, including dispensing fees, for the State under this title during 2003 for covered outpatient drugs, determined per full-benefit-dual-eligible-individual for such individuals not receiving medical assistance for such drugs through a medicaid managed care plan.

“(ii) DETERMINATION.—In determining the amount under clause (i), the Secretary shall—

“(I) use data from the Medicaid Statistical Information System (MSIS) and other available data;

“(II) exclude expenditures attributable to covered outpatient prescription drugs that are not covered part D drugs (as defined in section 1860D-2(e)); and

“(III) reduce such expenditures by the product of such portion and the adjustment factor (described in clause (iii)).

“(iii) ADJUSTMENT FACTOR.—The adjustment factor described in this clause for a State is equal to the ratio for the State for 2003 of—

“(I) aggregate payments under agreements under section 1927; to

“(II) the gross expenditures under this title for covered outpatient drugs referred to in clause (i).

Such factor shall be determined based on information reported by the State in the medicaid financial management reports (form CMS-64) for the 4 quarters of calendar year 2003 and such other data as the Secretary may require.

“(C) WEIGHTED AVERAGE.—The weighted average under subparagraph (A) shall be determined taking into account—

“(i) with respect to subparagraph (A)(i), the average number of full-benefit dual eligible individuals in 2003 who are not described in clause (ii); and

“(ii) with respect to subparagraph (A)(ii), the average number of full-benefit dual eligible individuals in such year who received in 2003 medical assistance for covered outpatient drugs through a medicaid managed care plan.

“(4) APPLICABLE GROWTH FACTOR.—The applicable growth factor under this paragraph for—

“(A) each of 2004, 2005, and 2006, is the average annual percent change (to that year from the previous year) of the per capita amount of prescription drug expenditures (as determined based on the most recent National Health Expenditure projections for the years involved); and

“(B) a succeeding year, is the annual percentage increase specified in section 1860D-2(b)(6) for the year.

“(5) FACTOR.—The factor under this paragraph for a month—

“(A) in 2006 is 90 percent;

“(B) in 2007 is $88\frac{2}{3}$ percent;

“(C) in 2008 is $86\frac{2}{3}$ percent;

“(D) in 2009 is 85 percent;

“(E) in 2010 is $83\frac{1}{3}$ percent;

“(F) in 2011 is $81\frac{2}{3}$ percent;

“(G) in 2012 is 80 percent;

“(H) in 2013 is $78\frac{1}{3}$ percent;

“(I) in 2014 is $76\frac{2}{3}$ percent; or

“(J) after December 2014, is 75 percent.

“(6) FULL-BENEFIT DUAL ELIGIBLE INDIVIDUAL DEFINED.—

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“(A) IN GENERAL.—For purposes of this section, the term ‘full-benefit dual eligible individual’ means for a State for a month an individual who—

“(i) has coverage for the month for covered part D drugs under a prescription drug plan under part D of title XVIII, or under an MA–PD plan under part C of such title; and

“(ii) is determined eligible by the State for medical assistance for full benefits under this title for such month under section 1902(a)(10)(A) or 1902(a)(10)(C), by reason of section 1902(f), or under any other category of eligibility for medical assistance for full benefits under this title, as determined by the Secretary.

“(B) TREATMENT OF MEDICALLY NEEDY AND OTHER INDIVIDUALS REQUIRED TO SPEND DOWN.—In applying subparagraph (A) in the case of an individual determined to be eligible by the State for medical assistance under section 1902(a)(10)(C) or by reason of section 1902(f), the individual shall be treated as meeting the requirement of subparagraph (A)(ii) for any month if such medical assistance is provided for in any part of the month.”

(c) MEDICAID COORDINATION WITH MEDICARE PRESCRIPTION DRUG BENEFITS.—Section 1935, as so inserted and amended, is further amended by adding at the end the following new subsection:

“(d) COORDINATION OF PRESCRIPTION DRUG BENEFITS.—

“(1) MEDICARE AS PRIMARY PAYOR.—In the case of a part D eligible individual (as defined in section 1860D–1(a)(3)(A)) who is described in subsection (c)(6)(A)(ii), notwithstanding any other provision of this title, medical assistance is not available under this title for such drugs (or for any cost-sharing respecting such drugs), and the rules under this title relating to the provision of medical assistance for such drugs shall not apply. The provision of benefits with respect to such drugs shall not be considered as the provision of care or services under the plan under this title. No payment may be made under section 1903(a) for prescribed drugs for which medical assistance is not available pursuant to this paragraph.

“(2) COVERAGE OF CERTAIN EXCLUDABLE DRUGS.—In the case of medical assistance under this title with respect to a covered outpatient drug (other than a covered part D drug) furnished to an individual who is enrolled in a prescription drug plan under part D of title XVIII or an MA–PD plan under part C of such title, the State may elect to provide such medical assistance in the manner otherwise provided in the case of individuals who are not full-benefit dual eligible individuals or through an arrangement with such plan.”

(d) TREATMENT OF TERRITORIES.—

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

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

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

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

“(e) TREATMENT OF TERRITORIES.—

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“(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 and submits to the Secretary a plan described in paragraph (2) (for providing medical assistance with respect to the provision of prescription drugs to part D eligible individuals), the amount otherwise determined under section 1108(f) (as increased under section 1108(g)) for the State shall be increased by the amount for the fiscal period specified in paragraph (3).

“(2) PLAN.—The Secretary shall determine that a plan is described in this paragraph if the plan—

“(A) provides medical assistance with respect to the provision of covered part D drugs (as defined in section 1860D–2(e)) to low-income part D eligible individuals;

“(B) provides assurances that additional amounts received by the State that are attributable to the operation of this subsection shall be used only for such assistance and related administrative expenses and that no more than 10 percent of the amount specified in paragraph (3)(A) for the State for any fiscal period shall be used for such administrative expenses; and

“(C) meets such other criteria as the Secretary may establish.

“(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 ratio (as estimated by the Secretary) of—

“(I) the number of individuals who are entitled to benefits under part A or enrolled under part B and who reside in the State (as determined by the Secretary based on the most recent available data before the beginning of the year); to

“(II) the sum of such numbers for all States that submit a plan described in paragraph (2).

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

“(i) the last 3 quarters of fiscal year 2006, is equal to \$28,125,000;

“(ii) fiscal year 2007, is equal to \$37,500,000; or

“(iii) 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 1860D–2(b)(6) for the year involved.

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

(2) CONFORMING AMENDMENT.—Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting “and section 1935(e)(1)(B)” after “Subject to subsection (g)”.

(e) AMENDMENT TO BEST PRICE.—

(1) IN GENERAL.—Section 1927(c)(1)(C)(i) (42 U.S.C. 1396r–8(c)(1)(C)(i)) is amended—

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- (A) by striking “and” at the end of subclause (III);
- (B) by striking the period at the end of subclause (IV) and inserting a semicolon; and
- (C) by adding at the end the following new subclauses:

“(V) the prices negotiated from drug manufacturers for covered discount card drugs under an endorsed discount card program under section 1860D–31; and

“(VI) any prices charged which are negotiated by a prescription drug plan under part D of title XVIII, by an MA–PD plan under part C of such title with respect to covered part D drugs or by a qualified retiree prescription drug plan (as defined in section 1860D–22(a)(2)) with respect to such drugs on behalf of individuals entitled to benefits under part A or enrolled under part B of such title.”.

(2) IN GENERAL.—Section 1927(c)(1)(C)(i)(VI) of the Social Security Act, as added by paragraph (1), shall apply to prices charged for drugs dispensed on or after January 1, 2006.

(f) EXTENSION OF MEDICARE COST-SHARING FOR PART B PREMIUM FOR QUALIFYING INDIVIDUALS THROUGH SEPTEMBER 2004.—

(1) IN GENERAL.—Section 1902(a)(10)(E)(iv) (42 U.S.C. 1396a(a)(10)(E)(iv)), as amended by section 401(a) of Public Law 108–89, is amended by striking “ending with March 2004” and inserting “ending with September 2004”.

(2) TOTAL AMOUNT AVAILABLE FOR ALLOCATION.—Section 1933(g) (42 U.S.C. 1396u–3(g)), as added by section 401(c) of Public Law 108–89, is amended—

(A) in the matter preceding paragraph (1), by striking “March 31, 2004” and inserting “September 30, 2004”; and

(B) in paragraph (2), by striking “\$100,000,000” and inserting “\$300,000,000”.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to calendar quarters beginning on or after April 1, 2004.

(g) OUTREACH BY THE COMMISSIONER OF SOCIAL SECURITY.—Section 1144 (42 U.S.C. 1320b–14) is amended—

(1) in the section heading, by inserting “AND SUBSIDIES FOR LOW-INCOME INDIVIDUALS UNDER TITLE XVIII” after “COST-SHARING”;

(2) in subsection (a)—

(A) in paragraph (1)—

(i) in subparagraph (A), by inserting “for the transitional assistance under section 1860D–31(f), or for premium and cost-sharing subsidies under section 1860D–14” before the semicolon; and

(ii) in subparagraph (B), by inserting “, program, and subsidies” after “medical assistance”; and

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by inserting “, the transitional assistance under section 1860D–31(f), or premium and cost-sharing subsidies under section 1860D–14” after “assistance”; and

(ii) in subparagraph (A), by striking “such eligibility” and inserting “eligibility for medicare cost-sharing under the medicaid program”; and

(3) in subsection (b)—

(A) in paragraph (1)(A), by inserting “, for transitional assistance under section 1860D–31(f), or for premium and cost-sharing subsidies for low-income individuals under section 1860D–14” after “1933”; and

(B) in paragraph (2), by inserting “, program, and subsidies” after “medical assistance”.

SEC. 104. MEDIGAP AMENDMENTS.

(a) RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.—

(1) IN GENERAL.—Section 1882 (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

“(v) RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.—

“(1) PROHIBITION ON SALE, ISSUANCE, AND RENEWAL OF NEW POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.—

“(A) IN GENERAL.—Notwithstanding any other provision of law, on or after January 1, 2006, a medigap Rx policy (as defined in paragraph (6)(A)) may not be sold, issued, or renewed under this section—

“(i) to an individual who is a part D enrollee (as defined in paragraph (6)(B)); or

“(ii) except as provided in subparagraph (B), to an individual who is not a part D enrollee.

“(B) CONTINUATION PERMITTED FOR NON-PART D ENROLLEES.—Subparagraph (A)(ii) shall not apply to the renewal of a medigap Rx policy that was issued before January 1, 2006.

“(C) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the offering on and after January 1, 2006, of ‘H’, ‘I’, and ‘J’ policies described in paragraph (2)(D)(i) if the benefit packages are modified in accordance with paragraph (2)(C).

“(2) ELIMINATION OF DUPLICATIVE COVERAGE UPON PART D ENROLLMENT.—

“(A) IN GENERAL.—In the case of an individual who is covered under a medigap Rx policy and enrolls under a part D plan—

“(i) before the end of the initial part D enrollment period, the individual may—

“(I) enroll in a medicare supplemental policy without prescription drug coverage under paragraph (3); or

“(II) continue the policy in effect subject to the modification described in subparagraph (C)(i);

or

“(ii) after the end of such period, the individual may continue the policy in effect subject to such modification.

“(B) NOTICE REQUIRED TO BE PROVIDED TO CURRENT POLICYHOLDERS WITH MEDIGAP RX POLICY.—No medicare supplemental policy of an issuer shall be deemed to meet the standards in subsection (c) unless the issuer provides written notice (in accordance with standards of the Secretary established in consultation with the National Association of Insurance Commissioners) during the 60-

day period immediately preceding the initial part D enrollment period, to each individual who is a policyholder or certificate holder of a medigap Rx policy (at the most recent available address of that individual) of the following:

“(i) If the individual enrolls in a plan under part D during the initial enrollment period under section 1860D–1(b)(2)(A), the individual has the option of—

“(I) continuing enrollment in the individual’s current plan, but the plan’s coverage of prescription drugs will be modified under subparagraph (C)(i); or

“(II) enrolling in another medicare supplemental policy pursuant to paragraph (3).

