



1 a covered drug for a medically accepted indication (as  
2 defined in section 1927(k)(6)).

3 “(B) EXCLUSIONS.—

4 “(i) IN GENERAL.—The term ‘covered drug’  
5 does not include drugs or classes of drugs, or their  
6 medical uses, which may be excluded from coverage  
7 or otherwise restricted under section 1927(d)(2),  
8 other than subparagraph (E) thereof (relating to  
9 smoking cessation agents), or under section  
10 1927(d)(3).

11 “(ii) AVOIDANCE OF DUPLICATE COVERAGE.—  
12 A drug prescribed for an individual that would oth-  
13 erwise be a covered drug under this part shall not  
14 be so considered if payment for such drug is avail-  
15 able under part A or B, but shall be so considered  
16 if such payment is not available under part A or  
17 B or because benefits under such parts have been  
18 exhausted.

19 “(C) APPLICATION OF FORMULARY RESTRIC-  
20 TIONS.—A drug prescribed for an individual that would  
21 otherwise be a covered drug under this part shall not  
22 be so considered under a plan if the plan excludes the  
23 drug under a formulary and such exclusion is not suc-  
24 cessfully resolved under subsection (d) or (e)(2) of sec-  
25 tion 1860D-5.

26 “(D) APPLICATION OF GENERAL EXCLUSION PRO-  
27 VISIONS.—A Medicare Prescription Drug plan or a  
28 MedicareAdvantage plan may exclude from qualified  
29 prescription drug coverage any covered drug—

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

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

34 Such exclusions are determinations subject to reconsid-  
35 eration and appeal pursuant to section 1860D-5(e).

36 “(3) ELIGIBLE BENEFICIARY.—The term ‘eligible ben-  
37 eficiary’ means an individual who is entitled to, or enrolled

1 for, benefits under part A and enrolled under part B (other  
2 than a dual eligible individual, as defined in section  
3 1860D-19(a)(4)(E)).

4 “(4) ELIGIBLE ENTITY.—The term ‘eligible entity’  
5 means any risk-bearing entity that the Administrator deter-  
6 mines to be appropriate to provide eligible beneficiaries  
7 with the benefits under a Medicare Prescription Drug plan,  
8 including—

9 “(A) a pharmaceutical benefit management com-  
10 pany;

11 “(B) a wholesale or retail pharmacist delivery sys-  
12 tem;

13 “(C) an insurer (including an insurer that offers  
14 medicare supplemental policies under section 1882);

15 “(D) any other risk-bearing entity; or

16 “(E) any combination of the entities described in  
17 subparagraphs (A) through (D).

18 “(5) INITIAL COVERAGE LIMIT.—The term ‘initial cov-  
19 erage limit’ means the limit as established under section  
20 1860D-6(c)(3), or, in the case of coverage that is not  
21 standard prescription drug coverage, the comparable limit  
22 (if any) established under the coverage.

23 “(6) MEDICAREADVANTAGE ORGANIZATION;  
24 MEDICAREADVANTAGE PLAN.—The terms  
25 ‘MedicareAdvantage organization’ and ‘MedicareAdvantage  
26 plan’ have the meanings given such terms in subsections  
27 (a)(1) and (b)(1), respectively, of section 1859 (relating to  
28 definitions relating to MedicareAdvantage organizations).

29 “(7) MEDICARE PRESCRIPTION DRUG PLAN.—The  
30 term ‘Medicare Prescription Drug plan’ means prescription  
31 drug coverage that is offered under a policy, contract, or  
32 plan—

33 “(A) that has been approved under section  
34 1860D-13; and

35 “(B) by an eligible entity pursuant to, and in ac-  
36 cordance with, a contract between the Administrator  
37 and the entity under section 1860D-7(b).



1           “(i) IN GENERAL.—Except as provided in  
2           clause (ii), an eligible beneficiary who is enrolled  
3           under this part and enrolled in a  
4           MedicareAdvantage plan offered by a  
5           MedicareAdvantage organization shall receive cov-  
6           erage of benefits under this part through such  
7           plan.

8           “(ii) EXCEPTION FOR ENROLLEES IN  
9           MEDICAREADVANTAGE MSA PLANS.—An eligible  
10          beneficiary who is enrolled under this part and en-  
11          rolled in an MSA plan under part C shall receive  
12          coverage of benefits under this part through enroll-  
13          ment in a Medicare Prescription Drug plan that is  
14          offered in the geographic area in which the bene-  
15          ficiary resides. For purposes of this part, the term  
16          ‘MSA plan’ has the meaning given such term in  
17          section 1859(b)(3).

18          “(iii) EXCEPTION FOR ENROLLEES IN  
19          MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE  
20          PLANS.—An eligible beneficiary who is enrolled  
21          under this part and enrolled in a private fee-for-  
22          service plan under part C shall—

23                 “(i) receive benefits under this part  
24                 through such plan if the plan provides qualified  
25                 prescription drug coverage; and

26                 “(ii) if the plan does not provide qualified  
27                 prescription drug coverage, receive coverage of  
28                 benefits under this part through enrollment in  
29                 a Medicare Prescription Drug plan that is of-  
30                 fered in the geographic area in which the bene-  
31                 ficiary resides. For purposes of this part, the  
32                 term ‘private fee-for-service plan’ has the  
33                 meaning given such term in section 1859(b)(2).

34          “(B) FEE-FOR-SERVICE ENROLLEES RECEIVE COV-  
35          ERAGE THROUGH A MEDICARE PRESCRIPTION DRUG  
36          PLAN.—An eligible beneficiary who is enrolled under  
37          this part but is not enrolled in a MedicareAdvantage

1 plan (except for an MSA plan or a private fee-for-serv-  
2 ice plan that does not provide qualified prescription  
3 drug coverage) shall receive coverage of benefits under  
4 this part through enrollment in a Medicare Prescription  
5 Drug plan that is offered in the geographic area in  
6 which the beneficiary resides.

7 “(2) VOLUNTARY NATURE OF PROGRAM.—Nothing in  
8 this part shall be construed as requiring an eligible bene-  
9 ficiary to enroll in the program under this part.

10 “(3) SCOPE OF BENEFITS.—Pursuant to section  
11 1860D–6(b)(3)(C), the program established under this part  
12 shall provide for coverage of all therapeutic categories and  
13 classes of covered drugs (although not necessarily for all  
14 drugs within such categories and classes).

15 “(4) PROGRAM TO BEGIN IN 2006.—The Administrator  
16 shall establish the program under this part in a manner so  
17 that benefits are first provided beginning on January 1, 2006.

18 “(b) ACCESS TO ALTERNATIVE PRESCRIPTION DRUG COV-  
19 ERAGE.—In the case of an eligible beneficiary who has cred-  
20 itable prescription drug coverage (as defined in section 1860D–  
21 2(b)(1)(F)), such beneficiary—

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

24 “(2) pursuant to section 1860D–2(b)(1)(C), is per-  
25 mitted to subsequently enroll under this part without any  
26 penalty and obtain access to qualified prescription drug  
27 coverage in the manner described in subsection (a) if the  
28 beneficiary involuntarily loses such coverage.

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

31 “ENROLLMENT UNDER PROGRAM

32 “SEC. 1860D–2. (a) ESTABLISHMENT OF ENROLLMENT  
33 PROCESS.—

34 “(1) PROCESS SIMILAR TO PART B ENROLLMENT.—  
35 The Administrator shall establish a process through which  
36 an eligible beneficiary (including an eligible beneficiary en-  
37 rolled in a MedicareAdvantage plan offered by a

1 MedicareAdvantage organization) may make an election to  
2 enroll under this part. Such process shall be similar to the  
3 process for enrollment in part B under section 1837, in-  
4 cluding the deeming provisions of such section.

5 “(2) CONDITION OF ENROLLMENT.—An eligible bene-  
6 ficiary must be enrolled under this part in order to be eligi-  
7 ble to receive access to qualified prescription drug coverage.

8 “(b) SPECIAL ENROLLMENT PROCEDURES.—

9 “(1) LATE ENROLLMENT PENALTY.—

10 “(A) INCREASE IN MONTHLY BENEFICIARY OBLI-  
11 GATION.—Subject to the succeeding provisions of this  
12 paragraph, in the case of an eligible beneficiary whose  
13 coverage period under this part began pursuant to an  
14 enrollment after the beneficiary’s initial enrollment pe-  
15 riod under part B (determined pursuant to section  
16 1837(d)) and not pursuant to the open enrollment pe-  
17 riod described in paragraph (2), the Administrator  
18 shall establish procedures for increasing the amount of  
19 the monthly beneficiary obligation under section  
20 1860D-17 applicable to such beneficiary by an amount  
21 that the Administrator determines is actuarially sound  
22 for each full 12-month period (in the same continuous  
23 period of eligibility) in which the eligible beneficiary  
24 could have been enrolled under this part but was not  
25 so enrolled.

26 “(B) PERIODS TAKEN INTO ACCOUNT.—For pur-  
27 poses of calculating any 12-month period under sub-  
28 paragraph (A), there shall be taken into account—

29 “(i) the months which elapsed between the  
30 close of the eligible beneficiary’s initial enrollment  
31 period and the close of the enrollment period in  
32 which the beneficiary enrolled; and

33 “(ii) in the case of an eligible beneficiary who  
34 reenrolls under this part, the months which elapsed  
35 between the date of termination of a previous cov-  
36 erage period and the close of the enrollment period  
37 in which the beneficiary reenrolled.

1                   “(C) PERIODS NOT TAKEN INTO ACCOUNT.—

2                   “(i) IN GENERAL.—For purposes of calcu-  
3                   lating any 12-month period under subparagraph  
4                   (A), subject to clause (ii), there shall not be taken  
5                   into account months for which the eligible bene-  
6                   ficiary can demonstrate that the beneficiary had  
7                   creditable prescription drug coverage (as defined in  
8                   subparagraph (F)).

9                   “(ii) BENEFICIARY MUST INVOLUNTARILY  
10                   LOSE COVERAGE.—Clause (i) shall only apply with  
11                   respect to coverage—

12                   “(I) in the case of coverage described in  
13                   clause (ii) of subparagraph (F), if the plan ter-  
14                   minates, ceases to provide, or reduces the value  
15                   of the prescription drug coverage under such  
16                   plan to below the actuarial value of standard  
17                   prescription drug coverage (as determined  
18                   under section 1860D-6(f));

19                   “(II) in the case of coverage described in  
20                   clause (i), (iii), or (iv) of subparagraph (F), if  
21                   the beneficiary is involuntarily disenrolled or  
22                   becomes ineligible for such coverage; or

23                   “(III) in the case of a beneficiary with  
24                   coverage described in clause (v) of subpara-  
25                   graph (F), if the issuer of the policy terminates  
26                   coverage under the policy.

27                   “(D) PERIODS TREATED SEPARATELY.—Any in-  
28                   crease in an eligible beneficiary’s monthly beneficiary  
29                   obligation under subparagraph (A) with respect to a  
30                   particular continuous period of eligibility shall not be  
31                   applicable with respect to any other continuous period  
32                   of eligibility which the beneficiary may have.

33                   “(E) CONTINUOUS PERIOD OF ELIGIBILITY.—

34                   “(i) IN GENERAL.—Subject to clause (ii), for  
35                   purposes of this paragraph, an eligible beneficiary’s  
36                   ‘continuous period of eligibility’ is the period that  
37                   begins with the first day on which the beneficiary

1 is eligible to enroll under section 1836 and ends  
2 with the beneficiary's death.

3 “(ii) SEPARATE PERIOD.—Any period during  
4 all of which an eligible beneficiary satisfied para-  
5 graph (1) of section 1836 and which terminated in  
6 or before the month preceding the month in which  
7 the beneficiary attained age 65 shall be a separate  
8 ‘continuous period of eligibility’ with respect to the  
9 beneficiary (and each such period which terminates  
10 shall be deemed not to have existed for purposes of  
11 subsequently applying this paragraph).

12 “(F) CREDITABLE PRESCRIPTION DRUG COV-  
13 ERAGE DEFINED.—Subject to subparagraph (G), for  
14 purposes of this part, the term ‘creditable prescription  
15 drug coverage’ means any of the following:

16 “(i) DRUG-ONLY COVERAGE UNDER MED-  
17 ICAID.—Coverage of covered outpatient drugs (as  
18 defined in section 1927) under title XIX or a waiv-  
19 er under 1115 that is provided to an individual who  
20 is not a dual eligible individual (as defined in sec-  
21 tion 1860D–19(a)(4)(E)).

22 “(ii) PRESCRIPTION DRUG COVERAGE UNDER  
23 A GROUP HEALTH PLAN.—Any outpatient prescrip-  
24 tion drug coverage under a group health plan, in-  
25 cluding a health benefits plan under chapter 89 of  
26 title 5, United States Code (commonly known as  
27 the Federal employees health benefits program),  
28 and a qualified retiree prescription drug plan (as  
29 defined in section 1860D–20(e)(4)).

30 “(iii) STATE PHARMACEUTICAL ASSISTANCE  
31 PROGRAM.—Coverage of prescription drugs under a  
32 State pharmaceutical assistance program.

33 “(iv) VETERANS’ COVERAGE OF PRESCRIPTION  
34 DRUGS.—Coverage of prescription drugs for vet-  
35 erans, and survivors and dependents of veterans,  
36 under chapter 17 of title 38, United States Code.

1                   “(v) PRESCRIPTION DRUG COVERAGE UNDER  
2                   MEDIGAP POLICIES.—Coverage under a medicare  
3                   supplemental policy under section 1882 that pro-  
4                   vides benefits for prescription drugs (whether or  
5                   not such coverage conforms to the standards for  
6                   packages of benefits under section 1882(p)(1)).

7                   “(G) REQUIREMENT FOR CREDITABLE COV-  
8                   ERAGE.—Coverage described in clauses (i) through (v)  
9                   of subparagraph (F) shall not be considered to be cred-  
10                  itable coverage under this part unless the coverage pro-  
11                  vides coverage of the cost of prescription drugs the actu-  
12                  arial value of which (as defined by the Adminis-  
13                  trator) to the beneficiary equals or exceeds the actu-  
14                  arial value of standard prescription drug coverage (as  
15                  determined under section 1860D–6(f)).

16                  “(H) DISCLOSURE.—

17                  “(i) IN GENERAL.—Each entity that offers  
18                  coverage of the type described in clause (ii) (iii),  
19                  (iv), or (v) of subparagraph (F) shall provide for  
20                  disclosure, consistent with standards established by  
21                  the Administrator, of whether the coverage provides  
22                  coverage of the cost of prescription drugs the actu-  
23                  arial value of which (as defined by the Adminis-  
24                  trator) to the beneficiary equals or exceeds the ac-  
25                  tuarial value of standard prescription drug cov-  
26                  erage (as determined under section 1860D–6(f)).

27                  “(ii) WAIVER OF LIMITATIONS.—An individual  
28                  may apply to the Administrator to waive the appli-  
29                  cation of subparagraph (G) if the individual estab-  
30                  lishes that the individual was not adequately in-  
31                  formed that the coverage the beneficiary was en-  
32                  rolled in did not provide the level of benefits re-  
33                  quired in order for the coverage to be considered  
34                  creditable coverage under subparagraph (F).

35                  “(2) INITIAL ELECTION PERIODS.—

36                  “(A) OPEN ENROLLMENT PERIOD FOR CURRENT  
37                  BENEFICIARIES IN WHICH LATE ENROLLMENT PROCE-

1 DURES DO NOT APPLY.—In the case of an individual  
2 who is an eligible beneficiary as of November 1, 2005,  
3 there shall be an open enrollment period of 6 months  
4 beginning on that date under which such beneficiary  
5 may enroll under this part without the application of  
6 the late enrollment procedures established under para-  
7 graph (1)(A).

8 “(B) INDIVIDUAL COVERED IN FUTURE.—In the  
9 case of an individual who becomes an eligible bene-  
10 ficiary after such date, there shall be an initial election  
11 period which is the same as the initial enrollment pe-  
12 riod under section 1837(d).

13 “(3) SPECIAL ENROLLMENT PERIOD FOR BENE-  
14 FICIARIES WHO INVOLUNTARILY LOSE CREDITABLE PRE-  
15 SCRIPTIION DRUG COVERAGE.—

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

20 “(B) SPECIAL OPEN ENROLLMENT PERIOD.—The  
21 special open enrollment period described in this sub-  
22 paragraph is the 63-day period that begins on—

23 “(i) in the case of a beneficiary with coverage  
24 described in clause (ii) of paragraph (1)(F), the  
25 later of the date on which the plan terminates,  
26 ceases to provide, or substantially reduces (as de-  
27 fined by the Administrator) the value of the pre-  
28 scription drug coverage under such plan or the date  
29 the beneficiary is provided with notice of such ter-  
30 mination or reduction;

31 “(ii) in the case of a beneficiary with coverage  
32 described in clause (i), (iii), or (iv) of paragraph  
33 (1)(F), the later of the date on which the bene-  
34 ficiary is involuntarily disenrolled or becomes ineli-  
35 gible for such coverage or the date the beneficiary  
36 is provided with notice of such loss of eligibility; or

1                   “(iii) in the case of a beneficiary with coverage  
2                   described in clause (v) of paragraph (1)(F), the lat-  
3                   ter of the date on which the issuer of the policy ter-  
4                   minates coverage under the policy or the date the  
5                   beneficiary is provided with notice of such termi-  
6                   nation.

7                   “(c) PERIOD OF COVERAGE.—

8                   “(1) IN GENERAL.—Except as provided in paragraph  
9                   (2) and subject to paragraph (3), an eligible beneficiary’s  
10                  coverage under the program under this part shall be effec-  
11                  tive for the period provided in section 1838, as if that sec-  
12                  tion applied to the program under this part.