“(ii) If the individual does not enroll in a plan under part D during such period, the individual may continue enrollment in the individual’s current plan without change, but—

“(I) the individual will not be guaranteed the option of enrollment in another medicare supplemental policy pursuant to paragraph (3); and

“(II) if the current plan does not provide creditable prescription drug coverage (as defined in section 1860D–13(b)(4)), notice of such fact and that there are limitations on the periods in a year in which the individual may enroll under a part D plan and any such enrollment is subject to a late enrollment penalty.

“(iii) Such other information as the Secretary may specify (in consultation with the National Association of Insurance Commissioners), including the potential impact of such election on premiums for medicare supplemental policies.

“(C) MODIFICATION.—

“(i) IN GENERAL.—The policy modification described in this subparagraph is the elimination of prescription coverage for expenses of prescription drugs incurred after the effective date of the individual’s coverage under a part D plan and the appropriate adjustment of premiums to reflect such elimination of coverage.

“(ii) CONTINUATION OF RENEWABILITY AND APPLICATION OF MODIFICATION.—No medicare supplemental policy of an issuer shall be deemed to meet the standards in subsection (c) unless the issuer—

“(I) continues renewability of medigap Rx policies that it has issued, subject to subclause (II); and

“(II) applies the policy modification described in clause (i) in the cases described in clauses (i)(II) and (ii) of subparagraph (A).

“(D) REFERENCES TO RX POLICIES.—

“(i) H, I, AND J POLICIES.—Any reference to a benefit package classified as ‘H’, ‘I’, or ‘J’ (including the benefit package classified as ‘J’ with a high deductible feature, as described in subsection (p)(11)) under the standards established under subsection (p)(2) shall be construed as including a reference to such a package as modified under subparagraph (C) and such packages

as modified shall not be counted as a separate benefit package under such subsection.

“(ii) APPLICATION IN WAIVERED STATES.—Except for the modification provided under subparagraph (C), the waivers previously in effect under subsection (p)(2) shall continue in effect.

“(3) AVAILABILITY OF SUBSTITUTE POLICIES WITH GUARANTEED ISSUE.—

“(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’, or ‘F’ (including the benefit package classified as ‘F’ with a high deductible feature, as described in subsection (p)(11)), under the standards established under subsection (p)(2), or a benefit package described in subparagraph (A) or (B) of subsection (w)(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 effective date of the individual’s coverage under a part D plan.

“(B) INDIVIDUAL COVERED.—An individual described in this subparagraph with respect to the issuer of a medicare supplemental policy is an individual who—

“(i) enrolls in a part D plan during the initial part D enrollment period;

“(ii) at the time of such enrollment was enrolled in a medigap Rx policy issued by such issuer; and

“(iii) terminates enrollment in such policy and submits evidence of such termination along with the application for the policy under subparagraph (A).

“(C) SPECIAL RULE FOR WAIVERED STATES.—For purposes of applying this paragraph in the case of a State that provides for offering of benefit packages other than under the classification referred to in subparagraph (A)(i), the references to benefit packages in such subparagraph are deemed references to comparable benefit packages offered in such State.

“(4) ENFORCEMENT.—

“(A) PENALTIES FOR DUPLICATION.—The penalties described in subsection (d)(3)(A)(ii) shall apply with respect to a violation of paragraph (1)(A).

“(B) GUARANTEED ISSUE.—The provisions of paragraph (4) of subsection (s) shall apply with respect to the requirements of paragraph (3) in the same manner as they apply to the requirements of such subsection.

“(5) 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 with

respect to a part D enrollee through the continuation of the policy subject to modification under paragraph (2)(C) or the offering of a substitute policy under paragraph (3). The previous sentence shall not be construed to affect the guaranteed renewability of such a modified or substitute policy.

“(6) DEFINITIONS.—For purposes of this subsection:

“(A) MEDIGAP RX POLICY.—The term ‘medigap Rx policy’ means a medicare supplemental policy—

“(i) which has a benefit package classified as ‘H’, ‘I’, or ‘J’ (including the benefit package classified as ‘J’ with a high deductible feature, as described in subsection (p)(11)) under the standards established under subsection (p)(2), without regard to this subsection; and

“(ii) to which such standards do not apply (or to which such standards have been waived under subsection (p)(6)) but which provides benefits for prescription drugs.

Such term does not include a policy with a benefit package as classified under clause (i) which has been modified under paragraph (2)(C)(i).

“(B) PART D ENROLLEE.—The term ‘part D enrollee’ means an individual who is enrolled in a part D plan.

“(C) PART D PLAN.—The term ‘part D plan’ means a prescription drug plan or an MA–PD plan (as defined for purposes of part D).

“(D) INITIAL PART D ENROLLMENT PERIOD.—The term ‘initial part D enrollment period’ means the initial enrollment period described in section 1860D–1(b)(2)(A).”

(2) CONFORMING CURRENT GUARANTEED ISSUE PROVISIONS.—

(A) EXTENDING GUARANTEED ISSUE POLICY FOR INDIVIDUALS ENROLLED IN MEDIGAP RX POLICIES WHO TRY MEDICARE ADVANTAGE.—Subsection (s)(3)(C)(ii) of such section is amended—

(i) by striking “(ii) Only” and inserting “(ii)(I) Subject to subclause (II), only”; and

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

“(II) If the medicare supplemental policy referred to in subparagraph (B)(v) was a medigap Rx policy (as defined in subsection (v)(6)(A)), a medicare supplemental policy described in this subparagraph is such policy in which the individual was most recently enrolled as modified under subsection (v)(2)(C)(i) or, at the election of the individual, a policy referred to in subsection (v)(3)(A)(i).”

(B) CONFORMING AMENDMENT.—Section 1882(s)(3)(C)(iii) is amended by inserting “and subject to subsection (v)(1)” after “subparagraph (B)(vi)”.

(b) DEVELOPMENT OF NEW STANDARDS FOR MEDIGAP POLICIES.—

(1) IN GENERAL.—Section 1882 (42 U.S.C. 1395ss) is further amended by adding at the end the following new subsection:

“(w) DEVELOPMENT OF NEW STANDARDS FOR MEDICARE SUPPLEMENTAL POLICIES.—

“(1) IN GENERAL.—The Secretary shall request the National Association of Insurance Commissioners to review and revise the standards for benefit packages under subsection (p)(1), taking into account the changes in benefits resulting from

enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and to otherwise update standards to reflect other changes in law included in such Act. Such revision shall incorporate the inclusion of the 2 benefit packages described in paragraph (2). Such revisions shall be made consistent with the rules applicable under subsection (p)(1)(E) with the reference to the ‘1991 NAIC Model Regulation’ deemed a reference to the NAIC Model Regulation as published in the Federal Register on December 4, 1998, and as subsequently updated by the National Association of Insurance Commissioners to reflect previous changes in law (and subsection (v)) and the reference to ‘date of enactment of this subsection’ deemed a reference to the date of enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. To the extent practicable, such revision shall provide for the implementation of revised standards for benefit packages as of January 1, 2006.

“(2) NEW BENEFIT PACKAGES.—The benefit packages described in this paragraph are the following (notwithstanding any other provision of this section relating to a core benefit package):

“(A) FIRST NEW BENEFIT PACKAGE.—A benefit package consisting of the following:

“(i) Subject to clause (ii), coverage of 50 percent of the cost-sharing otherwise applicable under parts A and B, except there shall be no coverage of the part B deductible and coverage of 100 percent of any cost-sharing otherwise applicable for preventive benefits.

“(ii) Coverage for all hospital inpatient coinsurance and 365 extra lifetime days of coverage of inpatient hospital services (as in the current core benefit package).

“(iii) A limitation on annual out-of-pocket expenditures under parts A and B to \$4,000 in 2006 (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 BENEFIT PACKAGE.—A benefit package consisting of the benefit package 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 (iii) of such subparagraph.”.

(2) CONFORMING AMENDMENTS.—Section 1882 (42 U.S.C. 1395ss) is amended—

(A) in subsection (g)(1), by inserting “a prescription drug plan under part D or” after “but does not include”; and

(B) in subsection (o)(1), by striking “subsection (p)” and inserting “subsections (p), (v), and (w)”.

(c) RULE OF CONSTRUCTION.—

(1) IN GENERAL.—Nothing in this Act shall be construed to require an issuer of a medicare supplemental policy under section 1882 of the Social Security Act (42 U.S.C. 1395rr) to participate as a PDP sponsor under part D of title XVIII of

such Act, as added by section 101, as a condition for issuing such policy.

(2) PROHIBITION ON STATE REQUIREMENT.—A State may not require an issuer of a medicare supplemental policy under section 1882 of the Social Security Act (42 U.S.C. 1395rr) to participate as a PDP sponsor under such part D as a condition for issuing such policy.

SEC. 105. ADDITIONAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG DISCOUNT CARD AND TRANSITIONAL ASSISTANCE PROGRAM.

(a) EXCLUSION OF COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.—Section 1839(g) (42 U.S.C. 1395r(g)) is amended—

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

“(1) the application of section”;

(2) by striking the period and inserting “; and”; and

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

“(2) the medicare prescription drug discount card and transitional assistance program under section 1860D–31.”.

(b) APPLICATION OF CONFIDENTIALITY FOR DRUG PRICING DATA.—The last sentence of section 1927(b)(3)(D) (42 U.S.C. 1396r–8(b)(3)(D)), as added by section 101(e)(4), is amended by inserting “and drug pricing data reported under the first sentence of section 1860D–31(i)(1)” after “section 1860D–4(c)(2)(E)”.

(c) RULES FOR IMPLEMENTATION.—The following rules shall apply to the medicare prescription drug discount card and transitional assistance program under section 1860D–31 of the Social Security Act, as added by section 101(a):

(1) In promulgating regulations pursuant to subsection (a)(2)(B) of such section 1860D–31—

(A) section 1871(a)(3) of the Social Security Act (42 U.S.C. 1395hh(a)(3)), as added by section 902(a)(1), shall not apply;

(B) chapter 35 of title 44, United States Code, shall not apply; and

(C) sections 553(d) and 801(a)(3)(A) of title 5, United States Code, shall not apply.

(2) Section 1857(c)(5) of the Social Security Act (42 U.S.C. 1395w–27(c)(5)) shall apply with respect to section 1860D–31 of such Act, as added by section 101(a), in the same manner as it applies to part C of title XVIII of such Act.

(3) The administration of such program shall be made without regard to chapter 35 of title 44, United States Code.

(4)(A) There shall be no judicial review of a determination not to endorse, or enter into a contract, with a prescription drug card sponsor under section 1860D–31 of the Social Security Act.

(B) In the case of any order issued to enjoin any provision of section 1860D–31 of the Social Security Act (or of any provision of this section), such order shall not affect any other provision of such section (or of this section) and all such provisions shall be treated as severable.

(d) CONFORMING AMENDMENTS TO FEDERAL SMI TRUST FUND FOR TRANSITIONAL ASSISTANCE ACCOUNT.—Section 1841 (42 U.S.C. 1395t), as amended by section 101(e)(3)(C), is amended—

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(1) in the last sentence of subsection (a), by inserting after “section 1860D–16” the following: “or the Transitional Assistance Account established by section 1860D–31(k)(1)”; and

(2) in subsection (g), by adding at the end the following: “The payments provided for under section 1860D–31(k)(2) shall be made from the Transitional Assistance Account in the Trust Fund.”.