13                  “(2) OPEN AND SPECIAL ENROLLMENT.—

14                  “(A) OPEN ENROLLMENT.—An eligible beneficiary  
15                  who enrolls under the program under this part pursu-  
16                  ant to subsection (b)(2) shall be entitled to the benefits  
17                  under this part beginning on January 1, 2006.

18                  “(B) SPECIAL ENROLLMENT.—Subject to para-  
19                  graph (3), an eligible beneficiary who enrolls under the  
20                  program under this part pursuant to subsection (b)(3)  
21                  shall be entitled to the benefits under this part begin-  
22                  ning on the first day of the month following the month  
23                  in which such enrollment occurs.

24                  “(3) LIMITATION.—Coverage under this part shall not  
25                  begin prior to January 1, 2006.

26                  “(d) TERMINATION.—

27                  “(1) IN GENERAL.—The causes of termination speci-  
28                  fied in section 1838 shall apply to this part in the same  
29                  manner as such causes apply to part B.

30                  “(2) COVERAGE TERMINATED BY TERMINATION OF  
31                  COVERAGE UNDER PART A OR B.—

32                  “(A) IN GENERAL.—In addition to the causes of  
33                  termination specified in paragraph (1), the Adminis-  
34                  trator shall terminate an individual’s coverage under  
35                  this part if the individual is no longer enrolled in both  
36                  parts A and B.

1           “(B) EFFECTIVE DATE.—The termination de-  
2           scribed in subparagraph (A) shall be effective on the ef-  
3           fective date of termination of coverage under part A or  
4           (if earlier) under part B.

5           “(3) PROCEDURES REGARDING TERMINATION OF A  
6           BENEFICIARY UNDER A PLAN.—The Administrator shall es-  
7           tablish procedures for determining the status of an eligible  
8           beneficiary’s enrollment under this part if the beneficiary’s  
9           enrollment in a Medicare Prescription Drug plan offered by  
10          an eligible entity under this part is terminated by the entity  
11          for cause (pursuant to procedures established by the Ad-  
12          ministrator under section 1860D–3(a)(1)).

13          “ELECTION OF A MEDICARE PRESCRIPTION DRUG PLAN

14          “SEC. 1860D–3. (a) IN GENERAL.—

15                  “(1) PROCESS.—

16                          “(A) ELECTION.—

17                                  “(i) IN GENERAL.—The Administrator shall  
18                                  establish a process through which an eligible bene-  
19                                  ficiary who is enrolled under this part but not en-  
20                                  rolled in a MedicareAdvantage plan (except for an  
21                                  MSA plan or a private fee-for-service plan that  
22                                  does not provide qualified prescription drug cov-  
23                                  erage) offered by a MedicareAdvantage  
24                                  organization—

25    “(I) shall make an election to enroll in any  
26    Medicare Prescription Drug plan that is offered  
27    by an eligible entity and that serves the geo-  
28    graphic area in which the beneficiary resides;  
29    and

30    “(II) may make an annual election to  
31    change the election under this clause.

32    “(ii) CLARIFICATION REGARDING ENROLL-  
33    MENT.—The process established under clause (i)  
34    shall include, in the case of an eligible beneficiary  
35    who is enrolled under this part but who has failed  
36    to make an election of a Medicare Prescription  
37    Drug plan in an area, for the enrollment in any

1 Medicare Prescription Drug plan that has been  
2 designated by the Administrator in the area. The  
3 Administrator shall establish a process for desig-  
4 nating a plan or plans in order to carry out the  
5 preceding sentence.

6 “(B) REQUIREMENTS FOR PROCESS.—In estab-  
7 lishing the process under subparagraph (A), the Ad-  
8 ministrator shall—

9 “(i) use rules similar to the rules for enroll-  
10 ment, disenrollment, and termination of enrollment  
11 with a MedicareAdvantage plan under section  
12 1851, including—

13 “(I) the establishment of special election  
14 periods under subsection (e)(4) of such section;  
15 and

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

21 “(ii) coordinate enrollments, disenrollments,  
22 and terminations of enrollment under part C with  
23 enrollments, disenrollments, and terminations of  
24 enrollment under this part.

25 “(2) FIRST ENROLLMENT PERIOD FOR PLAN ENROLL-  
26 MENT.—The process developed under paragraph (1) shall  
27 ensure that eligible beneficiaries who enroll under this part  
28 during the open enrollment period under section 1860D-  
29 2(b)(2) are permitted to elect an eligible entity prior to  
30 January 1, 2006, in order to ensure that coverage under  
31 this part is effective as of such date.

32 “(b) ENROLLMENT IN A MEDICAREADVANTAGE PLAN.—

33 “(1) IN GENERAL.—An eligible beneficiary who is en-  
34 rolled under this part and enrolled in a MedicareAdvantage  
35 plan (except for an MSA plan or a private fee-for-service  
36 plan that does not provide qualified prescription drug cov-  
37 erage) offered by a MedicareAdvantage organization shall

1 receive access to such coverage under this part through  
2 such plan.

3 “(2) RULES.—Enrollment in a MedicareAdvantage  
4 plan is subject to the rules for enrollment in such plan  
5 under section 1851.

6 “PROVIDING INFORMATION TO BENEFICIARIES

7 “SEC. 1860D–4. (a) ACTIVITIES.—

8 “(1) IN GENERAL.—The Administrator shall conduct  
9 activities that are designed to broadly disseminate informa-  
10 tion to eligible beneficiaries (and prospective eligible bene-  
11 ficiaries) regarding the coverage provided under this part.

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

17 “(b) REQUIREMENTS.—

18 “(1) IN GENERAL.—The activities described in sub-  
19 section (a) shall—

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

22 “(B) be coordinated with the activities performed  
23 by—

24 “(i) the Administrator under such section; and

25 “(ii) the Secretary under section 1804; and

26 “(C) provide for the dissemination of information  
27 comparing the plans offered by eligible entities under  
28 this part that are available to eligible beneficiaries re-  
29 siding in an area.

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

33 “(A) BENEFITS.—The benefits provided under the  
34 plan and the formularies and grievance and appeals  
35 processes under the plan.

36 “(B) MONTHLY BENEFICIARY OBLIGATION.—The  
37 monthly beneficiary obligation under the plan.

1           “(C) QUALITY AND PERFORMANCE.—The quality  
2           and performance of the eligible entity offering the plan.

3           “(D) BENEFICIARY COST-SHARING.—The cost-  
4           sharing required of eligible beneficiaries under the plan.

5           “(E) CONSUMER SATISFACTION SURVEYS.—The  
6           results of consumer satisfaction surveys regarding the  
7           plan and the eligible entity offering such plan (con-  
8           ducted pursuant to section 1860D–5(h).

9           “(F) ADDITIONAL INFORMATION.—Such addi-  
10          tional information as the Administrator may prescribe.

11          “BENEFICIARY PROTECTIONS

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

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

19                 “(A) Access to covered drugs, including access  
20                 through pharmacy networks.

21                 “(B) How any formulary used by the entity func-  
22                 tions.

23                 “(C) Copayments, coinsurance, and deductible re-  
24                 quirements.

25                 “(D) Grievance and appeals processes.

26          The information described in the preceding sentence shall  
27          also be made available on request to prospective enrollees  
28          during open enrollment periods.

29          “(2) DISCLOSURE UPON REQUEST OF GENERAL COV-  
30          ERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—  
31          Upon request of an individual eligible to enroll in a Medi-  
32          care Prescription Drug plan, the eligible entity offering  
33          such plan shall provide information similar (as determined  
34          by the Administrator) to the information described in sub-  
35          paragraphs (A), (B), and (C) of section 1852(c)(2) to such  
36          individual.

1           “(3) RESPONSE TO BENEFICIARY QUESTIONS.—An eli-  
2           gible entity offering a Medicare Prescription Drug plan  
3           shall have a mechanism for providing on a timely basis spe-  
4           cific information to enrollees upon request, including infor-  
5           mation on the coverage of specific drugs and changes in its  
6           formulary.

7           “(4) CLAIMS INFORMATION.—An eligible entity offer-  
8           ing a Medicare Prescription Drug plan must furnish to en-  
9           rolled individuals in a form easily understandable to such  
10          individuals—

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

13                 “(B) when prescription drug benefits are provided  
14                 under this part, a notice of the benefits in relation to  
15                 the initial coverage limit and annual out-of-pocket limit  
16                 for the current year (except that such notice need not  
17                 be provided more often than monthly).

18          “(5) APPROVAL OF MARKETING MATERIAL AND APPLI-  
19          CATION FORMS.—The provisions of section 1851(h) shall  
20          apply to marketing material and application forms under  
21          this part in the same manner as such provisions apply to  
22          marketing material and application forms under part C.

23          “(b) ACCESS TO COVERED DRUGS.—

24                 “(1) ACCESS TO NEGOTIATED PRICES FOR PRESCRIP-  
25                 TION DRUGS.—An eligible entity offering a Medicare Pre-  
26                 scription Drug plan shall have in place procedures to en-  
27                 sure that beneficiaries are not charged more than the nego-  
28                 tiated price of a covered drug. Such procedures shall in-  
29                 clude the issuance of a card (or other technology) that may  
30                 be used by an enrolled beneficiary for the purchase of pre-  
31                 scription drugs for which coverage is not otherwise provided  
32                 under the Medicare Prescription Drug plan.

33                 “(2) ASSURING PHARMACY ACCESS.—

34                 “(A) IN GENERAL.—An eligible entity offering a  
35                 Medicare Prescription Drug plan shall secure the par-  
36                 ticipation in its network of a sufficient number of phar-  
37                 macies that dispense (other than by mail order) drugs

1 directly to patients to ensure convenient access (as de-  
2 termined by the Administrator and including adequate  
3 emergency access) for enrolled beneficiaries, in accord-  
4 ance with standards established by the Administrator  
5 under section 1860D-7(g) that ensure such convenient  
6 access. Such standards shall take into account reason-  
7 able distances to pharmacy services in both urban and  
8 rural areas.

9 “(B) USE OF POINT-OF-SERVICE SYSTEM.—An eli-  
10 gible entity offering a Medicare Prescription Drug plan  
11 shall establish an optional point-of-service method of  
12 operation under which—

13 “(i) the plan provides access to any or all  
14 pharmacies that are not participating pharmacies  
15 in its network; and

16 “(ii) the plan may charge beneficiaries through  
17 adjustments in copayments any additional costs as-  
18 sociated with the point-of-service option.

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

21 “(3) REQUIREMENTS ON DEVELOPMENT AND APPLICA-  
22 TION OF FORMULARIES.—If an eligible entity offering a  
23 Medicare Prescription Drug plan uses a formulary, the fol-  
24 lowing requirements must be met:

25 “(A) PHARMACY AND THERAPEUTIC (P&T) COM-  
26 MITTEE.—

27 “(i) IN GENERAL.—The eligible entity must  
28 establish a pharmacy and therapeutic committee  
29 that develops and reviews the formulary.

30 “(ii) COMPOSITION.—A pharmacy and thera-  
31 peutic committee shall include at least 1 academic  
32 expert, at least 1 practicing physician, and at least  
33 1 practicing pharmacist, all of whom have expertise  
34 in the care of elderly or disabled persons, and a  
35 majority of the members of such committee shall  
36 consist of individuals who are a practicing physi-  
37 cian or a practicing pharmacist (or both).

1           “(B) FORMULARY DEVELOPMENT.—In developing  
2           and reviewing the formulary, the committee shall base  
3           clinical decisions on the strength of scientific evidence  
4           and standards of practice, including assessing peer-re-  
5           viewed medical literature, such as randomized clinical  
6           trials, pharmacoeconomic studies, outcomes research  
7           data, and such other information as the committee de-  
8           termines to be appropriate.

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

11           “(i) IN GENERAL.—The formulary must in-  
12          clude drugs within each therapeutic category and  
13          class of covered drugs (as defined by the Adminis-  
14          trator), although not necessarily for all drugs with-  
15          in such categories and classes.

16           “(ii) REQUIREMENT.—In defining therapeutic  
17          categories and classes of covered drugs pursuant to  
18          clause (i), the Administrator shall use—

19           “(I) the compendia referred to section  
20          1927(g)(1)(B)(i); and

21           “(II) other recognized sources of drug  
22          classifications and categorizations determined  
23          appropriate by the Administrator.

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

27          “(E) NOTICE BEFORE REMOVING DRUGS FROM  
28          FORMULARY.—Any removal of a drug from a formulary  
29          shall take effect only after appropriate notice is made  
30          available to beneficiaries, physicians, and pharmacists.

31          “(F) APPEALS AND EXCEPTIONS TO APPLICA-  
32          TION.—The eligible entity must have, as part of the ap-  
33          peals process under subsection (e), a process for timely  
34          appeals for denials of coverage based on such applica-  
35          tion of the formulary.

36          “(c) COST AND UTILIZATION MANAGEMENT; QUALITY AS-  
37          SURANCE; MEDICATION THERAPY MANAGEMENT PROGRAM.—

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

3           “(A) A cost-effective drug utilization management  
4 program, including incentives to reduce costs when ap-  
5 propriate.

6           “(B) Quality assurance measures to reduce med-  
7 ical errors and adverse drug interactions and to im-  
8 prove medication use, which—

9           “(i) shall include a medication therapy man-  
10 agement program described in paragraph (2); and

11           “(ii) may include beneficiary education pro-  
12 grams, counseling, medication refill reminders, and  
13 special packaging.

14           “(C) A program to control fraud, abuse, and  
15 waste.

16 Nothing in this section shall be construed as impairing an  
17 eligible entity from applying cost management tools (includ-  
18 ing differential payments) under all methods of operation.

19           “(2) MEDICATION THERAPY MANAGEMENT PRO-  
20 GRAM.—

21           “(A) IN GENERAL.—A medication therapy man-  
22 agement program described in this paragraph is a pro-  
23 gram of drug therapy management and medication ad-  
24 ministration that is designed to assure, with respect to  
25 beneficiaries with chronic diseases (such as diabetes,  
26 asthma, hypertension, hyperlipidemia, and congestive  
27 heart failure) or multiple prescriptions, that covered  
28 drugs under the Medicare Prescription Drug plan are  
29 appropriately used to optimize therapeutic outcomes  
30 through improved medication use and to achieve thera-  
31 peutic goals and reduce the risk of adverse events, in-  
32 cluding adverse drug interactions.

33           “(B) ELEMENTS.—Such program may include—

34           “(i) enhanced beneficiary understanding of  
35 such appropriate use through beneficiary education,  
36 counseling, and other appropriate means;

1                   “(ii) increased beneficiary adherence with pre-  
2                   scription medication regimens through medication  
3                   refill reminders, special packaging, and other ap-  
4                   propriate means; and

5                   “(iii) detection of patterns of overuse and  
6                   underuse of prescription drugs.

7                   “(C) DEVELOPMENT OF PROGRAM IN COOPERA-  
8                   TION WITH LICENSED PHARMACISTS.—The program  
9                   shall be developed in cooperation with licensed and  
10                  practicing pharmacists and physicians.

11                  “(D) CONSIDERATIONS IN PHARMACY FEES.—The  
12                  eligible entity offering a Medicare Prescription Drug  
13                  plan shall take into account, in establishing fees for  
14                  pharmacists and others providing services under the  
15                  medication therapy management program, the re-  
16                  sources and time used in implementing the program.

17                  “(3) PUBLIC DISCLOSURE OF PHARMACEUTICAL  
18                  PRICES FOR EQUIVALENT DRUGS.—The eligible entity of-  
19                  fering a Medicare Prescription Drug plan shall provide that  
20                  each pharmacy or other dispenser that arranges for the dis-  
21                  pensing of a covered drug shall inform the beneficiary at  
22                  the time of purchase of the drug of any differential between  
23                  the price of the prescribed drug to the enrollee and the  
24                  price of the lowest cost generic drug covered under the plan  
25                  that is therapeutically equivalent and bioequivalent.

26                  “(d) GRIEVANCE MECHANISM, COVERAGE DETERMINA-  
27                  TIONS, AND RECONSIDERATIONS.—

28                  “(1) IN GENERAL.—An eligible entity shall provide  
29                  meaningful procedures for hearing and resolving grievances  
30                  between the eligible entity (including any entity or indi-  
31                  vidual through which the eligible entity provides covered  
32                  benefits) and enrollees with Medicare Prescription Drug  
33                  plans of the eligible entity under this part in accordance  
34                  with section 1852(f).

35                  “(2) APPLICATION OF COVERAGE DETERMINATION  
36                  AND RECONSIDERATION PROVISIONS.—The requirements of  
37                  paragraphs (1) through (3) of section 1852(g) shall apply

1 to an eligible entity with respect to covered benefits under  
2 the Medicare Prescription Drug plan it offers under this  
3 part in the same manner as such requirements apply to a  
4 MedicareAdvantage organization with respect to benefits it  
5 offers under a MedicareAdvantage plan under part C.

6 “(3) REQUEST FOR REVIEW OF TIERED FORMULARY  
7 DETERMINATIONS.—In the case of a Medicare Prescription  
8 Drug plan offered by an eligible entity that provides for  
9 tiered cost-sharing for drugs included within a formulary  
10 and provides lower cost-sharing for preferred drugs in-  
11 cluded within the formulary, an individual who is enrolled  
12 in the plan may request coverage of a nonpreferred drug  
13 under the terms applicable for preferred drugs if the pre-  
14 scribing physician determines that the preferred drug for  
15 treatment of the same condition is not as effective for the  
16 individual or has adverse effects for the individual.

17 “(e) APPEALS.—

18 “(1) IN GENERAL.—Subject to paragraph (2), the re-  
19 quirements of paragraphs (4) and (5) of section 1852(g)  
20 shall apply to an eligible entity with respect to drugs not  
21 included on any formulary in a manner that is similar (as  
22 determined by the Administrator) to the manner that such  
23 requirements apply to a MedicareAdvantage organization  
24 with respect to benefits it offers under a  
25 MedicareAdvantage plan under part C.

26 “(2) FORMULARY DETERMINATIONS.—An individual  
27 who is enrolled in a Medicare Prescription Drug plan of-  
28 fered by an eligible entity may appeal to obtain coverage  
29 for a covered drug that is not on a formulary of the entity  
30 under the terms applicable for a formulary drug if the pre-  
31 scribing physician determines that the formulary drug for  
32 treatment of the same condition is not as effective for the  
33 individual or has adverse effects for the individual.

34 “(f) PRIVACY, CONFIDENTIALITY, AND ACCURACY OF EN-  
35 ROLLEE RECORDS.—Insofar as an eligible entity maintains in-  
36 dividually identifiable medical records or other health informa-  
37 tion regarding eligible beneficiaries enrolled in the Medicare

1 Prescription Drug plan offered by the entity, the entity shall  
2 have in place procedures to—

3 “(1) safeguard the privacy of any individually identifi-  
4 able beneficiary information in a manner consistent with  
5 the Federal regulations (concerning the privacy of individ-  
6 ually identifiable health information) promulgated under  
7 section 264(c) of the Health Insurance Portability and Ac-  
8 countability Act of 1996;

9 “(2) maintain such records and information in a man-  
10 ner that is accurate and timely;

11 “(3) ensure timely access by such beneficiaries to such  
12 records and information; and

13 “(4) otherwise comply with applicable laws relating to  
14 patient privacy and confidentiality.

15 “(g) UNIFORM MONTHLY PLAN PREMIUM.—An eligible  
16 entity shall ensure that the monthly plan premium for a Medi-  
17 care Prescription Drug plan charged under this part is the  
18 same for all eligible beneficiaries enrolled in the plan.

19 “(h) CONSUMER SATISFACTION SURVEYS.—An eligible en-  
20 tity shall conduct consumer satisfaction surveys with respect to  
21 the plan and the entity. The Administrator shall establish uni-  
22 form requirements for such surveys.

23 “PRESCRIPTION DRUG BENEFITS

24 “SEC. 1860D-6. (a) REQUIREMENTS.—

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

28 “(A) STANDARD PRESCRIPTION DRUG COVERAGE  
29 WITH ACCESS TO NEGOTIATED PRICES.—Standard pre-  
30 scription drug coverage (as defined in subsection (c))  
31 and access to negotiated prices under subsection (e).

32 “(B) ACTUARIALLY EQUIVALENT PRESCRIPTION  
33 DRUG COVERAGE WITH ACCESS TO NEGOTIATED  
34 PRICES.—Coverage of covered drugs which meets the  
35 alternative coverage requirements of subsection (d) and  
36 access to negotiated prices under subsection (e), but

1           only if it is approved by the Administrator as provided  
2           under subsection (d).

3           “(2) PERMITTING ADDITIONAL PRESCRIPTION DRUG  
4           COVERAGE.—

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

10          “(B) REQUIREMENT.—An eligible entity may not  
11          offer a Medicare Prescription Drug plan that provides  
12          additional benefits pursuant to subparagraph (A) in an  
13          area unless the eligible entity offering such plan also  
14          offers a Medicare Prescription Drug plan in the area  
15          that only provides the coverage of prescription drugs  
16          that is required under paragraph (1).

17          “(3) COST CONTROL MECHANISMS.—In providing  
18          qualified prescription drug coverage, the entity offering the  
19          Medicare Prescription Drug plan or the MedicareAdvantage  
20          plan may use a variety of cost control mechanisms, includ-  
21          ing the use of formularies, tiered copayments, selective con-  
22          tracting with providers of prescription drugs, and mail  
23          order pharmacies.

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

27          “(c) STANDARD PRESCRIPTION DRUG COVERAGE.—For  
28          purposes of this part and part C, the term ‘standard prescrip-  
29          tion drug coverage’ means coverage of covered drugs that meets  
30          the following requirements:

31                 “(1) DEDUCTIBLE.—

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

34                                 “(i) for 2006, that is equal to \$275; or

35                                 “(ii) for a subsequent year, that is equal to  
36                                 the amount specified under this paragraph for the

1 previous year increased by the percentage specified  
2 in paragraph (5) for the year involved.

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

6 “(2) LIMITS ON COST-SHARING.—The coverage has  
7 cost-sharing (for costs above the annual deductible specified  
8 in paragraph (1) and up to the initial coverage limit under  
9 paragraph (3)) that is equal to 50 percent or that is actu-  
10 arially consistent (using processes established under sub-  
11 section (f)) with an average expected payment of 50 per-  
12 cent of such costs.

13 “(3) INITIAL COVERAGE LIMIT.—

14 “(A) IN GENERAL.—Subject to paragraph (4), the  
15 coverage has an initial coverage limit on the maximum  
16 costs that may be recognized for payment purposes (in-  
17 cluding the annual deductible)—

18 “(i) for 2006, that is equal to \$4,500; or

19 “(ii) for a subsequent year, that is equal to  
20 the amount specified in this paragraph for the pre-  
21 vious year, increased by the annual percentage in-  
22 crease described in paragraph (5) for the year in-  
23 volved.

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

27 “(4) LIMITATION ON OUT-OF-POCKET EXPENDITURES  
28 BY BENEFICIARY.—

29 “(A) IN GENERAL.—The coverage provides bene-  
30 fits with cost-sharing that is equal to 10 percent after  
31 the individual has incurred costs (as described in sub-  
32 paragraph (C)) for covered drugs in a year equal to the  
33 annual out-of-pocket limit specified in subparagraph  
34 (B).

35 “(B) ANNUAL OUT-OF-POCKET LIMIT.—

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

4                   “(I) for 2006, is equal to \$3,700; or

5                   “(II) for a subsequent year, is equal to the  
6                   amount specified in this subparagraph for the  
7                   previous year, increased by the annual percent-  
8                   age increase described in paragraph (5) for the  
9                   year involved.

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

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

15                  “(i) incurred costs shall only include costs in-  
16                  curred, with respect to covered drugs, for the an-  
17                  nual deductible (described in paragraph (1)), cost-  
18                  sharing (described in paragraph (2)), and amounts  
19                  for which benefits are not provided because of the  
20                  application of the initial coverage limit described in  
21                  paragraph (3) (including costs incurred for covered  
22                  drugs described in section 1860D(a)(2)(C)); and

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

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

34                  “(d) ALTERNATIVE COVERAGE REQUIREMENTS.—A Medi-  
35                  care Prescription Drug plan or MedicareAdvantage plan may  
36                  provide a different prescription drug benefit design from the  
37                  standard prescription drug coverage described in subsection (c)

1 so long as the Administrator determines (based on an actuarial  
2 analysis by the Administrator) that the following requirements  
3 are met and the plan applies for, and receives, the approval of  
4 the Administrator for such benefit design:

5 “(1) ASSURING AT LEAST ACTUARIALLY EQUIVALENT  
6 PRESCRIPTION DRUG COVERAGE.—

7 “(A) ASSURING EQUIVALENT VALUE OF TOTAL  
8 COVERAGE.—The actuarial value of the total coverage  
9 (as determined under subsection (f)) is at least equal  
10 to the actuarial value (as so determined) of standard  
11 prescription drug coverage.

12 “(B) ASSURING EQUIVALENT UNSUBSIDIZED  
13 VALUE OF COVERAGE.—The unsubsidized value of the  
14 coverage is at least equal to the unsubsidized value of  
15 standard prescription drug coverage. For purposes of  
16 this subparagraph, the unsubsidized value of coverage  
17 is the amount by which the actuarial value of the cov-  
18 erage (as determined under subsection (f)) exceeds the  
19 actuarial value of the amounts associated with the ap-  
20 plication of section 1860D–17(c) and reinsurance pay-  
21 ments under section 1860D–20 with respect to such  
22 coverage.

23 “(C) ASSURING STANDARD PAYMENT FOR COSTS  
24 AT INITIAL COVERAGE LIMIT.—The coverage is de-  
25 signed, based upon an actuarially representative pat-  
26 tern of utilization (as determined under subsection (f)),  
27 to provide for the payment, with respect to costs in-  
28 curred that are equal to the initial coverage limit under  
29 subsection (c)(3), of an amount equal to at least the  
30 product of—

31 “(i) such initial coverage limit minus the de-  
32 ductible under subsection (c)(1); and

33 “(ii) the percentage specified in subsection  
34 (c)(2).

35 Benefits other than qualified prescription drug coverage  
36 shall not be taken into account for purposes of this para-  
37 graph.

1           “(2) DEDUCTIBLE AND LIMITATION ON OUT-OF-POCK-  
2           ET EXPENDITURES BY BENEFICIARIES MAY NOT VARY.—  
3           The coverage may not vary the deductible under subsection  
4           (c)(1) for the year or the limitation on out-of-pocket ex-  
5           penditures by beneficiaries described in subsection (c)(4)  
6           for the year.

7           “(e) ACCESS TO NEGOTIATED PRICES.—

8           “(1) ACCESS.—

9           “(A) IN GENERAL.—Under qualified prescription  
10           drug coverage offered by an eligible entity or a  
11           MedicareAdvantage organization, the entity or organi-  
12           zation shall provide beneficiaries with access to nego-  
13           tiated prices used for payment for covered drugs, re-  
14           gardless of the fact that no benefits may be payable  
15           under the coverage with respect to such drugs because  
16           of the application of the deductible, any cost-sharing,  
17           or an initial coverage limit (described in subsection  
18           (c)(3)). For purposes of this part, the term ‘negotiated  
19           prices’ includes all discounts, direct or indirect sub-  
20           sidies, rebates, or other price concessions or direct or  
21           indirect remunerations.

22           “(B) MEDICAID RELATED PROVISIONS.—Insofar  
23           as a State elects to provide medical assistance under  
24           title XIX for a drug based on the prices negotiated  
25           under a Medicare Prescription Drug plan under this  
26           part, the requirements of section 1927 shall not apply  
27           to such drugs. The prices negotiated under a Medicare  
28           Prescription Drug plan with respect to covered drugs,  
29           under a MedicareAdvantage plan with respect to such  
30           drugs, or under a qualified retiree prescription drug  
31           plan (as defined in section 1860D–20(e)(4)) with re-  
32           spect to such drugs, on behalf of eligible beneficiaries,  
33           shall (notwithstanding any other provision of law) not  
34           be taken into account for the purposes of establishing  
35           the best price under section 1927(c)(1)(C).

36           “(2) CARDS OR OTHER TECHNOLOGY.—

1           “(A) IN GENERAL.—In providing the access under  
2 paragraph (1), the eligible entity or MedicareAdvantage  
3 organization shall issue a card or use other technology  
4 pursuant to section 1860D–5(b)(1).

5           “(B) NATIONAL STANDARDS.—

6           “(i) DEVELOPMENT.—The Administrator shall  
7 provide for the development of national standards  
8 relating to a standardized format for the card or  
9 other technology required under subparagraph (A).  
10 Such standards shall be compatible with parts C  
11 and D of title XI and may be based on standards  
12 developed by an appropriate standard setting orga-  
13 nization.

14           “(ii) CONSULTATION.—In developing the  
15 standards under clause (i), the Administrator shall  
16 consult with the National Council for Prescription  
17 Drug Programs and other standard-setting organi-  
18 zations determined appropriate by the Adminis-  
19 trator.

20           “(iii) IMPLEMENTATION.—The Administrator  
21 shall implement the standards developed under  
22 clause (i) by January 1, 2008.

23           “(f) ACTUARIAL VALUATION; DETERMINATION OF AN-  
24 NUAL PERCENTAGE INCREASES.—

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

27           “(A) for determining the actuarial valuation of  
28 prescription drug coverage, including—

29           “(i) an actuarial valuation of standard pre-  
30 scription drug coverage and of the reinsurance pay-  
31 ments under section 1860D–20;

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

34           “(iii) applying the same methodology for de-  
35 terminations of alternative coverage under sub-  
36 section (d) as is used with respect to determina-

1                   tions of standard prescription drug coverage under  
2                   subsection (c); and

3                   “(B) for determining annual percentage increases  
4                   described in subsection (c)(5).

5                   “(2) USE OF OUTSIDE ACTUARIES.—Under the proc-  
6                   esses under paragraph (1)(A), eligible entities and  
7                   MedicareAdvantage organizations may use actuarial opin-  
8                   ions certified by independent, qualified actuaries to estab-  
9                   lish actuarial values, but the Administrator shall determine  
10                  whether such actuarial values meet the requirements under  
11                  subsection (c)(1).

12                  “REQUIREMENTS FOR ENTITIES OFFERING MEDICARE  
13                  PRESCRIPTION DRUG PLANS; ESTABLISHMENT OF STANDARDS

14                  “SEC. 1860D-7. (a) GENERAL REQUIREMENTS.—An eligi-  
15                  ble entity offering a Medicare Prescription Drug plan shall  
16                  meet the following requirements:

17                  “(1) LICENSURE.—Subject to subsection (c), the enti-  
18                  ty is organized and licensed under State law as a risk-bear-  
19                  ing entity eligible to offer health insurance or health bene-  
20                  fits coverage in each State in which it offers a Medicare  
21                  Prescription Drug plan.

22                  “(2) ASSUMPTION OF FINANCIAL RISK.—

23                  “(A) IN GENERAL.—Subject to subparagraph (B)  
24                  and subsections (d)(2) and (e) of section 1860D-13, to  
25                  the extent that the entity is at risk pursuant to such  
26                  section 1860D-16, the entity assumes financial risk on  
27                  a prospective basis for the benefits that it offers under  
28                  a Medicare Prescription Drug plan and that is not cov-  
29                  ered under section 1860D-20.

30                  “(B) REINSURANCE PERMITTED.—To the extent  
31                  that the entity is at risk pursuant to section 1860D-  
32                  16, the entity may obtain insurance or make other ar-  
33                  rangements for the cost of coverage provided to any en-  
34                  rolled member under this part.

35                  “(3) SOLVENCY FOR UNLICENSED ENTITIES.—In the  
36                  case of an eligible entity that is not described in paragraph  
37                  (1) and for which a waiver has been approved under sub-

1 section (c), such entity shall meet solvency standards estab-  
2 lished by the Administrator under subsection (d).

3 “(b) CONTRACT REQUIREMENTS.—The Administrator  
4 shall not permit an eligible beneficiary to elect a Medicare Pre-  
5 scription Drug plan offered by an eligible entity under this  
6 part, and the entity shall not be eligible for payments under  
7 section 1860D–16 or 1860D–20, unless the Administrator has  
8 entered into a contract under this subsection with the entity  
9 with respect to the offering of such plan. Such a contract with  
10 an entity may cover more than 1 Medicare Prescription Drug  
11 plan. Such contract shall provide that the entity agrees to com-  
12 ply with the applicable requirements and standards of this part  
13 and the terms and conditions of payment as provided for in  
14 this part.

15 “(c) WAIVER OF CERTAIN REQUIREMENTS IN ORDER TO  
16 ENSURE BENEFICIARY CHOICE.—

17 “(1) IN GENERAL.—In the case of an eligible entity  
18 that seeks to offer a Medicare Prescription Drug plan in  
19 a State, the Administrator shall waive the requirement of  
20 subsection (a)(1) that the entity be licensed in that State  
21 if the Administrator determines, based on the application  
22 and other evidence presented to the Administrator, that  
23 any of the grounds for approval of the application described  
24 in paragraph (2) have been met.

25 “(2) GROUNDS FOR APPROVAL.—The grounds for ap-  
26 proval under this paragraph are the grounds for approval  
27 described in subparagraphs (B), (C), and (D) of section  
28 1855(a)(2), and also include the application by a State of  
29 any grounds other than those required under Federal law.

30 “(3) APPLICATION OF WAIVER PROCEDURES.—With  
31 respect to an application for a waiver (or a waiver granted)  
32 under this subsection, the provisions of subparagraphs (E),  
33 (F), and (G) of section 1855(a)(2) shall apply.

34 “(4) REFERENCES TO CERTAIN PROVISIONS.—For  
35 purposes of this subsection, in applying the provisions of  
36 section 1855(a)(2) under this subsection to Medicare Pre-  
37 scription Drug plans and eligible entities—

1           “(A) any reference to a waiver application under  
2           section 1855 shall be treated as a reference to a waiver  
3           application under paragraph (1); and

4           “(B) any reference to solvency standards were  
5           treated as a reference to solvency standards established  
6           under subsection (d).

7           “(d) SOLVENCY STANDARDS FOR NON-LICENSED ENTI-  
8           TIES.—

9           “(1) ESTABLISHMENT AND PUBLICATION.—The Ad-  
10          ministrator, in consultation with the National Association  
11          of Insurance Commissioners, shall establish and publish, by  
12          not later than January 1, 2005, financial solvency and cap-  
13          ital adequacy standards for entities described in paragraph  
14          (2).

15          “(2) COMPLIANCE WITH STANDARDS.—An eligible en-  
16          tity that is not licensed by a State under subsection (a)(1)  
17          and for which a waiver application has been approved  
18          under subsection (c) shall meet solvency and capital ade-  
19          quacy standards established under paragraph (1). The Ad-  
20          ministrator shall establish certification procedures for such  
21          eligible entities with respect to such solvency standards in  
22          the manner described in section 1855(c)(2).

23          “(e) LICENSURE DOES NOT SUBSTITUTE FOR OR CON-  
24          STITUTE CERTIFICATION.—The fact that an entity is licensed  
25          in accordance with subsection (a)(1) or has a waiver application  
26          approved under subsection (c) does not deem the eligible entity  
27          to meet other requirements imposed under this part for an eli-  
28          gible entity.