(e) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF PROVIDING TRANSITIONAL ASSISTANCE UNDER MEDICARE DISCOUNT CARD PROGRAM.—

(1) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating to disclosure of returns and return information for purposes other than tax administration) is amended by adding at the end the following new paragraph:

“(19) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF PROVIDING TRANSITIONAL ASSISTANCE UNDER MEDICARE DISCOUNT CARD PROGRAM.—

“(A) IN GENERAL.—The Secretary, upon written request from the Secretary of Health and Human Services pursuant to carrying out section 1860D–31 of the Social Security Act, shall disclose to officers, employees, and contractors of the Department of Health and Human Services with respect to a taxpayer for the applicable year—

“(i)(I) whether the adjusted gross income, as modified in accordance with specifications of the Secretary of Health and Human Services for purposes of carrying out such section, of such taxpayer and, if applicable, such taxpayer’s spouse, for the applicable year, exceeds the amounts specified by the Secretary of Health and Human Services in order to apply the 100 and 135 percent of the poverty lines under such section, (II) whether the return was a joint return, and (III) the applicable year, or

“(ii) if applicable, the fact that there is no return filed for such taxpayer for the applicable year.

“(B) DEFINITION OF APPLICABLE YEAR.—For the purposes of this subsection, the term ‘applicable year’ means the most recent taxable year for which information is available in the Internal Revenue Service’s taxpayer data information systems, or, if there is no return filed for such taxpayer for such year, the prior taxable year.

“(C) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under this paragraph may be used only for the purposes of determining eligibility for and administering transitional assistance under section 1860D–31 of the Social Security Act.”.

(2) CONFIDENTIALITY.—Paragraph (3) of section 6103(a) of such Code is amended by striking “or (16)” and inserting “(16), or (19)”.

(3) PROCEDURES AND RECORDKEEPING RELATED TO DISCLOSURES.—Subsection (p)(4) of section 6103 of such Code is amended by striking “(l)(16) or (17)” each place it appears and inserting “(l)(16), (17), or (19)”.

(4) UNAUTHORIZED DISCLOSURE OR INSPECTION.—Paragraph (2) of section 7213(a) of such Code is amended by striking “or (16)” and inserting “(16), or (19)”.

SEC. 106. STATE PHARMACEUTICAL ASSISTANCE TRANSITION COMMISSION.

(a) **ESTABLISHMENT.**—

(1) **IN GENERAL.**—There is established, as of the first day of the third month beginning after the date of the enactment of this Act, a State Pharmaceutical Assistance Transition Commission (in this section referred to as the “Commission”) to develop a proposal for addressing the unique transitional issues facing State pharmaceutical assistance programs, and program participants, due to the implementation of the voluntary prescription drug benefit program under part D of title XVIII of the Social Security Act, as added by section 101.

(2) **DEFINITIONS.**—For purposes of this section:

(A) **STATE PHARMACEUTICAL ASSISTANCE PROGRAM DEFINED.**—The term “State pharmaceutical assistance program” means a program (other than the medicaid program) operated by a State (or under contract with a State) that provides as of the date of the enactment of this Act financial assistance to medicare beneficiaries for the purchase of prescription drugs.

(B) **PROGRAM PARTICIPANT.**—The term “program participant” means a low-income medicare beneficiary who is a participant in a State pharmaceutical assistance program.

(b) **COMPOSITION.**—The Commission shall include the following:

(1) A representative of each Governor of each State that the Secretary identifies as operating on a statewide basis a State pharmaceutical assistance program that provides for eligibility and benefits that are comparable or more generous than the low-income assistance eligibility and benefits offered under section 1860D–14 of the Social Security Act.

(2) Representatives from other States that the Secretary identifies have in operation other State pharmaceutical assistance programs, as appointed by the Secretary.

(3) Representatives of organizations that have an inherent interest in program participants or the program itself, as appointed by the Secretary but not to exceed the number of representatives under paragraphs (1) and (2).

(4) Representatives of Medicare Advantage organizations, pharmaceutical benefit managers, and other private health insurance plans, as appointed by the Secretary.

(5) The Secretary (or the Secretary’s designee) and such other members as the Secretary may specify.

The Secretary shall designate a member to serve as Chair of the Commission and the Commission shall meet at the call of the Chair.

(c) **DEVELOPMENT OF PROPOSAL.**—The Commission shall develop the proposal described in subsection (a) in a manner consistent with the following principles:

(1) Protection of the interests of program participants in a manner that is the least disruptive to such participants and that includes a single point of contact for enrollment and processing of benefits.

(2) Protection of the financial and flexibility interests of States so that States are not financially worse off as a result of the enactment of this title.

(3) Principles of medicare modernization under this Act.

(d) REPORT.—By not later than January 1, 2005, the Commission shall submit to the President and Congress a report that contains a detailed proposal (including specific legislative or administrative recommendations, if any) and such other recommendations as the Commission deems appropriate.

(e) SUPPORT.—The Secretary shall provide the Commission with the administrative support services necessary for the Commission to carry out its responsibilities under this section.

(f) TERMINATION.—The Commission shall terminate 30 days after the date of submission of the report under subsection (d).

SEC. 107. STUDIES AND REPORTS.

(a) STUDY REGARDING REGIONAL VARIATIONS IN PRESCRIPTION DRUG SPENDING.—

(1) IN GENERAL.—The Secretary shall conduct a study that examines variations in per capita spending for covered part D drugs under part D of title XVIII of the Social Security Act among PDP regions and, with respect to such spending, the amount of such variation that is attributable to—

(A) price variations (described in section 1860D–15(c)(2) of such Act); and

(B) differences in per capita utilization that is not taken into account in the health status risk adjustment provided under section 1860D–15(c)(1) of such Act.

(2) REPORT AND RECOMMENDATIONS.—Not later than January 1, 2009, the Secretary shall submit to Congress a report on the study conducted under paragraph (1). Such report shall include—

(A) information regarding the extent of geographic variation described in paragraph (1)(B);

(B) an analysis of the impact on direct subsidies under section 1860D–15(a)(1) of the Social Security Act in different PDP regions if such subsidies were adjusted to take into account the variation described in subparagraph (A); and

(C) recommendations regarding the appropriateness of applying an additional geographic adjustment factor under section 1860D–15(c)(2) that reflects some or all of the variation described in subparagraph (A).

(b) REVIEW AND REPORT ON CURRENT STANDARDS OF PRACTICE FOR PHARMACY SERVICES PROVIDED TO PATIENTS IN NURSING FACILITIES.—

(1) REVIEW.—

(A) IN GENERAL.—Not later than 12 months after the date of the enactment of this Act, the Secretary shall conduct a thorough review of the current standards of practice for pharmacy services provided to patients in nursing facilities.

(B) SPECIFIC MATTERS REVIEWED.—In conducting the review under subparagraph (A), the Secretary shall—

(i) assess the current standards of practice, clinical services, and other service requirements generally used for pharmacy services in long-term care settings; and

(ii) evaluate the impact of those standards with respect to patient safety, reduction of medication errors and quality of care.

(2) REPORT.—

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(A) IN GENERAL.—Not later than the date that is 18 months after the date of the enactment of this Act, the Secretary shall submit a report to Congress on the study conducted under paragraph (1)(A).

(B) CONTENTS.—The report submitted under subparagraph (A) shall contain—

(i) a description of the plans of the Secretary to implement the provisions of this Act in a manner consistent with applicable State and Federal laws designed to protect the safety and quality of care of nursing facility patients; and

(ii) recommendations regarding necessary actions and appropriate reimbursement to ensure the provision of prescription drugs to medicare beneficiaries residing in nursing facilities in a manner consistent with existing patient safety and quality of care standards under applicable State and Federal laws.

(c) IOM STUDY ON DRUG SAFETY AND QUALITY.—

(1) IN GENERAL.—The Secretary shall enter into a contract with the Institutes of Medicine of the National Academies of Science (such Institutes referred to in this subsection as the “IOM”) to carry out a comprehensive study (in this subsection referred to as the “study”) of drug safety and quality issues in order to provide a blueprint for system-wide change.

(2) OBJECTIVES.—

(A) The study shall develop a full understanding of drug safety and quality issues through an evidence-based review of literature, case studies, and analysis. This review will consider the nature and causes of medication errors, their impact on patients, the differences in causation, impact, and prevention across multiple dimensions of health care delivery—including patient populations, care settings, clinicians, and institutional cultures.

(B) The study shall attempt to develop credible estimates of the incidence, severity, costs of medication errors that can be useful in prioritizing resources for national quality improvement efforts and influencing national health care policy.

(C) The study shall evaluate alternative approaches to reducing medication errors in terms of their efficacy, cost-effectiveness, appropriateness in different settings and circumstances, feasibility, institutional barriers to implementation, associated risks, and the quality of evidence supporting the approach.

(D) The study shall provide guidance to consumers, providers, payers, and other key stakeholders on high-priority strategies to achieve both short-term and long-term drug safety goals, to elucidate the goals and expected results of such initiatives and support the business case for them, and to identify critical success factors and key levers for achieving success.

(E) The study shall assess the opportunities and key impediments to broad nationwide implementation of medication error reductions, and to provide guidance to policymakers and government agencies (including the Food and Drug Administration, the Centers for Medicare & Medicaid

Services, and the National Institutes of Health) in promoting a national agenda for medication error reduction.

(F) The study shall develop an applied research agenda to evaluate the health and cost impacts of alternative interventions, and to assess collaborative public and private strategies for implementing the research agenda through AHRQ and other government agencies.

(3) CONDUCT OF STUDY.—

(A) EXPERT COMMITTEE.—In conducting the study, the IOM shall convene a committee of leading experts and key stakeholders in pharmaceutical management and drug safety, including clinicians, health services researchers, pharmacists, system administrators, payer representatives, and others.

(B) COMPLETION.—The study shall be completed within an 18-month period.

(4) REPORT.—A report on the study shall be submitted to Congress upon the completion of the study.

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

(d) STUDY OF MULTI-YEAR CONTRACTS.—

(1) IN GENERAL.—The Secretary shall provide for a study on the feasibility and advisability of providing for contracting with PDP sponsors and MA organizations under parts C and D of title XVIII on a multi-year basis.

(2) REPORT.—Not later than January 1, 2007, the Secretary shall submit to Congress a report on the study under paragraph (1). The report shall include such recommendations as the Secretary deems appropriate.

(e) GAO STUDY REGARDING IMPACT OF ASSETS TEST FOR SUBSIDY ELIGIBLE INDIVIDUALS.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to determine the extent to which drug utilization and access to covered part D drugs under part D of title XVIII of the Social Security Act by subsidy eligible individuals differs from such utilization and access for individuals who would qualify as such subsidy eligible individuals but for the application of section 1860D–14(a)(3)(A)(iii) of such Act.

(2) REPORT.—Not later than September 30, 2007, the Comptroller General shall submit a report to Congress on the study conducted under paragraph (1) that includes such recommendations for legislation as the Comptroller General determines are appropriate.

(f) STUDY ON MAKING PRESCRIPTION PHARMACEUTICAL INFORMATION ACCESSIBLE FOR BLIND AND VISUALLY-IMPAIRED INDIVIDUALS.—

(1) STUDY.—

(A) IN GENERAL.—The Secretary shall undertake a study of how to make prescription pharmaceutical information, including drug labels and usage instructions, accessible to blind and visually-impaired individuals.

(B) STUDY TO INCLUDE EXISTING AND EMERGING TECHNOLOGIES.—The study under subparagraph (A) shall include a review of existing and emerging technologies, including assistive technology, that makes essential

information on the content and prescribed use of pharmaceutical medicines available in a usable format for blind and visually-impaired individuals.

(2) REPORT.—

(A) IN GENERAL.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall submit a report to Congress on the study required under paragraph (1).

(B) CONTENTS OF REPORT.—The report required under paragraph (1) shall include recommendations for the implementation of usable formats for making prescription pharmaceutical information available to blind and visually-impaired individuals and an estimate of the costs associated with the implementation of each format.

SEC. 108. GRANTS TO PHYSICIANS TO IMPLEMENT ELECTRONIC PRESCRIPTION DRUG PROGRAMS.

(a) IN GENERAL.—The Secretary is authorized to make grants to physicians for the purpose of assisting such physicians to implement electronic prescription drug programs that comply with the standards promulgated or modified under section 1860D-4(e) of the Social Security Act, as inserted by section 101(a).