29          “(f) INCORPORATION OF CERTAIN MEDICAREADVANTAGE  
30          CONTRACT REQUIREMENTS.—The following provisions of sec-  
31          tion 1857 shall apply, subject to subsection (c)(4), to contracts  
32          under this section in the same manner as they apply to con-  
33          tracts under section 1857(a):

34                  “(1) PROTECTIONS AGAINST FRAUD AND BENEFICIARY  
35                  PROTECTIONS.—Section 1857(d).

36                  “(2) INTERMEDIATE SANCTIONS.—Section 1857(g),  
37                  except that in applying such section—

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

3           “(B) the reference in section 1857(g)(1)(F) to sec-  
4           tion 1852(k)(2)(A)(ii) shall not be applied.

5           “(3) PROCEDURES FOR TERMINATION.—Section  
6           1857(h).

7           “(g) OTHER STANDARDS.—The Administrator shall estab-  
8           lish by regulation other standards (not described in subsection  
9           (d)) for eligible entities and Medicare Prescription Drug plans  
10          consistent with, and to carry out, this part. The Administrator  
11          shall publish such regulations by January 1, 2005.

12          “(h) PERIODIC REVIEW AND REVISION OF STANDARDS.—

13           “(1) IN GENERAL.—Subject to paragraph (2), the Ad-  
14          ministrator shall periodically review the standards estab-  
15          lished under this section and, based on such review, may  
16          revise such standards if the Administrator determines such  
17          revision to be appropriate.

18           “(2) PROHIBITION OF MIDYEAR IMPLEMENTATION OF  
19          SIGNIFICANT NEW REGULATORY REQUIREMENTS.—The Ad-  
20          ministrator may not implement, other than at the begin-  
21          ning of a calendar year, regulations under this section that  
22          impose new, significant regulatory requirements on an eligi-  
23          ble entity or a Medicare Prescription Drug plan.

24          “(h) RELATION TO STATE LAWS.—

25           “(1) IN GENERAL.—The standards established under  
26          this part shall supersede any State law or regulation (in-  
27          cluding standards described in paragraph (2)) with respect  
28          to Medicare Prescription Drug plans which are offered by  
29          eligible entities under this part—

30           “(A) to the extent such law or regulation is incon-  
31          sistent with such standards; and

32           “(B) in the same manner as such laws and regula-  
33          tions are superseded under section 1856(b)(3).

34           “(2) STANDARDS SPECIFICALLY SUPERSEDED.—State  
35          standards relating to the following are superseded under  
36          this section:

1           “(A) Benefit requirements, including requirements  
2 relating to cost-sharing and the structure of  
3 formularies.

4           “(B) Premiums.

5           “(C) Requirements relating to inclusion or treat-  
6 ment of providers.

7           “(D) Coverage determinations (including related  
8 appeals and grievance processes).

9           “(E) Requirements relating to marketing mate-  
10 rials and summaries and schedules of benefits regard-  
11 ing a Medicare Prescription Drug plan.

12           “(3) PROHIBITION OF STATE IMPOSITION OF PREMIUM  
13 TAXES.—No State may impose a premium tax or similar  
14 tax with respect to—

15           “(A) monthly beneficiary obligations paid to the  
16 Administrator for Medicare Prescription Drug plans  
17 under this part; or

18           “(B) any payments made by the Administrator  
19 under this part to an eligible entity offering such a  
20 plan.

21           “Subpart 2—Prescription Drug Delivery System

22           “ESTABLISHMENT OF SERVICE AREAS

23           “SEC. 1860D-10. (a) ESTABLISHMENT.—

24           “(1) INITIAL ESTABLISHMENT.—Not later than April  
25 15, 2005, the Administrator shall establish and publish the  
26 service areas in which Medicare Prescription Drug plans  
27 may offer benefits under this part.

28           “(2) PERIODIC REVIEW AND REVISION OF SERVICE  
29 AREAS.—The Administrator shall periodically review the  
30 service areas applicable under this section and, based on  
31 such review, may revise such service areas if the Adminis-  
32 trator determines such revision to be appropriate.

33           “(b) REQUIREMENTS FOR ESTABLISHMENT OF SERVICE  
34 AREAS.—

35           “(1) IN GENERAL.—The Administrator shall establish  
36 the service areas under subsection (a) in a manner that—

1                   “(A) maximizes the availability of Medicare Pre-  
2                   scription Drug plans to eligible beneficiaries; and

3                   “(B) minimizes the ability of eligible entities offer-  
4                   ing such plans to favorably select eligible beneficiaries.

5                   “(2) ADDITIONAL REQUIREMENTS.—The Adminis-  
6                   trator shall establish the service areas under subsection (a)  
7                   consistent with the following requirements:

8                   “(A) There shall be at least 10 service areas.

9                   “(B) Each service area must include at least 1  
10                  State.

11                  “(C) The Administrator may not divide States so  
12                  that portions of the State are in different service areas.

13                  “(D) To the extent possible, the Administrator  
14                  shall include multistate metropolitan statistical areas in  
15                  a single service area. The Administrator may divide  
16                  metropolitan statistical areas where it is necessary to  
17                  establish service areas of such size and geography as to  
18                  maximize the participation of Medicare Prescription  
19                  Drug plans.

20                  “(3) MAY CONFORM TO MEDICAREADVANTAGE PRE-  
21                  ferred PROVIDER REGIONS.—The Administrator may con-  
22                  form the service areas established under this section to the  
23                  preferred provider regions established under section  
24                  1858(a)(3).

25                  “PUBLICATION OF RISK ADJUSTERS

26                  “SEC. 1860D–11. (a) PUBLICATION.—Not later than  
27                  April 15 of each year (beginning in 2005), the Administrator  
28                  shall publish the risk adjusters established under subsection (b)  
29                  to be used in computing—

30                  “(1) the amount of payment to Medicare Prescription  
31                  Drug plans in the subsequent year under section 1860D–  
32                  16(a), insofar as it is attributable to standard prescription  
33                  drug coverage (or actuarially equivalent prescription drug  
34                  coverage); and

35                  “(2) the amount of payment to MedicareAdvantage  
36                  plans in the subsequent year under section 1858A(c), inso-

1 far as it is attributable to standard prescription drug cov-  
2 erage (or actuarially equivalent prescription drug coverage).

3 “(b) ESTABLISHMENT OF RISK ADJUSTERS.—

4 “(1) IN GENERAL.—Subject to paragraph (2), the Ad-  
5 ministrator shall establish an appropriate methodology for  
6 adjusting the amount of payment to plans referred to in  
7 subsection (a) to take into account variation in costs based  
8 on the differences in actuarial risk of different enrollees  
9 being served. Any such risk adjustment shall be designed  
10 in a manner as to not result in a change in the aggregate  
11 payments described in paragraphs (1) and (2) of subsection  
12 (a).

13 “(2) CONSIDERATIONS.—In establishing the method-  
14 ology under paragraph (1), the Administrator may take  
15 into account the similar methodologies used under section  
16 1853(a)(3) to adjust payments to MedicareAdvantage orga-  
17 nizations.

18 “(3) DATA COLLECTION.—In order to carry out this  
19 subsection, the Administrator shall require—

20 “(A) eligible entities to submit data regarding  
21 drug claims that can be linked at the beneficiary level  
22 to part A and part B data and such other information  
23 as the Administrator determines necessary; and

24 “(B) MedicareAdvantage organizations (except  
25 MSA plans or a private fee-for-service plan that does  
26 not provide qualified prescription drug coverage) to  
27 submit data regarding drug claims that can be linked  
28 to other data that such organizations are required to  
29 submit to the Administrator and such other informa-  
30 tion as the Administrator determines necessary.

31 “SUBMISSION OF BIDS FOR PROPOSED MEDICARE  
32 PRESCRIPTION DRUG PLANS

33 “SEC. 1860D–12. (a) SUBMISSION.—

34 “(1) IN GENERAL.—Each eligible entity that intends  
35 to offer a Medicare Prescription Drug plan in an area in  
36 a year (beginning with 2006) shall submit to the Adminis-  
37 trator, at such time in the previous year and in such man-

1 ner as the Administrator may specify, such information as  
2 the Administrator may require, including the information  
3 described in subsection (b).

4 “(2) ANNUAL SUBMISSION.—An eligible entity shall  
5 submit the information required under paragraph (1) with  
6 respect to a Medicare Prescription Drug plan that the enti-  
7 ty intends to offer on an annual basis.

8 “(b) INFORMATION DESCRIBED.—The information de-  
9 scribed in this subsection includes information on each of the  
10 following:

11 “(1) The benefits under the plan (as required under  
12 section 1860D–6).

13 “(2) The actuarial value of the qualified prescription  
14 drug coverage.

15 “(3) The amount of the monthly plan premium under  
16 the plan, including an actuarial certification of—

17 “(A) the actuarial basis for such monthly plan  
18 premium;

19 “(B) the portion of such monthly plan premium  
20 attributable to standard prescription drug coverage or  
21 actuarially equivalent prescription drug coverage and, if  
22 applicable, to benefits that are in addition to such cov-  
23 erage; and

24 “(C) the reduction in such monthly plan premium  
25 resulting from the payments provided under section  
26 1860D–20.

27 “(4) The service area for the plan.

28 “(5) Whether the entity plans to use any funds in the  
29 plan stabilization reserve fund in the Prescription Drug Ac-  
30 count that are available to the entity to stabilize or reduce  
31 the monthly plan premium submitted under paragraph (3),  
32 and if so, the amount in such reserve fund that is to be  
33 used.

34 “(6) Such other information as the Administrator may  
35 require to carry out this part.

36 “(c) OPTIONS REGARDING SERVICE AREAS.—

1           “(1) IN GENERAL.—The service area of a Medicare  
2 Prescription Drug plan shall be either—

3           “(A) the entire area of 1 of the service areas es-  
4 tablished by the Administrator under section 1860D-  
5 10; or

6           “(B) the entire area covered by the medicare pro-  
7 gram.

8           “(2) RULE OF CONSTRUCTION.—Nothing in this part  
9 shall be construed as prohibiting an eligible entity from  
10 submitting separate bids in multiple service areas as long  
11 as each bid is for a single service area.

12 “APPROVAL OF PROPOSED MEDICARE PRESCRIPTION DRUG  
13 PLANS

14 “SEC. 1860D-13. (a) APPROVAL.—

15           “(1) IN GENERAL.—The Administrator shall review  
16 the information filed under section 1860D-12 and shall ap-  
17 prove or disapprove the Medicare Prescription Drug plan.

18           “(2) REQUIREMENTS FOR APPROVAL.—The Adminis-  
19 trator may not approve a Medicare Prescription Drug plan  
20 unless the following requirements are met:

21           “(A) COMPLIANCE WITH REQUIREMENTS.—The  
22 plan and the entity offering the plan comply with the  
23 requirements under this part.

24           “(B) APPLICATION OF FEHBP STANDARD.—(i)  
25 The portion of the monthly plan premium submitted  
26 under section 1860D-12(b) that is attributable to  
27 standard prescription drug coverage reasonably and eq-  
28 uitably reflects the actuarial value of the standard pre-  
29 scription drug coverage less the actuarial value of the  
30 reinsurance payments under section 1860D-20 and the  
31 amount of any funds in the plan stabilization reserve  
32 fund in the Prescription Drug Account used to stabilize  
33 or reduce the monthly plan premium.

34           “(ii) If the plan provides additional prescription  
35 drug coverage pursuant to section 1860D-6(a)(2), the  
36 monthly plan premium reasonably and equitably re-  
37 flects the actuarial value of the coverage provided less

1           the actuarial value of the reinsurance payments under  
2           section 1860D-20 and the amount of any funds in the  
3           plan stabilization reserve fund in the Prescription Drug  
4           Account used to stabilize or reduce the monthly plan  
5           premium.

6           “(b) NEGOTIATION.—In exercising the authority under  
7 subsection (a), the Administrator shall have the authority to—

8           “(1) negotiate the terms and conditions of the pro-  
9           posed monthly plan premiums submitted and other terms  
10          and conditions of a proposed plan; and

11          “(2) disapprove, or limit enrollment in, a proposed  
12          plan based on—

13                  “(A) the costs to beneficiaries under the plan;

14                  “(B) the quality of the coverage and benefits  
15                  under the plan;

16                  “(C) the adequacy of the network under the plan;

17          or

18                  “(D) other factors determined appropriate by the  
19          Administrator.

20          “(c) SPECIAL RULES FOR APPROVAL.—The Administrator  
21 may approve a Medicare Prescription Drug plan submitted  
22 under section 1860D-12 only if the benefits under such plan—

23          “(1) include the required benefits under section  
24          1860D-6(a)(1); and

25          “(2) are not designed in such a manner that the Ad-  
26          ministrator finds is likely to result in favorable selection of  
27          eligible beneficiaries.

28          “(d) ACCESS TO COMPETITIVE COVERAGE.—

29          “(1) NUMBER OF CONTRACTS.—The Administrator,  
30 consistent with the requirements of this part and the goal  
31 of containing costs under this title, shall, with respect to  
32 a year, approve at least 2 contracts to offer a Medicare  
33 Prescription Drug plan in each service area (established  
34 under section 1860D-10) for the year.

35          “(2) AUTHORITY TO REDUCE RISK TO ENSURE AC-  
36          CESS.—

1           “(A) IN GENERAL.—Subject to subparagraph (B),  
2           if the Administrator determines, with respect to an  
3           area, that the access required under paragraph (1) is  
4           not going to be provided in the area during the subse-  
5           quent year, the Administrator shall—

6                   “(i) adjust the percents specified in para-  
7                   graphs (2) and (4) of section 1860D–16(b) in an  
8                   area in a year; or

9                   “(ii) increase the percent specified in section  
10                   1860D–20(c)(1) in an area in a year.

11           The administrator shall exercise the authority under  
12           the preceding sentence only so long as (and to the ex-  
13           tent) necessary to assure the access guaranteed under  
14           paragraph (1).

15           “(B) REQUIREMENTS FOR USE OF AUTHORITY.—  
16           In exercising authority under subparagraph (A), the  
17           Administrator—

18                   “(i) shall not provide for the full underwriting  
19                   of financial risk for any eligible entity;

20                   “(ii) shall not provide for any underwriting of  
21                   financial risk for a public eligible entity with re-  
22                   spect to the offering of a nationwide Medicare Pre-  
23                   scription Drug plan; and

24                   “(iii) shall seek to maximize the assumption of  
25                   financial risk by eligible entities to ensure fair com-  
26                   petition among Medicare Prescription Drug plans.

27           “(C) REQUIREMENT TO ACCEPT 2 FULL-RISK  
28           QUALIFIED BIDS BEFORE EXERCISING AUTHORITY.—  
29           The Administrator may not exercise the authority  
30           under subparagraph (A) with respect to an area and  
31           year if 2 or more qualified bids are submitted by eligi-  
32           ble entities to offer a Medicare Prescription Drug plan  
33           in the area for the year under paragraph (1) before the  
34           application of subparagraph (A).

35           “(D) REPORTS.—The Administrator, in each an-  
36           nual report to Congress under section 1808(c)(1)(D),  
37           shall include information on the exercise of authority

1 under subparagraph (A). The Administrator also shall  
2 include such recommendations as may be appropriate  
3 to limit the exercise of such authority.

4 “(e) GUARANTEED ACCESS.—

5 “(1) ACCESS.—In order to assure access to qualified  
6 prescription drug coverage in an area, the Administrator  
7 shall take the following steps:

8 “(A) DETERMINATION.—Not later than September  
9 1 of each year (beginning in 2005) and for each area  
10 (established under section 1860D–10), the Adminis-  
11 trator shall make a determination as to whether the ac-  
12 cess required under subsection (d)(1) is going to be  
13 provided in the area during the subsequent year. Such  
14 determination shall be made after the Administrator  
15 has exercised the authority under subsection (d)(2).

16 “(B) CONTRACT WITH AN ENTITY TO PROVIDE  
17 COVERAGE IN AN AREA.—Subject to paragraph (3), if  
18 the Administrator makes a determination under sub-  
19 paragraph (A) that the access required under sub-  
20 section (d)(1) is not going to be provided in an area  
21 during the subsequent year, the Administrator shall  
22 enter into a contract with an entity to provide eligible  
23 beneficiaries enrolled under this part (and not, except  
24 for an MSA plan or a private fee-for-service plan that  
25 does not provide qualified prescription drug coverage  
26 enrolled in a MedicareAdvantage plan) and residing in  
27 the area with standard prescription drug coverage (in-  
28 cluding access to negotiated prices for such bene-  
29 ficiaries pursuant to section 1860D–6(e)) during the  
30 subsequent year. An entity may be awarded a contract  
31 for more than 1 of the areas for which the Adminis-  
32 trator is required to enter into a contract under this  
33 paragraph but the Administrator may enter into only  
34 1 such contract in each such area. An entity with a  
35 contract under this part shall meet the requirements  
36 described in section 1860D–5 and such other require-  
37 ments determined appropriate by the Administrator.

1           “(C) REQUIREMENT TO ACCEPT 2 REDUCED-RISK  
2           QUALIFIED BIDS BEFORE ENTERING INTO CON-  
3           TRACT.—The Administrator may not enter into a con-  
4           tract under subparagraph (B) with respect to an area  
5           and year if 2 or more qualified bids are submitted by  
6           eligible entities to offer a Medicare Prescription Drug  
7           plan in the area for the year after the Administrator  
8           has exercised the authority under subsection (d)(2) in  
9           the area for the year.

10           “(D) ENTITY REQUIRED TO MEET BENEFICIARY  
11           PROTECTION AND OTHER REQUIREMENTS.—An entity  
12           with a contract under subparagraph (B) shall meet the  
13           requirements described in section 1860D–5 and such  
14           other requirements determined appropriate by the Ad-  
15           ministrator.

16           “(E) COMPETITIVE PROCEDURES.—Competitive  
17           procedures (as defined in section 4(5) of the Office of  
18           Federal Procurement Policy Act (41 U.S.C. 403(5)))  
19           shall be used to enter into a contract under subpara-  
20           graph (B).

21           “(2) MONTHLY BENEFICIARY OBLIGATION FOR EN-  
22           ROLLMENT.—

23           “(A) IN GENERAL.—In the case of an eligible ben-  
24           eficiary receiving access to qualified prescription drug  
25           coverage through enrollment with an entity with a con-  
26           tract under paragraph (1)(B), the monthly beneficiary  
27           obligation of such beneficiary for such enrollment shall  
28           be an amount equal to the applicable percent (for the  
29           area in which the beneficiary resides, as determined  
30           under section 1860D–17(c)) of the monthly national  
31           average premium (as computed under section 1860D–  
32           15) for the year as adjusted using the geographic ad-  
33           juster under subparagraph (B).

34           “(B) ESTABLISHMENT OF GEOGRAPHIC AD-  
35           JUSTER.—The Administrator shall establish an appro-  
36           priate methodology for adjusting the monthly national  
37           average premium (as computed under subsection (a))

1 for the year in an area to take into account differences  
2 in drug prices among areas. In establishing such meth-  
3 odology, the Administrator may take into account dif-  
4 ferences in drug utilization between eligible bene-  
5 ficiaries in an area and eligible beneficiaries in other  
6 areas and the results of the ongoing study required  
7 under section 106. Any such adjustment shall be ap-  
8 plied in a manner so as to not result in a change in  
9 the aggregate payments made under this part that  
10 would have been made if the Administrator had not ap-  
11 plied such adjustment.

12 “(3) PAYMENTS UNDER THE CONTRACT.—

13 “(A) IN GENERAL.—A contract entered into under  
14 paragraph (1)(B) shall provide for—

15 “(i) payment for the negotiated costs of cov-  
16 ered drugs provided to eligible beneficiaries enrolled  
17 with the entity; and

18 “(ii) payment of prescription management fees  
19 that are tied to performance requirements estab-  
20 lished by the Administrator for the management,  
21 administration, and delivery of the benefits under  
22 the contract.

23 “(B) PERFORMANCE REQUIREMENTS.—The per-  
24 formance requirements established by the Adminis-  
25 trator pursuant to subparagraph (A)(ii) shall include  
26 the following:

27 “(i) The entity contains costs to the Prescrip-  
28 tion Drug Account and to eligible beneficiaries en-  
29 rolled under this part and with the entity.

30 “(ii) The entity provides such beneficiaries  
31 with quality clinical care.

32 “(iii) The entity provides such beneficiaries  
33 with quality services.

34 “(C) ENTITY ONLY AT RISK TO THE EXTENT OF  
35 THE FEES TIED TO PERFORMANCE REQUIREMENTS.—  
36 An entity with a contract under paragraph (1)(B) shall  
37 only be at risk for the provision of benefits under the

1 contract to the extent that the management fees paid  
2 to the entity are tied to performance requirements  
3 under subparagraph (A)(ii).

4 “(4) ELIGIBLE ENTITY THAT SUBMITTED A BID FOR  
5 THE AREA NOT ELIGIBLE TO BE AWARDED THE CON-  
6 TRACT.—An eligible entity that submitted a bid to offer a  
7 Medicare Prescription Drug plan for an area for a year  
8 under section 1860D–12, including a bid submitted after  
9 the Administrator has exercised the authority under sub-  
10 section (d)(2), may not be awarded a contract under para-  
11 graph (1)(B) for that area and year. The previous sentence  
12 shall apply to an entity that was awarded a contract under  
13 paragraph (1)(B) for the area in the previous year and  
14 submitted such a bid under section 1860D–12 for the year.

15 “(5) TERM OF CONTRACT.—A contract entered into  
16 under paragraph (1)(B) shall be for a 1-year period. Such  
17 contract may provide for renewal at the discretion of the  
18 Administrator if the Administrator is required to enter into  
19 a contract under such paragraph with respect to the area  
20 covered by such contract for the subsequent year.

21 “(6) ENTITY NOT PERMITTED TO MARKET OR BRAND  
22 THE CONTRACT.—An entity with a contract under para-  
23 graph (1)(B) may not engage in any marketing or branding  
24 of such contract. For purposes of providing information to  
25 beneficiaries under sections 1860D–4 and 1860D–5(a),  
26 such contract shall be identified as the Medicare plan.

27 “(7) RULES FOR AREAS WHERE ONLY 1 COMPETI-  
28 TIVELY BID PLAN WAS APPROVED.—In the case of an area  
29 where (before the application of this subsection) only 1  
30 Medicare Prescription Drug plan was approved for a  
31 year—

32 “(A) the plan may (at the option of the plan) be  
33 offered in the area for the year (under rules applicable  
34 to such plans under this part and not under this sub-  
35 section);

36 “(B) eligible beneficiaries described in paragraph  
37 (1)(B) may receive access to qualified prescription drug

1 coverage through enrollment in the plan or with an en-  
2 tity with a contract under paragraph (1)(B); and

3 “(C) for purposes of applying section 1860D-  
4 3(a)(1)(A)(ii), such plan shall be the plan designated in  
5 the area under such section.

6 “(f) TWO-YEAR CONTRACTS.—Except for a contract en-  
7 tered into under subsection (e)(1)(B), a contract approved  
8 under this part (including a contract under) shall be for a 2-  
9 year period.

10 “COMPUTATION OF MONTHLY STANDARD PRESCRIPTION DRUG  
11 COVERAGE PREMIUMS

12 “SEC. 1860D-14. (a) IN GENERAL.—For each year (be-  
13 ginning with 2006), the Administrator shall compute a monthly  
14 standard prescription drug coverage premium for each Medi-  
15 care Prescription Drug plan approved under section 1860D-13  
16 and for each MedicareAdvantage plan.

17 “(b) REQUIREMENTS.—The monthly standard prescription  
18 drug coverage premium for a plan for a year shall be equal  
19 to—

20 “(1) in the case of a plan offered by an eligible entity  
21 or MedicareAdvantage organization that provides standard  
22 prescription drug coverage or an actuarially equivalent pre-  
23 scription drug coverage and does not provide additional  
24 prescription drug coverage pursuant to section 1860D-  
25 6(a)(2), the monthly plan premium approved for the plan  
26 under section 1860D-13 for the year; and

27 “(2) in the case of a plan offered by an eligible entity  
28 or MedicareAdvantage organization that provides additional  
29 prescription drug coverage pursuant to section 1860D-  
30 6(a)(2)—

31 “(A) an amount that reflects only the actuarial  
32 value of the standard prescription drug coverage of-  
33 fered under the plan; or

34 “(B) if determined appropriate by the Adminis-  
35 trator, the monthly plan premium approved under sec-  
36 tion 1860D-13 for the year for the Medicare Prescrip-  
37 tion Drug plan (or, if applicable, the

1 MedicareAdvantage plan) that, as required under sec-  
2 tion 1860D-6(a)(2)(B) for a Medicare Prescription  
3 Drug plans and a MedicareAdvantage plan—

4 “(i) is offered by such entity or organization  
5 in the same area as the plan; and

6 “(ii) does not provide additional prescription  
7 drug coverage pursuant to such section.

8 “COMPUTATION OF MONTHLY NATIONAL AVERAGE PREMIUM

9 “SEC. 1860D-15. (a) COMPUTATION.—

10 “(1) IN GENERAL.—For each year (beginning with  
11 2006) the Administrator shall compute a monthly national  
12 average premium equal to the average of the monthly  
13 standard prescription drug coverage premium for each  
14 Medicare Prescription Drug plan and each  
15 MedicareAdvantage plan (as computed under section  
16 1860D-14). Such premium may be adjusted pursuant to  
17 any methodology determined under subsection (b), as deter-  
18 mined appropriate by the Administrator.

19 “(2) WEIGHTED AVERAGE.—The monthly national av-  
20 erage premium computed under paragraph (1) shall be a  
21 weighted average, with the weight for each plan being equal  
22 to the average number of beneficiaries enrolled under such  
23 plan in the previous year.

24 “(b) GEOGRAPHIC ADJUSTMENT.—The Administrator  
25 shall establish an appropriate methodology for adjusting the  
26 monthly national average premium (as computed under sub-  
27 section (a)) for the year in an area to take into account dif-  
28 ferences in prices for covered drugs among different areas. In  
29 establishing such methodology, the Administrator may take into  
30 account differences in drug utilization between eligible bene-  
31 ficiaries in that area and other eligible beneficiaries. Any such  
32 adjustment shall be applied in a manner as to not result in a  
33 change in aggregate payments made under this part than  
34 would have been made if the Administrator had not applied  
35 such adjustment.

36 “(c) SPECIAL RULE FOR 2006.—For purposes of applying  
37 this section for 2006, the Administrator shall establish proce-

1 dures for determining the weighted average under subsection  
2 (a)(2) for 2005.

3 "PAYMENTS TO ELIGIBLE ENTITIES

4 "SEC. 1860D-16. (a) PAYMENT OF MONTHLY PLAN PRE-  
5 MIUMS.—For each year (beginning with 2006), the Adminis-  
6 trator shall pay to each entity offering a Medicare Prescription  
7 Drug plan in which an eligible beneficiary is enrolled an  
8 amount equal to the full amount of the monthly plan premium  
9 approved for the plan under section 1860D-13 on behalf of  
10 each eligible beneficiary enrolled in such plan for the year, as  
11 adjusted using the risk adjusters that apply to the standard  
12 prescription drug coverage published under section 1860D-11.

13 "(b) PORTION OF TOTAL PAYMENTS OF MONTHLY PLAN  
14 PREMIUMS SUBJECT TO RISK.—

15 "(1) NOTIFICATION OF SPENDING UNDER THE  
16 PLAN.—

17 "(A) IN GENERAL.—For each year (beginning in  
18 2007), the eligible entity offering a Medicare Prescrip-  
19 tion Drug plan shall notify the Administrator of the  
20 following:

21 "(i) TOTAL ACTUAL COSTS.—The total  
22 amount of costs that the entity incurred in pro-  
23 viding standard prescription drug coverage (or pre-  
24 scription drug coverage that is actuarially equiva-  
25 lent pursuant to section 1860D-6(a)(1)(B)) for all  
26 enrollees under the plan in the previous year.

27 "(ii) ACTUAL COSTS FOR SPECIFIC DRUGS.—  
28 With respect to the total amount under clause (i)  
29 for the year, a breakdown of—

30 "(I) each covered drug that constitutes a  
31 portion of such amount;

32 "(II) the negotiated price for the eligible  
33 entity for each such drug;

34 "(III) the number of prescriptions; and

35 "(IV) the average beneficiary coinsurance  
36 rate for a each covered drug that constitutes a  
37 portion of such amount.

1           “(B) CERTAIN EXPENSES NOT INCLUDED.—The  
2 amounts under clauses (i) and (ii)(II) of subparagraph  
3 (A) may not include—

4           “(i) administrative expenses incurred in pro-  
5 viding the coverage described in subparagraph  
6 (A)(i);

7           “(ii) amounts expended on providing addi-  
8 tional prescription drug coverage pursuant to sec-  
9 tion 1860D-6(a)(2); or

10           “(iii) amounts expended for which the entity is  
11 subsequently provided with reinsurance payments  
12 under section 1860D-20.

13           “(2) ADJUSTMENT OF PAYMENT.—

14           “(A) NO ADJUSTMENT IF ALLOWABLE COSTS  
15 WITHIN RISK CORRIDOR.—If the allowable costs (speci-  
16 fied in paragraph (3)) for the plan for the year are not  
17 more than the first threshold upper limit of the risk  
18 corridor (specified in paragraph (4)(A)(iii)) and are not  
19 less than the first threshold lower limit of the risk cor-  
20 ridor (specified in paragraph (4)(A)(i)) for the plan for  
21 the year, then no additional payments shall be made by  
22 the Administrator and no payments shall be made by  
23 (or collected from) the eligible entity offering the plan.

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

26           “(i) IN GENERAL.—If the allowable costs for  
27 the plan for the year are more than the first  
28 threshold upper limit of the risk corridor for the  
29 plan for the year, then the Administrator shall in-  
30 crease the total of the monthly payments made to  
31 the entity offering the plan for the year under sub-  
32 section (a) by an amount equal to the sum of—

33           “(I) the applicable percent (as defined in  
34 subparagraph (D)) of such allowable costs  
35 which are more than such first threshold upper  
36 limit of the risk corridor and not more than the  
37 second threshold upper limit of the risk cor-

1                   ridor for the plan for the year (as specified  
2                   under paragraph (4)(A)(iv)); and

3                   “(II) 90 percent of such allowable costs  
4                   which are more than such second threshold  
5                   upper limit of the risk corridor.

6                   “(ii) SPECIAL TRANSITIONAL CORRIDOR FOR  
7                   2006 AND 2007.—If the Administrator determines  
8                   with respect to 2006 or 2007 that at least 60 per-  
9                   cent of Medicare Prescription Drug plans and  
10                  Medicare Advantage Plans (excluding MSA plans or  
11                  private fee-for-service plans that do not provide  
12                  qualified prescription drug coverage) have allowable  
13                  costs for the plan for the year that are more than  
14                  the first threshold upper limit of the risk corridor  
15                  for the plan for the year and that such plans rep-  
16                  resent at least 60 percent of eligible beneficiaries  
17                  enrolled under this part, clause (i)(I) shall be ap-  
18                  plied by substituting ‘90 percent’ for ‘applicable  
19                  percent’.

20                  “(C) PLAN PAYMENT IF ALLOWABLE COSTS  
21                  BELOW LOWER LIMIT OF RISK CORRIDOR.—If the al-  
22                  lowable costs for the plan for the year are less than the  
23                  first threshold lower limit of the risk corridor for the  
24                  plan for the year, then the entity offering the plan shall  
25                  a make a payment to the Administrator of an amount  
26                  (or the Administrator shall otherwise recover from the  
27                  plan an amount) equal to—

28                  “(i) the applicable percent (as so defined) of  
29                  such allowable costs which are less than such first  
30                  threshold lower limit of the risk corridor and not  
31                  less than the second threshold lower limit of the  
32                  risk corridor for the plan for the year (as specified  
33                  under paragraph (4)(A)(ii)); and

34                  “(ii) 90 percent of such allowable costs which  
35                  are less than such second threshold lower limit of  
36                  the risk corridor.

1           “(D) APPLICABLE PERCENT DEFINED.—For pur-  
2           poses of this paragraph, the term ‘applicable percent’  
3           means—

4                   “(i) for 2006 and 2007, 75 percent; and

5                   “(ii) for 2008 and subsequent years, 50 per-  
6           cent.

7           “(3) ESTABLISHMENT OF ALLOWABLE COSTS.—

8                   “(A) IN GENERAL.—For each year, the Adminis-  
9           trator shall establish the allowable costs for each Medi-  
10          care Prescription Drug plan for the year. The allowable  
11          costs for a plan for a year shall be equal to the amount  
12          described in paragraph (1)(A)(i) for the plan for the  
13          year, adjusted under subparagraph (B)(ii).

14                   “(B) REPRICING OF COSTS.—

15                   “(i) CALCULATION OF AVERAGE PLAN COST.—  
16          Utilizing the information obtained under paragraph  
17          (1)(A)(ii) and section 1860D–20(b)(1)(B), for each  
18          year (beginning with 2006), the Administrator shall  
19          establish an average negotiated price with respect  
20          to all Medicare Prescription Drug plans for each  
21          covered drug.

22                   “(ii) ADJUSTMENT IF ACTUAL COSTS EXCEED  
23          AVERAGE COSTS.—With respect to a Medicare Pre-  
24          scription Drug plan for a year, the Administrator  
25          shall reduce the amount described in paragraph  
26          (1)(A)(i) for the plan for the year to the extent  
27          such amount is based on costs of specific covered  
28          drugs furnished under the plan in the year (as  
29          specified under paragraph (1)(A)(ii)) for which the  
30          negotiated prices are greater than the average ne-  
31          gotiated price for the covered drug for the year (as  
32          determined under clause (i)).

33           “(4) ESTABLISHMENT OF RISK CORRIDORS.—

34                   “(A) IN GENERAL.—For each year (beginning  
35          with 2006), the Administrator shall establish a risk  
36          corridor for each Medicare Prescription Drug plan. The

1 risk corridor for a plan for a year shall be equal to a  
2 range as follows:

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

6 “(I) the target amount described in sub-  
7 paragraph (B) for the plan; minus

8 “(II) an amount equal to the first thresh-  
9 old risk percentage for the plan (as determined  
10 under subparagraph (C)(i)) of such target  
11 amount.

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

15 “(I) the target amount described in sub-  
16 paragraph (B) for the plan; minus

17 “(II) an amount equal to the second  
18 threshold risk percentage for the plan (as de-  
19 termined under subparagraph (C)(ii)) of such  
20 target amount.