(b) AWARDING OF GRANTS.—

(1) APPLICATION.—No grant may be made under this section except pursuant to a grant application that is submitted and approved in a time, manner, and form specified by the Secretary.

(2) CONSIDERATIONS AND PREFERENCES.—In awarding grants under this section, the Secretary shall—

(A) give special consideration to physicians who serve a disproportionate number of medicare patients; and

(B) give preference to physicians who serve a rural or underserved area.

(3) LIMITATION ON GRANTS.—Only 1 grant may be awarded under this section with respect to any physician or group practice of physicians.

(c) TERMS AND CONDITIONS.—

(1) IN GENERAL.—Grants under this section shall be made under such terms and conditions as the Secretary specifies consistent with this section.

(2) USE OF GRANT FUNDS.—Funds provided under grants under this section may be used for any of the following:

(A) For purchasing, leasing, and installing computer software and hardware, including handheld computer technologies.

(B) Making upgrades and other improvements to existing computer software and hardware to enable e-prescribing.

(C) Providing education and training to eligible physician staff on the use of technology to implement the electronic transmission of prescription and patient information.

(3) PROVISION OF INFORMATION.—As a condition for the awarding of a grant under this section, an applicant shall provide to the Secretary such information as the Secretary may require in order to—

(A) evaluate the project for which the grant is made; and

(B) ensure that funding provided under the grant is expended only for the purposes for which it is made.

(4) AUDIT.—The Secretary shall conduct appropriate audits of grants under this section.

(5) MATCHING REQUIREMENT.—The applicant for a grant under this section shall agree, with respect to the costs to be incurred by the applicant in implementing an electronic prescription drug program, to make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount that is not less than 50 percent of such costs. Non-Federal contributions under the previous sentence may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section \$50,000,000 for fiscal year 2007 and such sums as may be necessary for each of fiscal years 2008 and 2009.

SEC. 109. EXPANDING THE WORK OF MEDICARE QUALITY IMPROVEMENT ORGANIZATIONS TO INCLUDE PARTS C AND D.

(a) APPLICATION TO MEDICARE MANAGED CARE AND PRESCRIPTION DRUG COVERAGE.—Section 1154(a)(1) (42 U.S.C. 1320c-3(a)(1)) is amended by inserting “, to Medicare Advantage organizations pursuant to contracts under part C, and to prescription drug sponsors pursuant to contracts under part D” after “under section 1876”.

(b) PRESCRIPTION DRUG THERAPY QUALITY IMPROVEMENT.—Section 1154(a) (42 U.S.C. 1320c-3(a)) is amended by adding at the end the following new paragraph:

“(17) The organization shall execute its responsibilities under subparagraphs (A) and (B) of paragraph (1) by offering to providers, practitioners, Medicare Advantage organizations offering Medicare Advantage plans under part C, and prescription drug sponsors offering prescription drug plans under part D quality improvement assistance pertaining to prescription drug therapy. For purposes of this part and title XVIII, the functions described in this paragraph shall be treated as a review function.”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply on and after January 1, 2004.

(d) IOM STUDY OF QIOS.—

(1) IN GENERAL.—The Secretary shall request the Institute of Medicine of the National Academy of Sciences to conduct an evaluation of the program under part B of title XI of the Social Security Act. The study shall include a review of the following:

(A) An overview of the program under such part.

(B) The duties of organizations with contracts with the Secretary under such part.

(C) The extent to which quality improvement organizations improve the quality of care for medicare beneficiaries.

(D) The extent to which other entities could perform such quality improvement functions as well as, or better than, quality improvement organizations.

(E) The effectiveness of reviews and other actions conducted by such organizations in carrying out those duties.

(F) The source and amount of funding for such organizations.

(G) The conduct of oversight of such organizations.

(2) REPORT TO CONGRESS.—Not later than June 1, 2006, the Secretary shall submit to Congress a report on the results of the study described in paragraph (1), including any recommendations for legislation.

(3) INCREASED COMPETITION.—If the Secretary finds based on the study conducted under paragraph (1) that other entities could improve quality in the medicare program as well as, or better than, the current quality improvement organizations, then the Secretary shall provide for such increased competition through the addition of new types of entities which may perform quality improvement functions.

SEC. 110. CONFLICT OF INTEREST STUDY.

(a) STUDY.—The Federal Trade Commission shall conduct a study of differences in payment amounts for pharmacy services provided to enrollees in group health plans that utilize pharmacy benefit managers. Such study shall include the following:

(1) An assessment of the differences in costs incurred by such enrollees and plans for prescription drugs dispensed by mail-order pharmacies owned by pharmaceutical benefit managers compared to mail-order pharmacies not owned by pharmaceutical benefit managers, and community pharmacies.

(2) Whether such plans are acting in a manner that maximizes competition and results in lower prescription drug prices for enrollees.

(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Commission shall submit to Congress a report on the study conducted under subsection (a). Such report shall include recommendations regarding any need for legislation to ensure the fiscal integrity of the voluntary prescription drug benefit program under part D of title XVIII, as added by section 101, that may be appropriated as the result of such study.

(c) EXEMPTION FROM PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code, shall not apply to the collection of information under subsection (a).

SEC. 111. STUDY ON EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.

(a) STUDY.—The Comptroller General of the United States shall conduct an initial and final study under this subsection to examine trends in employment-based retiree health coverage (as defined in 1860D–22(c)(1) of the Social Security Act, as added by section 101), including coverage under the Federal Employees Health Benefits Program (FEHBP), and the options and incentives available under this Act which may have an effect on the voluntary provision of such coverage.

(b) CONTENT OF INITIAL STUDY.—The initial study under this section shall consider the following:

(1) Trends in employment-based retiree health coverage prior to the date of the enactment of this Act.

(2) The opinions of sponsors of employment-based retiree health coverage concerning which of the options available under this Act they are most likely to utilize for the provision of

health coverage to their medicare-eligible retirees, including an assessment of the administrative burdens associated with the available options.

(3) The likelihood of sponsors of employment-based retiree health coverage to maintain or adjust their levels of retiree health benefits beyond coordination with medicare, including for prescription drug coverage, provided to medicare-eligible retirees after the date of the enactment of this Act.

(4) The factors that sponsors of employment-based retiree health coverage expect to consider in making decisions about any changes they may make in the health coverage provided to medicare-eligible retirees.

(5) Whether the prescription drug plan options available, or the health plan options available under the Medicare Advantage program, are likely to cause employers and other entities that did not provide health coverage to retirees prior to the date of the enactment of this Act to provide supplemental coverage or contributions toward premium expenses for medicare-eligible retirees who may enroll in such options in the future.

(c) CONTENTS OF FINAL STUDY.—The final study under this section shall consider the following:

(1) Changes in the trends in employment-based retiree health coverage since the completion of the initial study by the Comptroller General.

(2) Factors contributing to any changes in coverage levels.

(3) The number and characteristics of sponsors of employment-based retiree health coverage who receive the special subsidy payments under section 1860D–22 of the Social Security Act, as added by section 101, for the provision of prescription drug coverage to their medicare-eligible retirees that is the same or greater actuarial value as the prescription drug coverage available to other medicare beneficiaries without employment-based retiree health coverage.

(4) The extent to which sponsors of employment-based retiree health coverage provide supplemental health coverage or contribute to the premiums for medicare-eligible retirees who enroll in a prescription drug plan or an MA–PD plan.

(5) Other coverage options, including tax-preferred retirement or health savings accounts, consumer-directed health plans, or other vehicles that sponsors of employment-based retiree health coverage believe would assist retirees with their future health care needs and their willingness to sponsor such alternative plan designs.

(6) The extent to which employers or other entities that did not provide employment-based retiree health coverage prior to the date of the enactment of this Act provided some form of coverage or financial assistance for retiree health care needs after the date of the enactment of this Act.

(7) Recommendations by employers, benefits experts, academics, and others on ways that the voluntary provision of employment-based retiree health coverage may be improved and expanded.

(d) REPORTS.—The Comptroller General shall submit a report to Congress on—

(1) the initial study under subsection (b) not later than 1 year after the date of the enactment of this Act; and

(2) the final study under subsection (c) not later than January 1, 2007.

(e) CONSULTATION.—The Comptroller General shall consult with sponsors of employment-based retiree health coverage, benefits experts, human resources professionals, employee benefits consultants, and academics with experience in health benefits and survey research in the development and design of the initial and final studies under this section.

TITLE II—MEDICARE ADVANTAGE

Subtitle A—Implementation of Medicare Advantage Program

SEC. 201. IMPLEMENTATION OF MEDICARE ADVANTAGE PROGRAM.

(a) IN GENERAL.—There is hereby established the Medicare Advantage program. The Medicare Advantage program shall consist of the program under part C of title XVIII of the Social Security Act (as amended by this Act).

(b) REFERENCES.—Subject to subsection (c), any reference to the program under part C of title XVIII of the Social Security Act shall be deemed a reference to the Medicare Advantage program and, with respect to such part, any reference to “Medicare+Choice” is deemed a reference to “Medicare Advantage” and “MA”.

(c) TRANSITION.—In order to provide for an orderly transition and avoid beneficiary and provider confusion, the Secretary shall provide for an appropriate transition in the use of the terms “Medicare+Choice” and “Medicare Advantage” (or “MA”) in reference to the program under part C of title XVIII of the Social Security Act. Such transition shall be fully completed for all materials for plan years beginning not later than January 1, 2006. Before the completion of such transition, any reference to “Medicare Advantage” or “MA” shall be deemed to include a reference to “Medicare+Choice”.

Subtitle B—Immediate Improvements

SEC. 211. IMMEDIATE IMPROVEMENTS.

(a) EQUALIZING PAYMENTS WITH FEE-FOR-SERVICE.—

(1) IN GENERAL.—Section 1853(c)(1) (42 U.S.C. 1395w–23(c)(1)) is amended by adding at the end the following:

“(D) 100 PERCENT OF FEE-FOR-SERVICE COSTS.—

“(i) IN GENERAL.—For each year specified in clause (ii), the adjusted average per capita cost for the year involved, determined under section 1876(a)(4) and adjusted as appropriate for the purpose of risk adjustment, for the MA payment area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1886(h).

“(ii) PERIODIC REBASING.—The provisions of clause (i) shall apply for 2004 and for subsequent years as the Secretary shall specify (but not less than once every 3 years).

“(iii) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the adjusted average per capita cost under clause (i) for a year, such cost shall be adjusted to include the Secretary’s estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.”.

(2) CONFORMING AMENDMENT.—Such section is further amended, in the matter before subparagraph (A), by striking “or (C)” and inserting “(C), or (D)”.

(b) CHANGE IN BUDGET NEUTRALITY FOR BLEND.—Section 1853(c) (42 U.S.C. 1395w–23(c)) is amended—

(1) in paragraph (1)(A), by inserting “(for a year other than 2004)” after “multiplied”; and

(2) in paragraph (5), by inserting “(other than 2004)” after “for each year”.

(c) INCREASING MINIMUM PERCENTAGE INCREASE TO NATIONAL GROWTH RATE.—

(1) IN GENERAL.—Section 1853(c)(1) (42 U.S.C. 1395w–23(c)(1)) is amended—

(A) in subparagraph (A), by striking “The sum” and inserting “For a year before 2005, the sum”;

(B) in subparagraph (B)(iv), by striking “and each succeeding year” and inserting “, 2003, and 2004”;

(C) in subparagraph (C)(iv), by striking “and each succeeding year” and inserting “and 2003”; and

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

“(v) For 2004 and each succeeding year, the greater of—

“(I) 102 percent of the annual MA capitation rate under this paragraph for the area for the previous year; or

“(II) the annual MA capitation rate under this paragraph for the area for the previous year increased by the national per capita MA growth percentage, described in paragraph (6) for that succeeding year, but not taking into account any adjustment under paragraph (6)(C) for a year before 2004.”.

(2) CONFORMING AMENDMENT.—Section 1853(c)(6)(C) (42 U.S.C. 1395w–23(c)(6)(C)) is amended by inserting before the period at the end the following: “, except that for purposes of paragraph (1)(C)(v)(II), no such adjustment shall be made for a year before 2004”.