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

24 “(I) such target amount; and

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

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

30 “(I) such target amount; and

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

33 “(B) TARGET AMOUNT DESCRIBED.—The target  
34 amount described in this paragraph is, with respect to  
35 a Medicare Prescription Drug plan offered by an eligi-  
36 ble entity in a year—

1           “(i) in the case of a plan offered by an eligible  
2           entity that provides standard prescription drug cov-  
3           erage or actuarially equivalent prescription drug  
4           coverage and does not provide additional prescrip-  
5           tion drug coverage pursuant to section 1860D-  
6           6(a)(2), an amount equal to the total of the month-  
7           ly plan premiums paid to such entity for such plan  
8           for the year pursuant to subsection (a), reduced by  
9           the percentage specified in subparagraph (D); and

10           “(ii) in the case of a plan offered by an eligible  
11           entity that provides additional prescription drug  
12           coverage pursuant to section 1860D-6(a)(2), an  
13           amount equal to the total of the monthly plan pre-  
14           miums paid to such entity for such plan for the  
15           year pursuant to subsection (a) that are related to  
16           standard prescription drug coverage (determined  
17           using the rules under section 1860D-14(b)), re-  
18           duced by the percentage specified in subparagraph  
19           (D).

20           “(C) FIRST AND SECOND THRESHOLD RISK PER-  
21           CENTAGE DEFINED.—

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

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

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

27                   and

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

31           “(ii) SECOND THRESHOLD RISK PERCENT-  
32           AGE.—Subject to clause (iii), for purposes of this  
33           section, the second threshold risk percentage is—

34                   “(I) for 2006 and 2007, 5.0 percent;

35                   “(II) for 2008 through 2011, 10 percent

36                   “(III) for 2012 and subsequent years, a  
37                   percentage established by the Administrator

1                   that is greater than the percent established for  
2                   the year under clause (i)(III), but in no case  
3                   less than 10 percent.

4                   “(iii) REDUCTION OF RISK PERCENTAGE TO  
5                   ENSURE 2 PLANS IN AN AREA.—Pursuant to para-  
6                   graph (2) of section 1860D–13(d), the Adminis-  
7                   trator may reduce the applicable first or second  
8                   threshold risk percentage in an area in a year in  
9                   order to ensure the access to plans required under  
10                  paragraph (1) of such section.

11                  “(D) TARGET AMOUNT NOT TO INCLUDE ADMINIS-  
12                  TRATIVE EXPENSES NEGOTIATED BETWEEN THE AD-  
13                  MINISTRATOR AND THE ENTITY OFFERING THE  
14                  PLAN.—For each year (beginning in 2006), the Admin-  
15                  istrator and the entity offering a Medicare Prescription  
16                  Drug plan shall negotiate, as part of the negotiation  
17                  process described in section 1860D–13(b) during the  
18                  previous year, the percentage of the payments to the  
19                  entity under subsection (a) with respect to the plan  
20                  that are attributable and reasonably incurred for ad-  
21                  ministrative expenses for providing standard prescrip-  
22                  tion drug coverage or actuarially equivalent prescrip-  
23                  tion drug coverage in the year.

24                  “(5) PLANS AT RISK FOR ENTIRE AMOUNT OF ADDI-  
25                  TIONAL PRESCRIPTION DRUG COVERAGE.—An eligible enti-  
26                  ty that offers a Medicare Prescription Drug plan that pro-  
27                  vides additional prescription drug coverage pursuant to sec-  
28                  tion 1860D–6(a)(2) shall be at full financial risk for the  
29                  provision of such additional coverage.

30                  “(6) NO EFFECT ON ELIGIBLE BENEFICIARIES.—No  
31                  change in payments made by reason of this subsection shall  
32                  affect the beneficiary obligation under section 1860D–17  
33                  for the year in which such change in payments is made.

34                  “(7) DISCLOSURE OF INFORMATION.—

35                  “(A) IN GENERAL.—Each contract under this part  
36                  shall provide that—

1                   “(i) the entity offering a Medicare Prescrip-  
2                   tion Drug plan shall provide the Administrator  
3                   with such information as the Administrator deter-  
4                   mines is necessary to carry out this section; and

5                   “(ii) the Administrator shall have the right to  
6                   inspect and audit any books and records of the eli-  
7                   gible entity that pertain to the information regard-  
8                   ing costs provided to the Administrator under para-  
9                   graph (1).

10                   “(B) RESTRICTION ON USE OF INFORMATION.—  
11                   Information disclosed or obtained pursuant to the pro-  
12                   visions of this section may be used by officers and em-  
13                   ployees of the Department of Health and Human Serv-  
14                   ices only for the purposes of, and to the extent nec-  
15                   essary in, carrying out this section.

16                   “(c) STABILIZATION RESERVE FUND.—

17                   “(1) ESTABLISHMENT.—

18                   “(A) IN GENERAL.—There is established, within  
19                   the Prescription Drug Account, a stabilization reserve  
20                   fund in which the Administrator shall deposit amounts  
21                   on behalf of eligible entities in accordance with para-  
22                   graph (2) and such amounts shall be made available by  
23                   the Secretary for the use of eligible entities in contract  
24                   year 2008 and subsequent contract years in accordance  
25                   with paragraph (3).

26                   “(B) REVERSION OF UNUSED AMOUNTS.—Any  
27                   amount in the stabilization reserve fund established  
28                   under subparagraph (A) that is not expended by an eli-  
29                   gible entity in accordance with paragraph (3) or that  
30                   was deposited for the use of an eligible entity that no  
31                   longer has a contract under this part shall revert for  
32                   the use of the Prescription Drug Account.

33                   “(2) DEPOSIT OF AMOUNTS FOR 5 YEARS.—

34                   “(A) IN GENERAL.—If the target amount for a  
35                   Medicare Prescription Drug plan for 2006, 2007, 2008,  
36                   2009, or 2010 (as determined under subsection

1 (b)(4)(B)) exceeds the applicable costs for the plan for  
2 the year by more than 3 percent, then—

3 “(i) the entity offering the plan shall make a  
4 payment to the Administrator of an amount (or the  
5 Administrator shall otherwise recover from the plan  
6 an amount) equal to the portion of such excess that  
7 is in excess of 3 percent of the target amount; and

8 “(ii) the Administrator shall deposit an  
9 amount equal to the amount collected or otherwise  
10 recovered under clause (i) in the stabilization re-  
11 serve fund on behalf of the eligible entity offering  
12 such plan.

13 “(B) APPLICABLE COSTS.—For purposes of sub-  
14 paragraph (A), the term ‘applicable costs’ means, with  
15 respect to a Medicare Prescription Drug plan and year,  
16 an amount equal the sum of—

17 “(i) the allowable costs for the plan and year  
18 (as determined under subsection (b)(3)(A); and

19 “(ii) the total amount by which monthly pay-  
20 ments to the plan were reduced (or otherwise recov-  
21 ered from the plan) for the year under subsection  
22 (b)(2)(C).

23 “(3) USE OF RESERVE FUND TO STABILIZE OR RE-  
24 DUCE MONTHLY PLAN PREMIUMS.—

25 “(A) IN GENERAL.—For any contract year begin-  
26 ning after 2007, an eligible entity offering a Medicare  
27 Prescription Drug plan may use funds in the stabiliza-  
28 tion reserve fund in the Prescription Drug Account  
29 that were deposited in such fund on behalf of the entity  
30 to stabilize or reduce monthly plan premiums submitted  
31 under section 1860D–12(b)(3).

32 “(B) PROCEDURES.—The Administrator shall es-  
33 tablish procedures for—

34 “(i) reducing monthly plan premiums sub-  
35 mitted under section 1860D–12(b)(3) pursuant to  
36 subparagraph (A); and

1                   “(ii) making payments from the plan stabiliza-  
2                   tion reserve fund in the Prescription Drug Account  
3                   to eligible entities that inform the Secretary under  
4                   section 1860D–12(b)(5) of the entity’s intent to  
5                   use funds in such reserve fund to reduce such pre-  
6                   miums.

7                   “(d) PORTION OF PAYMENTS OF MONTHLY PLAN PRE-  
8                   MIUMS ATTRIBUTABLE TO ADMINISTRATIVE EXPENSES TIED  
9                   TO PERFORMANCE REQUIREMENTS.—

10                   “(1) IN GENERAL.—The Administrator shall establish  
11                   procedures to adjust the portion of the payments made to  
12                   an entity under subsection (a) that are attributable to ad-  
13                   ministrative expenses (as determined pursuant to sub-  
14                   section (b)(4)(D)) to ensure that the entity meets the per-  
15                   formance requirements described in clauses (ii) and (iii) of  
16                   section 1860D–13(e)(4)(B).

17                   “(2) NO EFFECT ON ELIGIBLE BENEFICIARIES.—No  
18                   change in payments made by reason of this subsection shall  
19                   affect the beneficiary obligation under section 1860D–17  
20                   for the year in which such change in payments is made.

21                   “(e) PAYMENT TERMS.—

22                   “(1) ADMINISTRATOR PAYMENTS.—Payments to an  
23                   entity offering a Medicare Prescription Drug plan under  
24                   this section shall be made in a manner determined by the  
25                   Administrator and based upon the manner in which pay-  
26                   ments are made under section 1853(a) (relating to pay-  
27                   ments to MedicareAdvantage organizations).

28                   “(2) PLAN PAYMENTS.—The Administrator shall es-  
29                   tablish a process for collecting (or other otherwise recover-  
30                   ing) amounts that an entity offering a Medicare Prescrip-  
31                   tion Drug plan is required to make to the Administrator  
32                   under this section.

33                   “(f) PAYMENTS TO MEDICAREADVANTAGE PLANS.—For  
34                   provisions related to payments to MedicareAdvantage organiza-  
35                   tions offering MedicareAdvantage plans for qualified prescrip-  
36                   tion drug coverage made available under the plan, see section  
37                   1858A(c).

1           “(g) SECONDARY PAYER PROVISIONS.—The provisions of  
2 section 1862(b) shall apply to the benefits provided under this  
3 part.

4           “COMPUTATION OF MONTHLY BENEFICIARY OBLIGATION

5           “SEC. 1860D–17. (a) BENEFICIARIES ENROLLED IN A  
6 MEDICARE PRESCRIPTION DRUG PLAN.—In the case of an eli-  
7 gible beneficiary enrolled under this part and in a Medicare  
8 Prescription Drug plan, the monthly beneficiary obligation for  
9 enrollment in such plan in a year shall be determined as fol-  
10 lows:

11           “(1) MONTHLY PLAN PREMIUM EQUALS MONTHLY NA-  
12 TIONAL AVERAGE PREMIUM.—If the amount of the monthly  
13 plan premium approved by the Administrator under section  
14 1860D–13 for a Medicare Prescription Drug plan for the  
15 year is equal to the monthly national average premium (as  
16 computed under section 1860D–15) for the year, the  
17 monthly beneficiary obligation of the eligible beneficiary in  
18 that year shall be an amount equal to the applicable per-  
19 cent (for the area in which the beneficiary resides, as deter-  
20 mined in subsection (c)) of the amount of the monthly na-  
21 tional average premium.

22           “(2) MONTHLY PLAN PREMIUM LESS THAN MONTHLY  
23 NATIONAL AVERAGE PREMIUM.—If the amount of the  
24 monthly plan premium approved by the Administrator  
25 under section 1860D–13 for the Medicare Prescription  
26 Drug plan for the year is less than the monthly national  
27 average premium (as computed under section 1860D–15)  
28 for the year, the monthly beneficiary obligation of the eli-  
29 gible beneficiary in that year shall be an amount equal to—

30           “(A) the applicable percent (for the area in which  
31 the beneficiary resides) of the amount of the monthly  
32 national average premium; minus

33           “(B) the amount by which the monthly national  
34 average premium exceeds the amount of the monthly  
35 plan premium approved by the Administrator for the  
36 plan.

1           “(3) MONTHLY PLAN PREMIUM EXCEEDS MONTHLY  
2 NATIONAL AVERAGE PREMIUM.—If the amount of the  
3 monthly plan premium approved by the Administrator  
4 under section 1860D–13 for a Medicare Prescription Drug  
5 plan for the year exceeds the monthly national average pre-  
6 mium (as computed under section 1860D–15) for the year,  
7 the monthly beneficiary obligation of the eligible beneficiary  
8 in that year shall be an amount equal to the sum of—

9           “(A) the applicable percent (for the area in which  
10 the beneficiary resides) of the amount of the monthly  
11 national average premium; plus

12           “(B) the amount by which the monthly plan pre-  
13 mium approved by the Administrator for the plan ex-  
14 ceeds the amount of the monthly national average pre-  
15 mium.

16           “(b) BENEFICIARIES ENROLLED IN A  
17 MEDICAREADVANTAGE PLAN.—In the case of an eligible bene-  
18 ficiary that is enrolled in a MedicareAdvantage plan (except for  
19 an MSA plan or a private fee-for-service plan that does not  
20 provide qualified prescription drug coverage), the Medicare  
21 monthly beneficiary obligation for qualified prescription drug  
22 coverage shall be determined pursuant to section 1858A(d).

23           “(c) APPLICABLE PERCENT.—

24           “(1) IN GENERAL.—For purposes of this section, ex-  
25 cept as provided in section 1860D–19 (relating to premium  
26 subsidies for low-income individuals), the term applicable  
27 percent for any year is the percentage equal to a fraction—

28           “(A) the numerator of which is 32 percent; and

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

31           “(i) the total reinsurance payments which the  
32 Administrator estimates will be made under section  
33 1860D–20 to qualifying entities described in sub-  
34 paragraphs (A) and (B) of subsection (e)(3) of  
35 such section during the year; divided by

36           “(ii) the sum of—

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

3                   “(II) the total payments which the Admin-  
4                   istrator estimates will be made under sections  
5                   1860D-16 and 1858A(c) during the year that  
6                   relate to standard prescription drug coverage  
7                   (or actuarially equivalent prescription drug cov-  
8                   erage).

9                   “(2) GEOGRAPHIC ADJUSTMENT.—

10                   “(A) ADJUSTMENT.—The applicable percent de-  
11                   termined under paragraph (1) for a year shall be ad-  
12                   justed using the methodology established under sub-  
13                   paragraph (B).

14                   “(B) METHODOLOGY.—The Administrator shall  
15                   establish an appropriate methodology for adjusting the  
16                   applicable percent referred to in paragraph (1) to take  
17                   into account variations in input prices for covered  
18                   drugs in different service areas established under sec-  
19                   tion 1860D-10. Any such adjustment shall be applied  
20                   in a manner as to not result in a change in aggregate  
21                   payments made under this part than would have been  
22                   made if the Administrator had not applied such adjust-  
23                   ment.

24                   “COLLECTION OF MONTHLY BENEFICIARY OBLIGATION

25                   “SEC. 1860D-18. (a) COLLECTION OF AMOUNT IN SAME  
26                   MANNER AS PART B PREMIUM.—

27                   “(1) IN GENERAL.—Subject to paragraph (2), the  
28                   amount of the monthly beneficiary obligation (determined  
29                   under section 1860D-17) applicable to an eligible bene-  
30                   ficiary under this part (after application of any increase  
31                   under section 1860D-2(b)(1)(A)) shall be collected and  
32                   credited to the Prescription Drug Account in the same  
33                   manner as the monthly premium determined under section  
34                   1839 is collected and credited to the Federal Supple-  
35                   mentary Medical Insurance Trust Fund under section  
36                   1840.



1 which the qualified medicare beneficiary resides;  
2 and

3 “(ii) in subsection (a)(3)(B), by substituting  
4 ‘the amount of the monthly plan premium for the  
5 Medicare Prescription Drug plan with the lowest  
6 monthly plan premium in the area that the bene-  
7 ficiary resides’ for ‘the amount of the monthly na-  
8 tional average premium’, but only if there is no  
9 Medicare Prescription Drug plan offered in the  
10 area in which the individual resides that has a  
11 monthly plan premium for the year that is equal to  
12 or less than the monthly national average premium  
13 (as computed under section 1860D-15) for the  
14 year;

15 “(B) the annual deductible applicable under sec-  
16 tion 1860D-6(c)(1) in a year shall be reduced to \$0;

17 “(C) section 1860D-6(c)(2) shall be applied by  
18 substituting ‘2.5 percent’ for ‘50 percent’ each place it  
19 appears;

20 “(D) such individual shall be responsible for cost-  
21 sharing for the cost of any covered drug provided in the  
22 year (after the individual has reached such initial cov-  
23 erage limit and before the individual has reached the  
24 annual out-of-pocket limit under section 1860D-  
25 6(c)(4)(A)), that is equal to 5.0 percent; and

26 “(E) section 1860D-6(c)(4)(A) shall be applied by  
27 substituting ‘2.5 percent’ for ‘10 percent’.

28 In no case may the application of subparagraph (A) result  
29 in a monthly beneficiary obligation that is below 0.

30 “(2) FULL PREMIUM SUBSIDY AND REDUCTION OF  
31 COST-SHARING FOR SPECIFIED LOW INCOME MEDICARE  
32 BENEFICIARIES AND QUALIFYING INDIVIDUALS.—In the  
33 case of a specified low income medicare beneficiary (as de-  
34 fined in paragraph (4)(B)) or a qualifying individual (as  
35 defined in paragraph (4)(C))—

36 “(A) section 1860D-17 shall be applied—

1                   “(i) in subsection (c), by substituting ‘0 per-  
2                   cent’ for the applicable percent that would other-  
3                   wise apply under such section in the service area in  
4                   which the specified low income medicare beneficiary  
5                   or the qualifying individual (as the case may be) re-  
6                   sides; and

7                   “(ii) in subsection (a)(3)(B), by substituting  
8                   ‘the amount of the monthly plan premium for the  
9                   Medicare Prescription Drug plan with the lowest  
10                  monthly plan premium in the area that the bene-  
11                  ficiary resides’ for ‘the amount of the monthly na-  
12                  tional average premium’, but only if there is no  
13                  Medicare Prescription Drug plan offered in the  
14                  area in which the individual resides that has a  
15                  monthly plan premium for the year that is equal to  
16                  or less than the monthly national average premium  
17                  (as computed under section 1860D-15) for the  
18                  year;

19                  “(B) the annual deductible applicable under sec-  
20                  tion 1860D-6(c)(1) in a year shall be reduced to \$0;

21                  “(C) section 1860D-6(c)(2) shall be applied by  
22                  substituting ‘5.0 percent’ for ‘50 percent’ each place it  
23                  appears;

24                  “(D) such individual shall be responsible for cost-  
25                  sharing for the cost of any covered drug provided in the  
26                  year (after the individual has reached such initial cov-  
27                  erage limit and before the individual has reached the  
28                  annual out-of-pocket limit under section 1860D-  
29                  6(c)(4)(A)), that is equal to 10.0 percent; and

30                  “(E) section 1860D-6(c)(4)(A) shall be applied by  
31                  substituting ‘2.5 percent’ for ‘10 percent’.

32                  In no case may the application of subparagraph (A) result  
33                  in a monthly beneficiary obligation that is below 0.

34                  “(3) SLIDING SCALE PREMIUM SUBSIDY AND REDUC-  
35                  TION OF COST-SHARING FOR SUBSIDY-ELIGIBLE INDIVID-  
36                  UALS.—

1           “(A) IN GENERAL.—In the case of a subsidy-  
2 eligible individual (as defined in paragraph (4)(D))—

3           “(i) section 1860D–17 shall be applied—

4           “(I) in subsection (c), by substituting  
5 ‘subsidy percent’ for the percentage that would  
6 otherwise apply under such section in the serv-  
7 ice area in which the subsidy-eligible individual  
8 resides; and

9           “(II) in subparagraphs (A) and (B) of  
10 subsection (a)(3), by substituting ‘the amount  
11 of the monthly plan premium for the Medicare  
12 Prescription Drug plan with the lowest monthly  
13 plan premium in the area that the beneficiary  
14 resides’ for ‘the amount of the monthly na-  
15 tional average premium’, but only if there is no  
16 Medicare Prescription Drug plan offered in the  
17 area in which the individual resides that has a  
18 monthly plan premium for the year that is  
19 equal to or less than the monthly national aver-  
20 age premium (as computed under section  
21 1860D–15) for the year; and

22           “(ii) the annual deductible applicable under  
23 section 1860D–6(c)(1) in a year shall be reduced to  
24 \$50;

25           “(iii) section 1860D–6(c)(2) shall be applied  
26 by substituting ‘10.0 percent’ for ‘50 percent’ each  
27 place it appears;

28           “(iv) such individual shall be responsible for  
29 cost-sharing for the cost of any covered drug pro-  
30 vided in the year (after the individual has reached  
31 such initial coverage limit and before the individual  
32 has reached the annual out-of-pocket limit under  
33 section 1860D–6(c)(4)(A)), that is equal to 20.0  
34 percent; and

35           “(v) such individual shall be responsible for  
36 the cost-sharing described in section 1860D–  
37 6(c)(4)(A).

1 In no case may the application of clause (i) result in  
2 a monthly beneficiary obligation that is below 0.

3 “(B) SUBSIDY PERCENT DEFINED.—For purposes  
4 of subparagraph (A)(i), the term ‘subsidy percent’  
5 means, with respect to a State, a percent determined  
6 on a linear sliding scale ranging from—

7 “(i) 0 percent with respect to a subsidy-eligible  
8 individual residing in the State whose income does  
9 not exceed 135 percent of the poverty line; to

10 “(ii) the highest percentage that would other-  
11 wise apply under section 1860D–17 in the service  
12 area in which the subsidy-eligible individual resides,  
13 in the case of a subsidy-eligible individual residing  
14 in the State whose income equals 160 percent of  
15 the poverty line.

16 “(4) DEFINITIONS.—In this part:

17 “(A) QUALIFIED MEDICARE BENEFICIARY.—Sub-  
18 ject to subparagraph (H), the term ‘qualified medicare  
19 beneficiary’ means an individual who—

20 “(i) is enrolled under this part, including an  
21 individual who is enrolled under a  
22 MedicareAdvantage plan;

23 “(ii) is described in section 1905(p)(1); and

24 “(iii) is not—

25 “(I) a specified low-income medicare bene-  
26 ficiary;

27 “(II) a qualifying individual; or

28 “(III) a dual eligible individual.

29 “(B) SPECIFIED LOW INCOME MEDICARE BENE-  
30 FICIARY.—Subject to subparagraph (H), the term  
31 ‘specified low income medicare beneficiary’ means an  
32 individual who—

33 “(i) is enrolled under this part, including an  
34 individual who is enrolled under a  
35 MedicareAdvantage plan;

36 “(ii) is described in section  
37 1902(a)(10)(E)(iii); and

1                   “(iii) is not—  
2                   “(I) a qualified medicare beneficiary;  
3                   “(II) a qualifying individual; or  
4                   “(III) a dual eligible individual.  
5                   “(C) QUALIFYING INDIVIDUAL.—Subject to sub-  
6                   paragraph (H), the term ‘qualifying individual’ means  
7                   an individual who—  
8                   “(i) is enrolled under this part, including an  
9                   individual who is enrolled under a  
10                   MedicareAdvantage plan;  
11                   “(ii) is described in section 1902(a)(10)(E)(iv)  
12                   (without regard to any termination of the applica-  
13                   tion of such section under title XIX); and  
14                   “(iii) is not—  
15                   “(I) a qualified medicare beneficiary;  
16                   “(II) a specified low-income medicare ben-  
17                   eficiary; or  
18                   “(III) a dual eligible individual.  
19                   “(D) SUBSIDY-ELIGIBLE INDIVIDUAL.—Subject to  
20                   subparagraph (H), the term ‘subsidy-eligible individual’  
21                   means an individual—  
22                   “(i) who is enrolled under this part, including  
23                   an individual who is enrolled under a  
24                   MedicareAdvantage plan;  
25                   “(ii) whose income is less than 160 percent of  
26                   the poverty line; and  
27                   “(iii) who is not—  
28                   “(I) a qualified medicare beneficiary;  
29                   “(II) a specified low-income medicare ben-  
30                   eficiary;  
31                   “(III) a qualifying individual; or  
32                   “(IV) a dual eligible individual.  
33                   “(E) DUAL ELIGIBLE INDIVIDUAL.—  
34                   “(i) IN GENERAL.—The term ‘dual eligible in-  
35                   dividual’ means an individual who is—  
36                   “(I) enrolled under title XIX or under a  
37                   waiver under section 1115 of the requirements

1 of such title for medical assistance that is not  
2 less than the medical assistance provided to an  
3 individual described in section  
4 1902(a)(10)(A)(i) and includes covered out-  
5 patient drugs (as such term is defined for pur-  
6 poses of section 1927); and

7 “(II) entitled to benefits under part A and  
8 enrolled under part B.

9 “(ii) INCLUSION OF MEDICALLY NEEDY.—  
10 Such term includes an individual described in sec-  
11 tion 1902(a)(10)(C).

12 “(F) POVERTY LINE.—The term ‘poverty line’ has  
13 the meaning given such term in section 673(2) of the  
14 Community Services Block Grant Act (42 U.S.C.  
15 9902(2)), including any revision required by such sec-  
16 tion.

17 “(G) ELIGIBILITY DETERMINATIONS.—Beginning  
18 on November 1, 2005, the determination of whether an  
19 individual residing in a State is an individual described  
20 in subparagraph (A), (B), (C), (D), or (E) and, for  
21 purposes of paragraph (3), the amount of an individ-  
22 ual’s income, shall be determined under the State med-  
23 icaid plan for the State under section 1935(a). In the  
24 case of a State that does not operate such a medicaid  
25 plan (either under title XIX or under a statewide waiv-  
26 er granted under section 1115), such determination  
27 shall be made under arrangements made by the Admin-  
28 istrator.

29 “(H) FULL PREMIUM AND COST-SHARING SUBSIDY  
30 FOR DUAL ELIGIBLE INDIVIDUALS.—

31 “(i) IN GENERAL.—Notwithstanding section  
32 1860D(a)(3), section 1807A(j)(2)(A), or any other  
33 provision of law—

34 “(I) a dual eligible individual may enroll  
35 for prescription drug coverage under this part  
36 and in the transitional prescription drug assist-  
37 ance card program under section 1807A;

1                   “(II) a dual eligible individual shall be  
2                   treated as an eligible low-income beneficiary for  
3                   purposes of the transitional prescription drug  
4                   assistance program under section 1807A;

5                   “(III) prescription drug coverage under  
6                   this part shall be provided to a dual eligible in-  
7                   dividual in the same manner as such coverage  
8                   is provided to a qualified medicare beneficiary  
9                   under subparagraph (A); and

10                   “(IV) to the extent coverage for a covered  
11                   outpatient drug (as defined for purposes of sec-  
12                   tion 1927) is not provided under the Medicare  
13                   Prescription Drug plan in which the dual eligi-  
14                   ble individual is enrolled (or under the transi-  
15                   tional prescription drug assistance program  
16                   under section 1807A), but is available under  
17                   the State medicaid program in which the dual  
18                   eligible individual is enrolled, coverage for such  
19                   covered outpatient drug shall be provided under  
20                   the State medicaid program.

21                   “(ii) ELIMINATION OF UNNECESSARY PROVI-  
22                   SIONS.—

23                   “(I) Section 1935 shall be applied without  
24                   regard to subsections (c) and (d).

25                   “(II) Sections 1817 and 1841 shall be ap-  
26                   plied without regard to the amendments made  
27                   by section 104(a)(3) of the Prescription Drug  
28                   and Medicare Improvement Act of 2003.

29                   “(III) Section 104 of the Prescription  
30                   Drug and Medicare Improvement Act of 2003  
31                   shall be applied without regard to subsection  
32                   (e).

33                   “(I) NONAPPLICATION TO TERRITORIAL RESI-  
34                   DENTS.—In the case of an individual who is not a resi-  
35                   dent of the 50 States or the District of Columbia—

36                   “(i) the subsidies provided under this section  
37                   shall not apply; and

1                   “(ii) such individuals may be provided with  
2                   medical assistance for covered outpatient drugs (as  
3                   such term is defined for purposes of section 1927)  
4                   in accordance with section 1935 under the State  
5                   medicaid program under title XIX.

6                   “(b) RULES IN APPLYING COST-SHARING SUBSIDIES.—  
7                   Nothing in this section shall be construed as preventing an eli-  
8                   gible entity offering a Medicare Prescription Drug plan or a  
9                   MedicareAdvantage organization offering a MedicareAdvantage  
10                  plan from waiving or reducing the amount of the deductible or  
11                  other cost-sharing otherwise applicable pursuant to section  
12                  1860D-6(a)(2).

13                  “(c) ADMINISTRATION OF SUBSIDY PROGRAM.—The Ad-  
14                  ministrators shall establish a process whereby, in the case of an  
15                  individual eligible for a cost-sharing subsidy under subsection  
16                  (a) who is enrolled in a Medicare Prescription Drug plan or a  
17                  MedicareAdvantage plan—

18                  “(1) the Administrator provides for a notification of  
19                  the eligible entity or MedicareAdvantage organization in-  
20                  volved that the individual is eligible for a cost-sharing sub-  
21                  sidy and the amount of the subsidy under such subsection;

22                  “(2) the entity or organization involved reduces the  
23                  cost-sharing otherwise imposed by the amount of the appli-  
24                  cable subsidy and submits to the Administrator information  
25                  on the amount of such reduction; and

26                  “(3) the Administrator periodically and on a timely  
27                  basis reimburses the entity or organization for the amount  
28                  of such reductions.

29                  The reimbursement under paragraph (3) may be computed on  
30                  a capitated basis, taking into account the actuarial value of the  
31                  subsidies and with appropriate adjustments to reflect dif-  
32                  ferences in the risks actually involved.

33                  “(d) RELATION TO MEDICAID PROGRAM.—For provisions  
34                  providing for eligibility determinations and additional Federal  
35                  payments for expenditures related to providing prescription  
36                  drug coverage for dual eligible individuals and territorial resi-  
37                  dents under the medicaid program, see section 1935.

1 “REINSURANCE PAYMENTS FOR EXPENSES INCURRED IN PRO-  
2 VIDING PRESCRIPTION DRUG COVERAGE ABOVE THE ANNUAL  
3 OUT-OF-POCKET THRESHOLD

4 “SEC. 1860D-20. (a) REINSURANCE PAYMENTS.—

5 “(1) IN GENERAL.—Subject to section 1860D-21(b),  
6 the Administrator shall provide in accordance with this sec-  
7 tion for payment to a qualifying entity of the reinsurance  
8 payment amount (as specified in subsection (c)(1)) for  
9 costs incurred by the entity in providing prescription drug  
10 coverage for a qualifying covered individual after the indi-  
11 vidual has reached the annual out-of-pocket threshold spec-  
12 ified in section 1860D-6(c)(4)(B) for the year.

13 “(2) BUDGET AUTHORITY.—This section constitutes  
14 budget authority in advance of appropriations Acts and  
15 represents the obligation of the Administrator to provide  
16 for the payment of amounts provided under this section.

17 “(b) NOTIFICATION OF SPENDING UNDER THE PLAN FOR  
18 COSTS INCURRED IN PROVIDING PRESCRIPTION DRUG COV-  
19 ERAGE ABOVE THE ANNUAL OUT-OF-POCKET THRESHOLD.—

20 “(1) IN GENERAL.—Each qualifying entity shall notify  
21 the Administrator of the following with respect to a quali-  
22 fying covered individual for a coverage year:

23 “(A) TOTAL ACTUAL COSTS.—The total amount  
24 (if any) of costs that the qualifying entity incurred in  
25 providing prescription drug coverage for the individual  
26 in the year after the individual had reached the annual  
27 out-of-pocket threshold specified in section 1860D-  
28 6(c)(4)(B) for the year.

29 “(B) ACTUAL COSTS FOR SPECIFIC DRUGS.—With  
30 respect to the total amount under subparagraph (A) for  
31 the year, a breakdown of—

32 “(i) each covered drug that constitutes a por-  
33 tion of such amount;

34 “(ii) the negotiated price for the qualifying en-  
35 tity for each such drug;

36 “(iii) the number of prescriptions; and

1                   “(iv) the average beneficiary coinsurance rate  
2                   for a each covered drug that constitutes a portion  
3                   of such amount.

4                   “(2) CERTAIN EXPENSES NOT INCLUDED.—The  
5                   amounts under subparagraphs (A) and (B)(ii) of paragraph  
6                   (1) may not include—

7                   “(A) administrative expenses incurred in providing  
8                   the coverage described in paragraph (1)(A); or

9                   “(B) amounts expended on providing additional  
10                  prescription drug coverage pursuant to section 1860D-  
11                  6(a)(2).

12                  “(3) RESTRICTION ON USE OF INFORMATION.—The  
13                  restriction specified in section 1860D-16(b)(7)(B) shall  
14                  apply to information disclosed or obtained pursuant to the  
15                  provisions of this section.

16                  “(c) REINSURANCE PAYMENT AMOUNT.—

17                  “(1) IN GENERAL.—The reinsurance payment amount  
18                  under this subsection for a qualifying covered individual for  
19                  a coverage year is an amount equal to 80 percent of the  
20                  allowable costs (as specified in paragraph (2)) incurred by  
21                  the qualifying entity with respect to the individual and  
22                  year.

23                  “(2) ALLOWABLE COSTS.—

24                  “(A) IN GENERAL.—In the case of a qualifying en-  
25                  tity that has incurred costs described in subsection  
26                  (b)(1)(A) with respect to a qualifying covered indi-  
27                  vidual for a coverage year, the Administrator shall es-  
28                  tablish the allowable costs for the individual and year.  
29                  Such allowable costs shall be equal to the amount de-  
30                  scribed in such subsection for the individual and year,  
31                  adjusted under subparagraph (B).

32                  “(B) REPRICING OF COSTS IF ACTUAL COSTS EX-  
33                  CEED AVERAGE COSTS.—The Administrator shall re-  
34                  duce the amount described in subsection (b)(1)(A) with  
35                  respect to a qualifying covered individual for a coverage  
36                  year to the extent such amount is based on costs of  
37                  specific covered drugs furnished under the plan in the

1           year (as specified under subsection (b)(1)(B)) that are  
2           greater than the average cost for the covered drug for  
3           the year (as determined under section 1860D-  
4           16(b)(3)(A)).

5           “(d) PAYMENT METHODS.—

6           “(1) IN GENERAL.—Payments under this section shall  
7           be based on such a method as the Administrator deter-  
8           mines. The Administrator may establish a payment method by  
9           which interim payments of amounts under this section are made  
10          during a year based on the Administrator’s best estimate of  
11          amounts that will be payable after obtaining all of the informa-  
12          tion.

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

15          “(e) DEFINITIONS.—In this section:

16          “(1) COVERAGE YEAR.—The term ‘coverage year’  
17          means a calendar year in which covered drugs are dis-  
18          pensed if a claim for payment is made under the plan for  
19          such drugs, regardless of when the claim is paid.

20          “(2) QUALIFYING COVERED INDIVIDUAL.—The term  
21          ‘qualifying covered individual’ means an individual who—

22                  “(A) is enrolled in this part and in a Medicare  
23                  Prescription Drug plan;

24                  “(B) is enrolled in this part and in a  
25                  MedicareAdvantage plan (except for an MSA plan or a  
26                  private fee-for-service plan that does not provide quali-  
27                  fied prescription drug coverage); or

28                  “(C) is eligible for, but not enrolled in, the pro-  
29                  gram under this part, and is covered under a qualified  
30                  retiree prescription drug plan.