(d) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES IN CALCULATION OF PAYMENT RATES.—Section 1853(c)(3) (42 U.S.C. 1395w–23(c)(3)) is amended—

(1) in subparagraph (A), by striking “subparagraph (B)” and inserting “subparagraphs (B) and (E)”; and

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

“(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.— In determining the area-specific MA capitation rate under subparagraph (A) for a year (beginning with 2004), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary’s estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.”.

(e) EXTENDING SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS TO REHABILITATION HOSPITALS AND LONG-TERM CARE HOSPITALS.—

(1) IN GENERAL.—Section 1853(g) (42 U.S.C. 1395w–23(g)) is amended—

(A) in the matter preceding paragraph (1), by inserting “, a rehabilitation hospital described in section 1886(d)(1)(B)(ii) or a distinct part rehabilitation unit described in the matter following clause (v) of section 1886(d)(1)(B), or a long-term care hospital (described in section 1886(d)(1)(B)(iv))” after “1886(d)(1)(B)”; and

(B) in paragraph (2)(B), by inserting “or other payment provision under this title for inpatient services for the type of facility, hospital, or unit involved, described in the matter preceding paragraph (1), as the case may be,” after “1886(d)”.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to contract years beginning on or after January 1, 2004.

(f) MEDPAC STUDY OF AAPCC.—

(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study that assesses the method used for determining the adjusted average per capita cost (AAPCC) under section 1876(a)(4) of the Social Security Act (42 U.S.C. 1395mm(a)(4)) as applied under section 1853(c)(1)(A) of such Act (as amended by subsection (a)). Such study shall include an examination of—

(A) the bases for variation in such costs between different areas, including differences in input prices, utilization, and practice patterns;

(B) the appropriate geographic area for payment of MA local plans under the Medicare Advantage program under part C of title XVIII of such Act; and

(C) the accuracy of risk adjustment methods in reflecting differences in costs of providing care to different groups of beneficiaries served under such program.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Commission shall submit to Congress a report on the study conducted under paragraph (1).

(g) REPORT ON IMPACT OF INCREASED FINANCIAL ASSISTANCE TO MEDICARE ADVANTAGE PLANS.—Not later than July 1, 2006, the Secretary shall submit to Congress a report that describes the impact of additional financing provided under this Act and other Acts (including the Medicare, Medicaid, and SCHIP Balanced

Budget Refinement Act of 1999 and BIPA) on the availability of Medicare Advantage plans in different areas and its impact on lowering premiums and increasing benefits under such plans.

(h) MEDPAC STUDY AND REPORT ON CLARIFICATION OF AUTHORITY REGARDING DISAPPROVAL OF UNREASONABLE BENEFICIARY COST-SHARING.—

(1) STUDY.—The Medicare Payment Advisory Commission, in consultation with beneficiaries, consumer groups, employers, and organizations offering plans under part C of title XVIII of the Social Security Act, shall conduct a study to determine the extent to which the cost-sharing structures under such plans affect access to covered services or select enrollees based on the health status of eligible individuals described in section 1851(a)(3) of the Social Security Act (42 U.S.C. 1395w–21(a)(3)).

(2) REPORT.—Not later than December 31, 2004, the Commission shall submit a report to Congress on the study conducted under paragraph (1) together with recommendations for such legislation and administrative actions as the Commission considers appropriate.

(i) IMPLEMENTATION OF PROVISIONS.—

(1) ANNOUNCEMENT OF REVISED MEDICARE ADVANTAGE PAYMENT RATES.—Within 6 weeks after the date of the enactment of this Act, the Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties) MA capitation rates under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for 2004, revised in accordance with the provisions of this section.

(2) TRANSITION TO REVISED PAYMENT RATES.—The provisions of section 604 of BIPA (114 Stat. 2763A–555) (other than subsection (a)) shall apply to the provisions of subsections (a) through (d) of this section for 2004 in the same manner as the provisions of such section 604 applied to the provisions of BIPA for 2001.

(3) SPECIAL RULE FOR PAYMENT RATES IN 2004.—

(A) JANUARY AND FEBRUARY.—Notwithstanding the amendments made by subsections (a) through (d), for purposes of making payments under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for January and February 2004, the annual capitation rate for a payment area shall be calculated and the excess amount under section 1854(f)(1)(B) of such Act (42 U.S.C. 1395w–24(f)(1)(B)) shall be determined as if such amendments had not been enacted.

(B) MARCH THROUGH DECEMBER.—Notwithstanding the amendments made by subsections (a) through (d), for purposes of making payments under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for March through December 2004, the annual capitation rate for a payment area shall be calculated and the excess amount under section 1854(f)(1)(B) of such Act (42 U.S.C. 1395w–24(f)(1)(B)) shall be determined, in such manner as the Secretary estimates will ensure that the total of such payments with respect to 2004 is the same as the amounts that would have been if subparagraph (A) had not been enacted.

(C) CONSTRUCTION.—Subparagraphs (A) and (B) shall not be taken into account in computing such capitation rate for 2005 and subsequent years.

(4) **PLANS REQUIRED TO PROVIDE NOTICE OF CHANGES IN PLAN BENEFITS.**—In the case of an organization offering a plan under part C of title XVIII of the Social Security Act that revises its submission of the information described in section 1854(a)(1) of such Act (42 U.S.C. 1395w–23(a)(1)) for a plan pursuant to the application of paragraph (2), if such revision results in changes in beneficiary premiums, beneficiary cost-sharing, or benefits under the plan, then by not later than 3 weeks after the date the Secretary approves such submission, the organization offering the plan shall provide each beneficiary enrolled in the plan with written notice of such changes.

(5) **LIMITATION ON REVIEW.**—There shall be no administrative or judicial review under section 1869 or section 1878 of the Social Security Act (42 U.S.C. 1395ff and 1395oo), or otherwise of any determination made by the Secretary under this subsection or the application of the payment rates determined pursuant to this subsection.

(j) **ADDITIONAL AMENDMENTS.**—Section 1852(d)(4) (42 U.S.C. 1395w–22(d)(4)) is amended—

(1) in subparagraph (B), by inserting “(other than deemed contracts or agreements under subsection (j)(6))” after “the plan has contracts or agreements”; and

(2) in the last sentence, by inserting before the period at the end the following: “, except that, if a plan entirely meets such requirement with respect to a category of health care professional or provider on the basis of subparagraph (B), it may provide for a higher beneficiary copayment in the case of health care professionals and providers of that category who do not have contracts or agreements (other than deemed contracts or agreements under subsection (j)(6)) to provide covered services under the terms of the plan”.

Subtitle C—Offering of Medicare Advantage (MA) Regional Plans; Medicare Advantage Competition

SEC. 221. ESTABLISHMENT OF MA REGIONAL PLANS.

(a) **OFFERING OF MA REGIONAL PLANS.**—

(1) **IN GENERAL.**—Section 1851(a)(2)(A) is amended—

(A) by striking “COORDINATED CARE PLANS.—Coordinated” and inserting the following: “COORDINATED CARE PLANS (INCLUDING REGIONAL PLANS).—

“(i) **IN GENERAL.**—Coordinated”;

(B) by inserting “regional or local” before “preferred provider organization plans”; and

(C) by inserting “(including MA regional plans)” after “preferred provider organization plans”.

(2) **MORATORIUM ON NEW LOCAL PREFERRED PROVIDER ORGANIZATION PLANS.**—The Secretary shall not permit the offering of a local preferred provider organization plan under part C of title XVIII of the Social Security Act during 2006 or 2007 in a service area unless such plan was offered under such part (including under a demonstration project under such part) in such area as of December 31, 2005.

(b) **DEFINITION OF MA REGIONAL PLAN; MA LOCAL PLAN.**—

(1) IN GENERAL.—Section 1859(b) (42 U.S.C. 1395w–29(b)) is amended by adding at the end the following new paragraphs:

“(4) MA REGIONAL PLAN.—The term ‘MA regional plan’ means an MA plan described in section 1851(a)(2)(A)(i)—

“(A) that has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

“(B) that provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

“(C) the service area of which is one or more entire MA regions.

“(5) MA LOCAL PLAN.—The term ‘MA local plan’ means an MA plan that is not an MA regional plan.”.

(2) CONSTRUCTION.—Nothing in part C of title XVIII of the Social Security Act shall be construed as preventing an MSA plan or MA private fee-for-service plan from having a service area that covers one or more MA regions or the entire nation.

(c) RULES FOR MA REGIONAL PLANS.—Part C of title XVIII (42 U.S.C. 1395w–21 et seq.) is amended by inserting after section 1857 the following new section:

“SPECIAL RULES FOR MA REGIONAL PLANS

“SEC. 1858. (a) REGIONAL SERVICE AREA; ESTABLISHMENT OF MA REGIONS.—

“(1) COVERAGE OF ENTIRE MA REGION.—The service area for an MA regional plan shall consist of an entire MA region established under paragraph (2) and the provisions of section 1854(h) shall not apply to such a plan.

“(2) ESTABLISHMENT OF MA REGIONS.—

“(A) MA REGION.—For purposes of this title, the term ‘MA region’ means such a region within the 50 States and the District of Columbia as established by the Secretary under this paragraph.

“(B) ESTABLISHMENT.—

“(i) INITIAL ESTABLISHMENT.—Not later than January 1, 2005, the Secretary shall first establish and publish MA regions.

“(ii) PERIODIC REVIEW AND REVISION OF SERVICE AREAS.—The Secretary may periodically review MA regions under this paragraph and, based on such review, may revise such regions if the Secretary determines such revision to be appropriate.

“(C) REQUIREMENTS FOR MA REGIONS.—The Secretary shall establish, and may revise, MA regions under this paragraph in a manner consistent with the following:

“(i) NUMBER OF REGIONS.—There shall be no fewer than 10 regions, and no more than 50 regions.

“(ii) MAXIMIZING AVAILABILITY OF PLANS.—The regions shall maximize the availability of MA regional plans to all MA eligible individuals without regard to health status, especially those residing in rural areas.

“(D) MARKET SURVEY AND ANALYSIS.—Before establishing MA regions, the Secretary shall conduct a market survey and analysis, including an examination of current

insurance markets, to determine how the regions should be established.

“(3) NATIONAL PLAN.—Nothing in this subsection shall be construed as preventing an MA regional plan from being offered in more than one MA region (including all regions).

“(b) APPLICATION OF SINGLE DEDUCTIBLE AND CATASTROPHIC LIMIT ON OUT-OF-POCKET EXPENSES.—An MA regional plan shall include the following:

“(1) SINGLE DEDUCTIBLE.—Any deductible for benefits under the original medicare fee-for-service program option shall be a single deductible (instead of a separate inpatient hospital deductible and a part B deductible) and may be applied differentially for in-network services and may be waived for preventive or other items and services.

“(2) CATASTROPHIC LIMIT.—

“(A) IN-NETWORK.—A catastrophic limit on out-of-pocket expenditures for in-network benefits under the original medicare fee-for-service program option.

“(B) TOTAL.—A catastrophic limit on out-of-pocket expenditures for all benefits under the original medicare fee-for-service program option.

“(c) PORTION OF TOTAL PAYMENTS TO AN ORGANIZATION SUBJECT TO RISK FOR 2006 AND 2007.—

“(1) APPLICATION OF RISK CORRIDORS.—

“(A) IN GENERAL.—This subsection shall only apply to MA regional plans offered during 2006 or 2007.

“(B) NOTIFICATION OF ALLOWABLE COSTS UNDER THE PLAN.—In the case of an MA organization that offers an MA regional plan in an MA region in 2006 or 2007, the organization shall notify the Secretary, before such date in the succeeding year as the Secretary specifies, of—

“(i) its total amount of costs that the organization incurred in providing benefits covered under the original medicare fee-for-service program option for all enrollees under the plan in the region in the year and the portion of such costs that is attributable to administrative expenses described in subparagraph (C); and

“(ii) its total amount of costs that the organization incurred in providing rebatable integrated benefits (as defined in subparagraph (D)) and with respect to such benefits the portion of such costs that is attributable to administrative expenses described in subparagraph (C) and not described in clause (i) of this subparagraph.

“(C) ALLOWABLE COSTS DEFINED.—For purposes of this subsection, the term ‘allowable costs’ means, with respect to an MA regional plan for a year, the total amount of costs described in subparagraph (B) for the plan and year, reduced by the portion of such costs attributable to administrative expenses incurred in providing the benefits described in such subparagraph.

“(D) REBATABLE INTEGRATED BENEFITS.—For purposes of this subsection, the term ‘rebatable integrated benefits’ means such non-drug supplemental benefits under subclause (I) of section 1854(b)(1)(C)(ii) pursuant to a rebate under such section that the Secretary determines are

integrated with the benefits described in subparagraph (B)(i).

“(2) ADJUSTMENT OF PAYMENT.—

“(A) NO ADJUSTMENT IF ALLOWABLE COSTS WITHIN 3 PERCENT OF TARGET AMOUNT.—If the allowable costs for the plan for the year are at least 97 percent, but do not exceed 103 percent, of the target amount for the plan and year, there shall be no payment adjustment under this subsection for the plan and year.

“(B) INCREASE IN PAYMENT IF ALLOWABLE COSTS ABOVE 103 PERCENT OF TARGET AMOUNT.—

“(i) COSTS BETWEEN 103 AND 108 PERCENT OF TARGET AMOUNT.—If the allowable costs for the plan for the year are greater than 103 percent, but not greater than 108 percent, of the target amount for the plan and year, the Secretary shall increase the total of the monthly payments made to the organization offering the plan for the year under section 1853(a) by an amount equal to 50 percent of the difference between such allowable costs and 103 percent of such target amount.

“(ii) COSTS ABOVE 108 PERCENT OF TARGET AMOUNT.—If the allowable costs for the plan for the year are greater than 108 percent of the target amount for the plan and year, the Secretary shall increase the total of the monthly payments made to the organization offering the plan for the year under section 1853(a) by an amount equal to the sum of—

“(I) 2.5 percent of such target amount; and

“(II) 80 percent of the difference between such allowable costs and 108 percent of such target amount.

“(C) REDUCTION IN PAYMENT IF ALLOWABLE COSTS BELOW 97 PERCENT OF TARGET AMOUNT.—

“(i) COSTS BETWEEN 92 AND 97 PERCENT OF TARGET AMOUNT.—If the allowable costs for the plan for the year are less than 97 percent, but greater than or equal to 92 percent, of the target amount for the plan and year, the Secretary shall reduce the total of the monthly payments made to the organization offering the plan for the year under section 1853(a) by an amount (or otherwise recover from the plan an amount) equal to 50 percent of the difference between 97 percent of the target amount and such allowable costs.

“(ii) COSTS BELOW 92 PERCENT OF TARGET AMOUNT.—If the allowable costs for the plan for the year are less than 92 percent of the target amount for the plan and year, the Secretary shall reduce the total of the monthly payments made to the organization offering the plan for the year under section 1853(a) by an amount (or otherwise recover from the plan an amount) equal to the sum of—

“(I) 2.5 percent of such target amount; and

“(II) 80 percent of the difference between 92 percent of such target amount and such allowable costs.

“(D) TARGET AMOUNT DESCRIBED.—For purposes of this paragraph, the term ‘target amount’ means, with respect to an MA regional plan offered by an organization in a year, an amount equal to—

“(i) the sum of—

“(I) the total monthly payments made to the organization for enrollees in the plan for the year that are attributable to benefits under the original medicare fee-for-service program option (as defined in section 1852(a)(1)(B));

“(II) the total of the MA monthly basic beneficiary premium collectable for such enrollees for the year; and

“(III) the total amount of the rebates under section 1854(b)(1)(C)(ii) that are attributable to rebatable integrated benefits; reduced by

“(ii) the amount of administrative expenses assumed in the bid insofar as the bid is attributable to benefits described in clause (i)(I) or (i)(III).

“(3) DISCLOSURE OF INFORMATION.—

“(A) IN GENERAL.—Each contract under this part shall provide—

“(i) that an MA organization offering an MA regional plan shall provide the Secretary with such information as the Secretary determines is necessary to carry out this subsection; and

“(ii) that, pursuant to section 1857(d)(2)(B), the Secretary has the right to inspect and audit any books and records of the organization that pertain to the information regarding costs provided to the Secretary under paragraph (1)(B).

“(B) RESTRICTION ON USE OF INFORMATION.—Information disclosed or obtained pursuant to the provisions of this subsection may be used by officers, employees, and contractors of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this subsection.

“(d) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS.—

“(1) IN GENERAL.—In the case of an MA organization that is offering an MA regional plan in an MA region and—

“(A) meets the requirements of section 1855(a)(1) with respect to at least one such State in such region; and

“(B) with respect to each other State in such region in which it does not meet requirements, it demonstrates to the satisfaction of the Secretary that it has filed the necessary application to meet such requirements,

the Secretary may waive such requirement with respect to each State described in subparagraph (B) for such period of time as the Secretary determines appropriate for the timely processing of such an application by the State (and, if such application is denied, through the end of such plan year as the Secretary determines appropriate to provide for a transition).

“(2) SELECTION OF APPROPRIATE STATE.—In applying paragraph (1) in the case of an MA organization that meets the requirements of section 1855(a)(1) with respect to more than one State in a region, the organization shall select, in a manner

specified by the Secretary among such States, one State the rules of which shall apply in the case of the States described in paragraph (1)(B).

“(e) STABILIZATION FUND.—

“(1) ESTABLISHMENT.—The Secretary shall establish under this subsection an MA Regional Plan Stabilization Fund (in this subsection referred to as the ‘Fund’) which shall be available for two purposes:

“(A) PLAN ENTRY.—To provide incentives to have MA regional plans offered in each MA region under paragraph (3).

“(B) PLAN RETENTION.—To provide incentives to retain MA regional plans in certain MA regions with below-national-average MA market penetration under paragraph (4).

“(2) FUNDING.—

“(A) INITIAL FUNDING.—

“(i) IN GENERAL.—There shall be available to the Fund, for expenditures from the Fund during the period beginning on January 1, 2007, and ending on December 31, 2013, a total of \$10,000,000,000.

“(ii) PAYMENT FROM TRUST FUNDS.—Such amount shall be available to the Fund, as expenditures are made from the Fund, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in the proportion specified in section 1853(f).

“(B) ADDITIONAL FUNDING FROM SAVINGS.—

“(i) IN GENERAL.—There shall also be made available to the Fund, 50 percent of savings described in clause (ii).

“(ii) SAVINGS.—The savings described in this clause are 25 percent of the average per capita savings described in section 1854(b)(4)(C) for which monthly rebates are provided under section 1854(b)(1)(C) in the fiscal year involved that are attributable to MA regional plans.

“(iii) AVAILABILITY.—Funds made available under this subparagraph shall be transferred into a special account in the Treasury from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in the proportion specified in section 1853(f) on a monthly basis.

“(C) OBLIGATIONS.—Amounts in the Fund shall be available in advance of appropriations to MA regional plans in qualifying MA regions only in accordance with paragraph (5).

“(D) ORDERING.—Expenditures from the Fund shall first be made from amounts made available under subparagraph (A).

“(3) PLAN ENTRY FUNDING.—

“(A) IN GENERAL.—Funding is available under this paragraph for a year only as follows:

“(i) NATIONAL PLAN.—For a national bonus payment described in subparagraph (B) for the offering by a single MA organization of an MA regional plan in each MA region in the year, but only if there was

not such a plan offered in each such region in the previous year. Funding under this clause is only available with respect to any individual MA organization for a single year, but may be made available to more than one such organization in the same year.

“(ii) REGIONAL PLANS.—Subject to clause (iii), for an increased amount under subparagraph (C) for an MA regional plan offered in an MA region which did not have any MA regional plan offered in the prior year.

“(iii) LIMITATION ON REGIONAL PLAN FUNDING IN CASE OF NATIONAL PLAN.—In no case shall there be any payment adjustment under subparagraph (C) for a year for which a national payment adjustment is made under subparagraph (B).

“(B) NATIONAL BONUS PAYMENT.—The national bonus payment under this subparagraph shall—

“(i) be available to an MA organization only if the organization offers MA regional plans in every MA region;

“(ii) be available with respect to all MA regional plans of the organization regardless of whether any other MA regional plan is offered in any region; and

“(iii) subject to amounts available under paragraph (5) for a year, be equal to 3 percent of the benchmark amount otherwise applicable for each MA regional plan offered by the organization.

“(C) REGIONAL PAYMENT ADJUSTMENT.—

“(i) IN GENERAL.—The increased amount under this subparagraph for an MA regional plan in an MA region for a year shall be an amount, determined by the Secretary, based on the bid submitted for such plan (or plans) and shall be available to all MA regional plans offered in such region and year. Such amount may be based on the mean, mode, or median, or other measure of such bids and may vary from region to region. The Secretary may not limit the number of plans or bids in a region.

“(ii) MULTI-YEAR FUNDING.—

“(I) IN GENERAL.—Subject to amounts available under paragraph (5), funding under this subparagraph shall be available for a period determined by the Secretary.

“(II) REPORT.—If the Secretary determines that funding will be provided for a second consecutive year with respect to an MA region, the Secretary shall submit to the Congress a report that describes the underlying market dynamics in the region and that includes recommendations concerning changes in the payment methodology otherwise provided for MA regional plans under this part.

“(iii) APPLICATION TO ALL PLANS IN A REGION.—Funding under this subparagraph with respect to an MA region shall be made available with respect to all MA regional plans offered in the region.

“(iv) LIMITATION ON AVAILABILITY OF PLAN RETENTION FUNDING IN NEXT YEAR.—If an increased amount is made available under this subparagraph with respect to an MA region for a period determined by the Secretary under clause (ii)(I), in no case shall funding be available under paragraph (4) with respect to MA regional plans offered in the region in the year following such period.

“(D) APPLICATION.—Any additional payment under this paragraph provided for an MA regional plan for a year shall be treated as if it were an addition to the benchmark amount otherwise applicable to such plan and year, but shall not be taken into account in the computation of any benchmark amount for any subsequent year.

“(4) PLAN RETENTION FUNDING.—

“(A) IN GENERAL.—Funding is available under this paragraph for a year with respect to MA regional plans offered in an MA region for the increased amount specified in subparagraph (B) but only if the region meets the requirements of subparagraphs (C) and (E).

“(B) PAYMENT INCREASE.—The increased amount under this subparagraph for an MA regional plan in an MA region for a year shall be an amount, determined by the Secretary, that does not exceed the greater of—

“(i) 3 percent of the benchmark amount applicable in the region; or

“(ii) such amount as (when added to the benchmark amount applicable to the region) will result in the ratio of—

“(I) such additional amount plus the benchmark amount computed under section 1854(b)(4)(B)(i) for the region and year, to the adjusted average per capita cost for the region and year, as estimated by the Secretary under section 1876(a)(4) and adjusted as appropriate for the purpose of risk adjustment; being equal to

“(II) the weighted average of such benchmark amounts for all the regions and such year, to the average per capita cost for the United States and such year, as estimated by the Secretary under section 1876(a)(4) and adjusted as appropriate for the purpose of risk adjustment.

“(C) REGIONAL REQUIREMENTS.—The requirements of this subparagraph for an MA region for a year are as follows:

“(i) NOTIFICATION OF PLAN EXIT.—The Secretary has received notice (in such form and manner as the Secretary specifies) before a year that one or more MA regional plans that were offered in the region in the previous year will not be offered in the succeeding year.

“(ii) REGIONAL PLANS AVAILABLE FROM FEWER THAN 2 MA ORGANIZATIONS IN THE REGION.—The Secretary determines that if the plans referred to in clause (i) are not offered in the year, fewer than 2 MA organizations will be offering MA regional plans in the region in the year involved.

“(iii) PERCENTAGE ENROLLMENT IN MA REGIONAL PLANS BELOW NATIONAL AVERAGE.—For the previous year, the Secretary determines that the average percentage of MA eligible individuals residing in the region who are enrolled in MA regional plans is less than the average percentage of such individuals in the United States enrolled in such plans.

“(D) APPLICATION.—Any additional payment under this paragraph provided for an MA regional plan for a year shall be treated as if it were an addition to the benchmark amount otherwise applicable to such plan and year, but shall not be taken into account in the computation of any benchmark amount for any subsequent year.

“(E) 2-CONSECUTIVE-YEAR LIMITATION.—

“(i) IN GENERAL.—In no case shall any funding be available under this paragraph in an MA region in a period of consecutive years that exceeds 2 years.

“(ii) REPORT.—If the Secretary determines that funding will be provided under this paragraph for a second consecutive year with respect to an MA region, the Secretary shall submit to the Congress a report that describes the underlying market dynamics in the region and that includes recommendations concerning changes in the payment methodology otherwise provided for MA regional plans under this part.

“(5) FUNDING LIMITATION.—

“(A) IN GENERAL.—The total amount expended from the Fund as a result of the application of this subsection through the end of a calendar year may not exceed the amount available to the Fund as of the first day of such year. For purposes of this subsection, amounts that are expended under this title insofar as such amounts would not have been expended but for the application of this subsection shall be counted as amounts expended as a result of such application.

“(B) APPLICATION OF LIMITATION.—The Secretary may obligate funds from the Fund for a year only if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services and the appropriate budget officer certify) that there are available in the Fund at the beginning of the year sufficient amounts to cover all such obligations incurred during the year consistent with subparagraph (A). The Secretary shall take such steps, in connection with computing additional payment amounts under paragraphs (3) and (4) and including limitations on enrollment in MA regional plans receiving such payments, as will ensure that sufficient funds are available to make such payments for the entire year. Funds shall only be made available from the Fund pursuant to an apportionment made in accordance with applicable procedures.

“(6) SECRETARY REPORTS.—Not later than April 1 of each year (beginning in 2008), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

“(A) a detailed description of—

“(i) the total amount expended as a result of the application of this subsection in the previous year compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

“(ii) the projections of the total amount that will be expended as a result of the application of this subsection in the year in which the report is submitted compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

“(iii) amounts remaining within the funding limitation specified in paragraph (5); and

“(iv) the steps that the Secretary will take under paragraph (5)(B) to ensure that the application of this subsection will not cause expenditures to exceed the amount available in the Fund; and

“(B) a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the description provided under subparagraph (A) is reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

“(7) BIENNIAL GAO REPORTS.—Not later than January 1 of 2009, 2011, 2013, and 2015, the Comptroller General of the United States shall submit to the Secretary and Congress a report on the application of additional payments under this subsection. Each report shall include—

“(A) an evaluation of—

“(i) the quality of care provided to individuals enrolled in MA regional plans for which additional payments were made under this subsection;

“(ii) the satisfaction of such individuals with benefits under such a plan;

“(iii) the costs to the medicare program for payments made to such plans; and

“(iv) any improvements in the delivery of health care services under such a plan;

“(B) a comparative analysis of the performance of MA regional plans receiving payments under this subsection with MA regional plans not receiving such payments; and

“(C) recommendations for such legislation or administrative action as the Comptroller General determines to be appropriate.

“(f) COMPUTATION OF APPLICABLE MA REGION-SPECIFIC NON-DRUG MONTHLY BENCHMARK AMOUNTS.—

“(1) COMPUTATION FOR REGIONS.—For purposes of section 1853(j)(2) and this section, subject to subsection (e), the term ‘MA region-specific non-drug monthly benchmark amount’ means, with respect to an MA region for a month in a year, the sum of the 2 components described in paragraph (2) for the region and year. The Secretary shall compute such benchmark amount for each MA region before the beginning of each annual, coordinated election period under section 1851(e)(3)(B) for each year (beginning with 2006).

“(2) 2 COMPONENTS.—For purposes of paragraph (1), the 2 components described in this paragraph for an MA region and a year are the following:

“(A) STATUTORY COMPONENT.—The product of the following:

“(i) STATUTORY REGION-SPECIFIC NON-DRUG AMOUNT.—The statutory region-specific non-drug amount (as defined in paragraph (3)) for the region and year.

“(ii) STATUTORY NATIONAL MARKET SHARE.—The statutory national market share percentage, determined under paragraph (4) for the year.

“(B) PLAN-BID COMPONENT.—The product of the following:

“(i) WEIGHTED AVERAGE OF MA PLAN BIDS IN REGION.—The weighted average of the plan bids for the region and year (as determined under paragraph (5)(A)).

“(ii) NON-STATUTORY MARKET SHARE.—1 minus the statutory national market share percentage, determined under paragraph (4) for the year.

“(3) STATUTORY REGION-SPECIFIC NON-DRUG AMOUNT.—For purposes of paragraph (2)(A)(i), the term ‘statutory region-specific non-drug amount’ means, for an MA region and year, an amount equal the sum (for each MA local area within the region) of the product of—

“(A) MA area-specific non-drug monthly benchmark amount under section 1853(j)(1)(A) for that area and year; and

“(B) the number of MA eligible individuals residing in the local area, divided by the total number of MA eligible individuals residing in the region.

“(4) COMPUTATION OF STATUTORY MARKET SHARE PERCENTAGE.—

“(A) IN GENERAL.—The Secretary shall determine for each year a statutory national market share percentage that is equal to the proportion of MA eligible individuals nationally who were not enrolled in an MA plan during the reference month.

“(B) REFERENCE MONTH DEFINED.—For purposes of this part, the term ‘reference month’ means, with respect to a year, the most recent month during the previous year for which the Secretary determines that data are available to compute the percentage specified in subparagraph (A) and other relevant percentages under this part.

“(5) DETERMINATION OF WEIGHTED AVERAGE MA BIDS FOR A REGION.—

“(A) IN GENERAL.—For purposes of paragraph (2)(B)(i), the weighted average of plan bids for an MA region and a year is the sum, for MA regional plans described in subparagraph (D) in the region and year, of the products (for each such plan) of the following:

“(i) MONTHLY MA STATUTORY NON-DRUG BID AMOUNT.—The unadjusted MA statutory non-drug monthly bid amount for the plan.

“(ii) PLAN’S SHARE OF MA ENROLLMENT IN REGION.—The factor described in subparagraph (B) for the plan.

“(B) PLAN’S SHARE OF MA ENROLLMENT IN REGION.—

“(i) IN GENERAL.—Subject to the succeeding provisions of this subparagraph, the factor described in this subparagraph for a plan is equal to the number of individuals described in subparagraph (C) for such plan, divided by the total number of such individuals for all MA regional plans described in subparagraph (D) for that region and year.

“(ii) SINGLE PLAN RULE.—In the case of an MA region in which only a single MA regional plan is being offered, the factor described in this subparagraph shall be equal to 1.

“(iii) EQUAL DIVISION AMONG MULTIPLE PLANS IN YEAR IN WHICH PLANS ARE FIRST AVAILABLE.—In the case of an MA region in the first year in which any MA regional plan is offered, if more than one MA regional plan is offered in such year, the factor described in this subparagraph for a plan shall (as specified by the Secretary) be equal to—

“(I) 1 divided by the number of such plans offered in such year; or

“(II) a factor for such plan that is based upon the organization’s estimate of projected enrollment, as reviewed and adjusted by the Secretary to ensure reasonableness and as is certified by the Chief Actuary of the Centers for Medicare & Medicaid Services.

“(C) COUNTING OF INDIVIDUALS.—For purposes of subparagraph (B)(i), the Secretary shall count for each MA regional plan described in subparagraph (D) for an MA region and year, the number of individuals who reside in the region and who were enrolled under such plan under this part during the reference month.

“(D) PLANS COVERED.—For an MA region and year, an MA regional plan described in this subparagraph is an MA regional plan that is offered in the region and year and was offered in the region in the reference month.

“(g) ELECTION OF UNIFORM COVERAGE DETERMINATION.—Instead of applying section 1852(a)(2)(C) with respect to an MA regional plan, the organization offering the plan may elect to have a local coverage determination for the entire MA region be the local coverage determination applied for any part of such region (as selected by the organization).

“(h) ASSURING NETWORK ADEQUACY.—

“(1) IN GENERAL.—For purposes of enabling MA organizations that offer MA regional plans to meet applicable provider access requirements under section 1852 with respect to such plans, the Secretary may provide for payment under this section to an essential hospital that provides inpatient hospital services to enrollees in such a plan where the MA organization offering the plan certifies to the Secretary that the organization was unable to reach an agreement between the hospital and the organization regarding provision of such services under the plan. Such payment shall be available only if—

“(A) the organization provides assurances satisfactory to the Secretary that the organization will make payment to the hospital for inpatient hospital services of an amount that is not less than the amount that would be payable

to the hospital under section 1886 with respect to such services; and

“(B) with respect to specific inpatient hospital services provided to an enrollee, the hospital demonstrates to the satisfaction of the Secretary that the hospital’s costs of such services exceed the payment amount described in subparagraph (A).

“(2) PAYMENT AMOUNTS.—The payment amount under this subsection for inpatient hospital services provided by a subsection (d) hospital to an enrollee in an MA regional plan shall be, subject to the limitation of funds under paragraph (3), the amount (if any) by which—

“(A) the amount of payment that would have been paid for such services under this title if the enrollees were covered under the original medicare fee-for-service program option and the hospital were a critical access hospital; exceeds

“(B) the amount of payment made for such services under paragraph (1)(A).

“(3) AVAILABLE AMOUNTS.—There shall be available for payments under this subsection—

“(A) in 2006, \$25,000,000; and

“(B) in each succeeding year the amount specified in this paragraph for the preceding year increased by the market basket percentage increase (as defined in section 1886(b)(3)(B)(iii)) for the fiscal year ending in such succeeding year.

Payments under this subsection shall be made from the Federal Hospital Insurance Trust Fund.

“(4) ESSENTIAL HOSPITAL.—In this subsection, the term ‘essential hospital’ means, with respect to an MA regional plan offered by an MA organization, a subsection (d) hospital (as defined in section 1886(d)) that the Secretary determines, based upon an application filed by the organization with the Secretary, is necessary to meet the requirements referred to in paragraph (1) for such plan.”.

(d) CONFORMING AMENDMENTS.—

(1) RELATING TO MA REGIONS.—Section 1853(d) (42 U.S.C. 1395w–23(d)) is amended—

(A) by amending the heading to read as follows: “MA PAYMENT AREA; MA LOCAL AREA; MA REGION DEFINED”;

(B) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively;

(C) by amending paragraph (1) to read as follows:

“(1) MA PAYMENT AREA.—In this part, except as provided in this subsection, the term ‘MA payment area’ means—

“(A) with respect to an MA local plan, an MA local area (as defined in paragraph (2)); and

“(B) with respect to an MA regional plan, an MA region (as established under section 1858(a)(2)).”;

(D) by inserting after paragraph (1) the following new paragraph:

“(2) MA LOCAL AREA.—The term ‘MA local area’ means a county or equivalent area specified by the Secretary.”; and

(E) in paragraph (4), as so redesignated—

(i) in subparagraph (A), by inserting “for MA local plans” after “paragraph (1)”;

(ii) in subparagraph (A)(iii), by striking “paragraph (1)” and inserting “paragraph (1)(A)”; and
(iii) in subparagraph (B)—

(I) by inserting “with respect to MA local plans” after “established under this section”;

(II) by inserting “for such plans” after “payments under this section”; and

(III) by inserting “for such plans” after “made under this section”.

(2) MA LOCAL AREA DEFINED.—Section 1859(c) (42 U.S.C. 1395w–29(c)) is amended by adding at the end the following:

“(5) MA LOCAL AREA.—The term ‘MA local area’ is defined in section 1853(d)(2).”.

(3) APPLICATION OF SPECIAL BENEFIT RULES TO PPOS AND REGIONAL PLANS.—Section 1852(a) (42 U.S.C. 1395w–22(a)) is amended—

(A) in paragraph (1), by inserting “and except as provided in paragraph (6) for MA regional plans” after “MSA plans”; and

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

“(6) SPECIAL BENEFIT RULES FOR REGIONAL PLANS.—In the case of an MA plan that is an MA regional plan, benefits under the plan shall include the benefits described in paragraphs (1) and (2) of section 1858(b).”.

(4) APPLICATION OF CAPITATION RATES TO LOCAL AREAS.—Section 1853(c)(1) (42 U.S.C. 1395w–23(c)(1)) is amended by inserting “that is an MA local area” after “for a Medicare+Choice payment area”.

(5) NETWORK ADEQUACY HOSPITAL PAYMENTS.—Section 1851(i)(2) (42 U.S.C. 1395w–21(i)(2)) is amended by inserting “1858(h),” after “1857(f)(2),”.

SEC. 222. COMPETITION PROGRAM BEGINNING IN 2006.

(a) SUBMISSION OF BIDDING AND REBATE INFORMATION BEGINNING IN 2006.—

(1) IN GENERAL.—Section 1854 (42 U.S.C. 1395w–24) is amended—

(A) by amending paragraph (1) of subsection (a) to read as follows:

“(1) IN GENERAL.—

“(A) INITIAL SUBMISSION.—Not later than the second Monday in September of 2002, 2003, and 2004 (or the first Monday in June of each subsequent year), each MA organization shall submit to the Secretary, in a form and manner specified by the Secretary and for each MA plan for the service area (or segment of such an area if permitted under subsection (h)) in which it intends to be offered in the following year the following:

“(i) The information described in paragraph (2), (3), (4), or (6)(A) for the type of plan and year involved.

“(ii) The plan type for each plan.

“(iii) The enrollment capacity (if any) in relation to the plan and area.

“(B) BENEFICIARY REBATE INFORMATION.—In the case of a plan required to provide a monthly rebate under subsection (b)(1)(C) for a year, the MA organization offering the plan shall submit to the Secretary, in such form and

manner and at such time as the Secretary specifies, information on—

“(i) the manner in which such rebate will be provided under clause (ii) of such subsection; and

“(ii) the MA monthly prescription drug beneficiary premium (if any) and the MA monthly supplemental beneficiary premium (if any).

“(C) PAPERWORK REDUCTION FOR OFFERING OF MA REGIONAL PLANS NATIONALLY OR IN MULTI-REGION AREAS.—The Secretary shall establish requirements for information submission under this subsection in a manner that promotes the offering of MA regional plans in more than one region (including all regions) through the filing of consolidated information.”; and

(B) by adding at the end of subsection (a) the following:

“(6) SUBMISSION OF BID AMOUNTS BY MA ORGANIZATIONS BEGINNING IN 2006.—

“(A) INFORMATION TO BE SUBMITTED.—For an MA plan (other than an MSA plan) for a plan year beginning on or after January 1, 2006, the information described in this subparagraph is as follows:

“(i) The monthly aggregate bid amount for the provision of all items and services under the plan, which amount shall be based on average revenue requirements (as used for purposes of section 1302(8) of the Public Health Service Act) in the payment area for an enrollee with a national average risk profile for the factors described in section 1853(a)(1)(C) (as specified by the Secretary).

“(ii) The proportions of such bid amount that are attributable to—

“(I) the provision of benefits under the original medicare fee-for-service program option (as defined in section 1852(a)(1)(B));

“(II) the provision of basic prescription drug coverage; and

“(III) the provision of supplemental health care benefits.

“(iii) The actuarial basis for determining the amount under clause (i) and the proportions described in clause (ii) and such additional information as the Secretary may require to verify such actuarial bases and the projected number of enrollees in each MA local area.

“(iv) A description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of such deductibles, coinsurance, and copayments, described in subsection (e)(4)(A).

“(v) With respect to qualified prescription drug coverage, the information required under section 1860D–4, as incorporated under section 1860D–11(b)(2), with respect to such coverage.

In the case of a specialized MA plan for special needs individuals, the information described in this subparagraph is such information as the Secretary shall specify.

“(B) ACCEPTANCE AND NEGOTIATION OF BID AMOUNTS.—

“(i) AUTHORITY.—Subject to clauses (iii) and (iv), the Secretary has the authority to negotiate regarding monthly bid amounts submitted under subparagraph (A) (and the proportions described in subparagraph (A)(ii)), including supplemental benefits provided under subsection (b)(1)(C)(ii)(I) and in exercising such authority the Secretary shall have authority similar to the authority of the Director of the Office of Personnel Management with respect to health benefits plans under chapter 89 of title 5, United States Code.

“(ii) APPLICATION OF FEHBP STANDARD.—Subject to clause (iv), the Secretary may only accept such a bid amount or proportion if the Secretary determines that such amount and proportions are supported by the actuarial bases provided under subparagraph (A) and reasonably and equitably reflects the revenue requirements (as used for purposes of section 1302(8) of the Public Health Service Act) of benefits provided under that plan.

“(iii) NONINTERFERENCE.—In order to promote competition under this part and part D and in carrying out such parts, the Secretary may not require any MA organization to contract with a particular hospital, physician, or other entity or individual to furnish items and services under this title or require a particular price structure for payment under such a contract to the extent consistent with the Secretary’s authority under this part.

“(iv) EXCEPTION.—In the case of a plan described in section 1851(a)(2)(C), the provisions of clauses (i) and (ii) shall not apply and the provisions of paragraph (5)(B), prohibiting the review, approval, or disapproval of amounts described in such paragraph, shall apply to the negotiation and rejection of the monthly bid amounts and the proportions referred to in subparagraph (A).”.

(2) DEFINITION OF BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—Section 1852(a)(1) (42 U.S.C. 1395w–22(a)(1)) is amended—

(A) by striking “IN GENERAL.—Except” and inserting “REQUIREMENT.—

“(A) IN GENERAL.—Except”; and

(B) by striking “title XI” and all that follows and inserting the following: “title XI, benefits under the original medicare fee-for-service program option (and, for plan years before 2006, additional benefits required under section 1854(f)(1)(A)).

“(B) BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION DEFINED.—

“(i) IN GENERAL.—For purposes of this part, the term ‘benefits under the original medicare fee-for-service program option’ means those items and services (other than hospice care) for which benefits are available under parts A and B to individuals entitled to benefits under part A and enrolled under part B, with cost-sharing for those services as required under parts

A and B or an actuarially equivalent level of cost-sharing as determined in this part.

“(ii) SPECIAL RULE FOR REGIONAL PLANS.—In the case of an MA regional plan in determining an actuarially equivalent level of cost-sharing with respect to benefits under the original medicare fee-for-service program option, there shall only be taken into account, with respect to the application of section 1858(b)(2), such expenses only with respect to subparagraph (A) of such section.”

(3) CONFORMING AMENDMENT RELATING TO SUPPLEMENTAL HEALTH BENEFITS.—Section 1852(a)(3) (42 U.S.C. 1395w-22(a)(3)) is amended by adding at the end the following: “Such benefits may include reductions in cost-sharing below the actuarial value specified in section 1854(e)(4)(B).”

(b) PROVIDING FOR BENEFICIARY SAVINGS FOR CERTAIN PLANS.—

(1) BENEFICIARY REBATES.—Section 1854(b)(1) (42 U.S.C. 1395w-24(b)(1)) is amended—

(A) in subparagraph (A), by striking “The monthly amount” and inserting “Subject to the rebate under subparagraph (C), the monthly amount (if any)”; and

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

“(C) BENEFICIARY REBATE RULE.—

“(i) REQUIREMENT.—The MA plan shall provide to the enrollee a monthly rebate equal to 75 percent of the average per capita savings (if any) described in paragraph (3)(C) or (4)(C), as applicable to the plan and year involved.

“(ii) FORM OF REBATE.—A rebate required under this subparagraph shall be provided through the application of the amount of the rebate toward one or more of the following:

“(I) PROVISION OF SUPPLEMENTAL HEALTH CARE BENEFITS AND PAYMENT FOR PREMIUM FOR SUPPLEMENTAL BENEFITS.—The provision of supplemental health care benefits described in section 1852(a)(3) in a manner specified under the plan, which may include the reduction of cost-sharing otherwise applicable as well as additional health care benefits which are not benefits under the original medicare fee-for-service program option, or crediting toward an MA monthly supplemental beneficiary premium (if any).

“(II) PAYMENT FOR PREMIUM FOR PRESCRIPTION DRUG COVERAGE.—Crediting toward the MA monthly prescription drug beneficiary premium.

“(III) PAYMENT TOWARD PART B PREMIUM.—Crediting toward the premium imposed under part B (determined without regard to the application of subsections (b), (h), and (i) of section 1839).

“(iii) DISCLOSURE RELATING TO REBATES.—The plan shall disclose to the Secretary information on the form and amount of the rebate provided under this subparagraph or the actuarial value in the case of supplemental health care benefits.

“(iv) APPLICATION OF PART B PREMIUM REDUCTION.—Insofar as an MA organization elects to provide a rebate under this subparagraph under a plan as a credit toward the part B premium under clause (ii)(III), the Secretary shall apply such credit to reduce the premium under section 1839 of each enrollee in such plan as provided in section 1840(i).”

(2) REVISION OF PREMIUM TERMINOLOGY.—Section 1854(b)(2) (42 U.S.C. 1395w–24(b)(2)) is amended—

(A) in the heading, by inserting “AND BID” after “PREMIUM”;

(B) by redesignating subparagraph (C) as subparagraph (D);

(C) by striking subparagraphs (A) and (B) and inserting the following:

“(A) MA MONTHLY BASIC BENEFICIARY PREMIUM.—The term ‘MA monthly basic beneficiary premium’ means, with respect to an MA plan—

“(i) described in section 1853(a)(1)(B)(i) (relating to plans providing rebates), zero; or

“(ii) described in section 1853(a)(1)(B)(ii), the amount (if any) by which the unadjusted MA statutory non-drug monthly bid amount (as defined in subparagraph (E)) exceeds the applicable unadjusted MA area-specific non-drug monthly benchmark amount (as defined in section 1853(j)).

“(B) MA MONTHLY PRESCRIPTION DRUG BENEFICIARY PREMIUM.—The term ‘MA monthly prescription drug beneficiary premium’ means, with respect to an MA plan, the base beneficiary premium (as determined under section 1860D–13(a)(2) and as adjusted under section 1860D–13(a)(1)(B)), less the amount of rebate credited toward such amount under section 1854(b)(1)(C)(ii)(II).

“(C) MA MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The term ‘MA monthly supplemental beneficiary premium’ means, with respect to an MA plan, the portion of the aggregate monthly bid amount submitted under clause (i) of subsection (a)(6)(A) for the year that is attributable under clause (ii)(III) of such subsection to the provision of supplemental health care benefits, less the amount of rebate credited toward such portion under section 1854(b)(1)(C)(ii)(I).”; and

(D) by adding at the end the following:

“(E) UNADJUSTED MA STATUTORY NON-DRUG MONTHLY BID AMOUNT.—The term ‘unadjusted MA statutory non-drug monthly bid amount’ means the portion of the bid amount submitted under clause (i) of subsection (a)(6)(A) for the year that is attributable under clause (ii)(I) of such subsection to the provision of benefits under the original medicare fee-for-service program option (as defined in section 1852(a)(1)(B)).”

(3) COMPUTATION OF SAVINGS.—Section 1854(b) (42 U.S.C. 1395w–24(b)) is further amended by adding at the end the following new paragraphs:

“(3) COMPUTATION OF AVERAGE PER CAPITA MONTHLY SAVINGS FOR LOCAL PLANS.—For purposes of paragraph (1)(C)(i),