31          “(3) QUALIFYING ENTITY.—The term ‘qualifying enti-  
32          ty’ means any of the following that has entered into an  
33          agreement with the Administrator to provide the Adminis-  
34          trator with such information as may be required to carry  
35          out this section:

36                  “(A) An eligible entity offering a Medicare Pre-  
37                  scription Drug plan under this part.

1           “(B) A MedicareAdvantage organization offering a  
2 MedicareAdvantage plan under part C (except for an  
3 MSA plan or a private fee-for-service plan that does  
4 not provide qualified prescription drug coverage).

5           “(C) The sponsor of a qualified retiree prescrip-  
6 tion drug plan.

7           “(4) QUALIFIED RETIREE PRESCRIPTION DRUG  
8 PLAN.—

9           “(A) IN GENERAL.—The term ‘qualified retiree  
10 prescription drug plan’ means employment-based re-  
11 tiree health coverage if, with respect to a qualifying  
12 covered individual who is covered under the plan, the  
13 following requirements are met:

14           “(i) ASSURANCE.—The sponsor of the plan  
15 shall annually attest, and provide such assurances  
16 as the Administrator may require, that the cov-  
17 erage meets or exceeds the requirements for quali-  
18 fied prescription drug coverage.

19           “(ii) DISCLOSURE OF INFORMATION.—The  
20 sponsor complies with the requirements described  
21 in clauses (i) and (ii) of section 1860D-  
22 16(b)(7)(A).

23           “(B) EMPLOYMENT-BASED RETIREE HEALTH COV-  
24 ERAGE.—The term ‘employment-based retiree health  
25 coverage’ means health insurance or other coverage,  
26 whether provided by voluntary insurance coverage or  
27 pursuant to statutory or contractual obligation, of  
28 health care costs for retired individuals (or for such in-  
29 dividuals and their spouses and dependents) based on  
30 their status as former employees or labor union mem-  
31 bers.

32           “(5) SPONSOR.—The term ‘sponsor’ means a plan  
33 sponsor, as defined in section 3(16)(B) of the Employee  
34 Retirement Income Security Act of 1974.

1 “DIRECT SUBSIDY FOR SPONSOR OF A QUALIFIED RETIREE  
2 PRESCRIPTION DRUG PLAN FOR PLAN ENROLLEES ELIGIBLE  
3 FOR, BUT NOT ENROLLED IN, THIS PART

4 “SEC. 1860D-21. (a) DIRECT SUBSIDY.—

5 “(1) IN GENERAL.—The Administrator shall provide  
6 for the payment to a sponsor of a qualified retiree prescrip-  
7 tion drug plan (as defined in section 1860D-20(e)(4)) for  
8 each qualifying covered individual (described in subpara-  
9 graph (C) of section 1860D-20(e)(2)) enrolled in the plan  
10 for each month for which such individual is so enrolled.

11 “(2) AMOUNT OF PAYMENT.—

12 “(A) IN GENERAL.—The amount of the payment  
13 under paragraph (1) shall be an amount equal to the  
14 direct subsidy percent (for the area for the year) of the  
15 monthly national average premium for the year (deter-  
16 mined under section 1860D-15), as adjusted using the  
17 risk adjusters that apply to the standard prescription  
18 drug coverage published under section 1860D-11.

19 “(B) DIRECT SUBSIDY PERCENT.—For purposes  
20 of subparagraph (A), the term ‘direct subsidy percent’  
21 means the percentage equal to—

22 “(i) 100 percent; minus

23 “(ii) the applicable percent for the year and  
24 for the area in which the individual resides for the  
25 year (as determined under section 1860D-17(c).

26 “(b) PAYMENT METHODS.—

27 “(1) IN GENERAL.—Payments under this section shall  
28 be based on such a method as the Administrator deter-  
29 mines. The Administrator may establish a payment method  
30 by which interim payments of amounts under this section  
31 are made during a year based on the Administrator’s best  
32 estimate of amounts that will be payable after obtaining all  
33 of the information.

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

1                   “Subpart 3—Miscellaneous Provisions  
2                   “PRESCRIPTION DRUG ACCOUNT IN THE FEDERAL  
3                   SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND  
4                   “SEC. 1860D-25. (a) ESTABLISHMENT.—  
5                   “(1) IN GENERAL.—There is created within the Fed-  
6                   eral Supplementary Medical Insurance Trust Fund estab-  
7                   lished by section 1841 an account to be known as the ‘Pre-  
8                   scription Drug Account’ (in this section referred to as the  
9                   ‘Account’).  
10                  “(2) FUNDS.—The Account shall consist of such gifts  
11                  and bequests as may be made as provided in section  
12                  201(i)(1), and such amounts as may be deposited in, or ap-  
13                  propriated to, the Account as provided in this part.  
14                  “(3) SEPARATE FROM REST OF TRUST FUND.—Funds  
15                  provided under this part to the Account shall be kept sepa-  
16                  rate from all other funds within the Federal Supplementary  
17                  Medical Insurance Trust Fund.  
18                  “(b) PAYMENTS FROM ACCOUNT.—  
19                  “(1) IN GENERAL.—The Managing Trustee shall pay  
20                  from time to time from the Account such amounts as the  
21                  Secretary certifies are necessary to make payments to oper-  
22                  ate the program under this part, including—  
23                       “(A) payments to eligible entities under section  
24                       1860D-16;  
25                       “(B) payments under 1860D-19 for low-income  
26                       subsidy payments for cost-sharing;  
27                       “(C) reinsurance payments under section 1860D-  
28                       20;  
29                       “(D) payments to sponsors of qualified retiree pre-  
30                       scription drug plans under section 1860D-21;  
31                       “(E) payments to MedicareAdvantage organiza-  
32                       tions for the provision of qualified prescription drug  
33                       coverage under section 1858A(c); and  
34                       “(F) payments with respect to administrative ex-  
35                       penses under this part in accordance with section  
36                       201(g).

1           “(2) TREATMENT IN RELATION TO PART B PRE-  
2           MIUM.—Amounts payable from the Account shall not be  
3           taken into account in computing actuarial rates or pre-  
4           mium amounts under section 1839.

5           “(c) APPROPRIATIONS TO COVER BENEFITS AND ADMIN-  
6           ISTRATIVE COSTS.—There are appropriated to the Account in  
7           a fiscal year, out of any moneys in the Treasury not otherwise  
8           appropriated, an amount equal to the payments and transfers  
9           made from the Account in the year.

10                   “OTHER RELATED PROVISIONS

11           “SEC. 1860D–26. (a) RESTRICTION ON ENROLLMENT IN  
12           A MEDICARE PRESCRIPTION DRUG PLAN OFFERED BY A  
13           SPONSOR OF EMPLOYMENT-BASED RETIREE HEALTH COV-  
14           ERAGE.—

15                   “(1) IN GENERAL.—In the case of a Medicare Pre-  
16           scription Drug plan offered by an eligible entity that is a  
17           sponsor (as defined in paragraph (5) of section 1860D–  
18           20(e)) of employment-based retiree health coverage (as de-  
19           fined in paragraph (4)(B) of such section), notwithstanding  
20           any other provision of this part and in accordance with reg-  
21           ulations of the Administrator, the entity offering the plan  
22           may restrict the enrollment of eligible beneficiaries enrolled  
23           under this part to eligible beneficiaries who are enrolled in  
24           such coverage.

25                   “(2) LIMITATION.—The sponsor of the employment-  
26           based retiree health coverage described in paragraph (1)  
27           may not offer enrollment in the Medicare Prescription  
28           Drug plan described in such paragraph based on the health  
29           status of eligible beneficiaries enrolled for such coverage.

30           “(b) COORDINATION WITH STATE PHARMACEUTICAL AS-  
31           SISTANCE PROGRAMS.—

32                   “(1) IN GENERAL.—An eligible entity offering a Medi-  
33           care Prescription Drug plan, or a MedicareAdvantage orga-  
34           nization offering a MedicareAdvantage plan (other than an  
35           MSA plan or a private fee-for-service plan that does not  
36           provide qualified prescription drug coverage), may enter  
37           into an agreement with a State pharmaceutical assistance

1 program described in paragraph (2) to coordinate the cov-  
2 erage provided under the plan with the assistance provided  
3 under the State pharmaceutical assistance program.

4 “(2) STATE PHARMACEUTICAL ASSISTANCE PROGRAM  
5 DESCRIBED.—For purposes of paragraph (1), a State phar-  
6 maceutical assistance program described in this paragraph  
7 is a program that has been established pursuant to a waiv-  
8 er under section 1115 or otherwise.

9 (c) REGULATIONS TO CARRY OUT THIS PART.—

10 (1) AUTHORITY FOR INTERIM FINAL REGULATIONS.—  
11 The Secretary may promulgate initial regulations imple-  
12 menting this part in interim final form without prior oppor-  
13 tunity for public comment.

14 (2) FINAL REGULATIONS.—A final regulation reflect-  
15 ing public comments must be published within 1 year of the  
16 interim final regulation promulgated under paragraph  
17 (1).”.

18 (b) CONFORMING AMENDMENTS TO FEDERAL SUPPLE-  
19 MENTARY MEDICAL INSURANCE TRUST FUND.—Section 1841  
20 (42 U.S.C. 1395t) is amended—

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

22 (A) by striking “and” before “such amounts”; and

23 (B) by inserting before the period the following: “,  
24 and such amounts as may be deposited in, or appro-  
25 priated to, the Prescription Drug Account established  
26 by section 1860D-25”;

27 (2) in subsection (g), by inserting after “by this part,”  
28 the following: “the payments provided for under part D (in  
29 which case the payments shall be made from the Prescrip-  
30 tion Drug Account in the Trust Fund),”;

31 (3) in subsection (h), by inserting after “1840(d)” the  
32 following: “and sections 1860D-18 and 1858A(e) (in which  
33 case the payments shall be made from the Prescription  
34 Drug Account in the Trust Fund)”;

35 (4) in subsection (i), by inserting after “section  
36 1840(b)(1)” the following: “, sections 1860D-18 and

1 1858A(e) (in which case the payments shall be made from  
2 the Prescription Drug Account in the Trust Fund),”.

3 (c) CONFORMING REFERENCES TO PREVIOUS PART D.—  
4 Any reference in law (in effect before the date of enactment of  
5 this Act) to part D of title XVIII of the Social Security Act  
6 is deemed a reference to part F of such title (as in effect after  
7 such date).

8 (d) SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later  
9 than 6 months after the date of the enactment of this Act, the  
10 Secretary shall submit to the appropriate committees of Con-  
11 gress a legislative proposal providing for such technical and  
12 conforming amendments in the law as are required by the pro-  
13 visions of this Act.

14 **SEC. 102. STUDY AND REPORT ON PERMITTING PART B**  
15 **ONLY INDIVIDUALS TO ENROLL IN MEDI-**  
16 **CARE VOLUNTARY PRESCRIPTION DRUG DE-**  
17 **LIVERY PROGRAM.**

18 (a) STUDY.—The Administrator of the Centers for Medi-  
19 care & Medicaid Services shall conduct a study on the need for  
20 rules relating to permitting individuals who are enrolled under  
21 part B of title XVIII of the Social Security Act but are not  
22 entitled to benefits under part A of such title to buy into the  
23 medicare voluntary prescription drug delivery program under  
24 part D of such title (as so added).

25 (b) REPORT.—Not later than January 1, 2005, such Ad-  
26 ministrator shall submit a report to Congress on the study con-  
27 ducted under subsection (a), together with any recommenda-  
28 tions for legislation that the Administrator determines to be ap-  
29 propriate as a result of such study.

30 **SEC. 103. RULES RELATING TO MEDIGAP POLICIES**  
31 **THAT PROVIDE PRESCRIPTION DRUG COV-**  
32 **ERAGE.**

33 (a) RULES RELATING TO MEDIGAP POLICIES THAT PRO-  
34 VIDE PRESCRIPTION DRUG COVERAGE.—Section 1882 (42  
35 U.S.C. 1395ss) is amended by adding at the end the following  
36 new subsection:

37 “(v) RULES RELATING TO MEDIGAP POLICIES THAT PRO-  
38 VIDE PRESCRIPTION DRUG COVERAGE.—

1           “(1) PROHIBITION ON SALE, ISSUANCE, AND RENEWAL  
2           OF POLICIES THAT PROVIDE PRESCRIPTION DRUG COV-  
3           ERAGE TO PART D ENROLLEES.—

4           “(A) IN GENERAL.—Notwithstanding any other  
5           provision of law, on or after January 1, 2006, no medi-  
6           care supplemental policy that provides coverage of ex-  
7           penses for prescription drugs may be sold, issued, or  
8           renewed under this section to an individual who is en-  
9           rolled under part D.

10          “(B) PENALTIES.—The penalties described in sub-  
11          section (d)(3)(A)(ii) shall apply with respect to a viola-  
12          tion of subparagraph (A).

13          “(2) ISSUANCE OF SUBSTITUTE POLICIES IF THE POL-  
14          ICYHOLDER OBTAINS PRESCRIPTION DRUG COVERAGE  
15          UNDER PART D.—

16          “(A) IN GENERAL.—The issuer of a medicare sup-  
17          plemental policy—

18               “(i) may not deny or condition the issuance or  
19               effectiveness of a medicare supplemental policy that  
20               has a benefit package classified as ‘A’, ‘B’, ‘C’, ‘D’,  
21               ‘E’, ‘F’ (including the benefit package classified as  
22               ‘F’ with a high deductible feature, as described in  
23               subsection (p)(11)), or ‘G’ (under the standards es-  
24               tablished under subsection (p)(2)) and that is of-  
25               fered and is available for issuance to new enrollees  
26               by such issuer;

27               “(ii) may not discriminate in the pricing of  
28               such policy, because of health status, claims experi-  
29               ence, receipt of health care, or medical condition;  
30               and

31               “(iii) may not impose an exclusion of benefits  
32               based on a pre-existing condition under such policy,  
33               in the case of an individual described in subparagraph  
34               (B) who seeks to enroll under the policy during the  
35               open enrollment period established under section  
36               1860D-2(b)(2) and who submits evidence that they  
37               meet the requirements under subparagraph (B) along

1 with the application for such medicare supplemental  
2 policy.

3 “(B) INDIVIDUAL DESCRIBED.—An individual de-  
4 scribed in this subparagraph is an individual who—

5 “(i) enrolls in the medicare prescription drug  
6 delivery program under part D; and

7 “(ii) at the time of such enrollment was en-  
8 rolled and terminates enrollment in a medicare sup-  
9 plemental policy which has a benefit package classi-  
10 fied as ‘H’, ‘I’, or ‘J’ (including the benefit package  
11 classified as ‘J’ with a high deductible feature, as  
12 described in section 1882(p)(11)) under the stand-  
13 ards referred to in subparagraph (A)(i) or termi-  
14 nates enrollment in a policy to which such stand-  
15 ards do not apply but which provides benefits for  
16 prescription drugs.

17 “(C) ENFORCEMENT.—The provisions of subpara-  
18 graph (A) shall be enforced as though they were in-  
19 cluded in subsection (s).

20 “(3) NOTICE REQUIRED TO BE PROVIDED TO CUR-  
21 RENT POLICYHOLDERS WITH PRESCRIPTION DRUG COV-  
22 ERAGE.—No medicare supplemental policy of an issuer  
23 shall be deemed to meet the standards in subsection (c) un-  
24 less the issuer provides written notice during the 60-day  
25 period immediately preceding the period established for the  
26 open enrollment period established under section 1860D-  
27 2(b)(2), to each individual who is a policyholder or certifi-  
28 cate holder of a medicare supplemental policy issued by  
29 that issuer that provides some coverage of expenses for pre-  
30 scription drugs (at the most recent available address of  
31 that individual) of—

32 “(A) the ability to enroll in a new medicare sup-  
33 plemental policy pursuant to paragraph (2); and

34 “(B) the fact that, so long as such individual re-  
35 tains coverage under such policy, the individual shall be  
36 ineligible for coverage of prescription drugs under part  
37 D.”.

1 (b) RULE OF CONSTRUCTION.—

2 (1) IN GENERAL.—Nothing in this Act shall be con-  
3 strued to require an issuer of a medicare supplemental pol-  
4 icy under section 1882 of the Social Security Act (42  
5 U.S.C. 1395rr) to participate as an eligible entity under  
6 part D of such Act, as added by section 101, as a condition  
7 for issuing such policy.

8 (2) PROHIBITION ON STATE REQUIREMENT.—A State  
9 may not require an issuer of a medicare supplemental pol-  
10 icy under section 1882 of the Social Security Act (42  
11 U.S.C. 1395rr) to participate as an eligible entity under  
12 part D of such Act, as added by section 101, as a condition  
13 for issuing such policy.

14 **SEC. 104. MEDICAID AND OTHER AMENDMENTS RE-**  
15 **LATED TO LOW-INCOME BENEFICIARIES.**

16 (a) DETERMINATIONS OF ELIGIBILITY FOR LOW-INCOME  
17 SUBSIDIES.—

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

20 (A) in subsection (a)—

21 (i) by striking “and” at the end of paragraph  
22 (64);

23 (ii) by striking the period at the end of para-  
24 graph (65) and inserting “; and”; and

25 (iii) by inserting after paragraph (65) the fol-  
26 lowing new paragraph:

27 “(66) provide for making eligibility determinations  
28 under section 1935(a).”.

29 (2) NEW SECTION.—Title XIX (42 U.S.C. 1396 et  
30 seq.) is amended—

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

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



1           that section in a manner that is similar to the manner  
2           in which presumptive eligibility is provided to children  
3           and pregnant women under this title;

4           “(C) inform the Administrator of the Centers for  
5           Medicare & Medicaid Services of such determinations in  
6           cases in which such eligibility is established; and

7           “(D) otherwise provide such Administrator with  
8           such information as may be required to carry out part  
9           D of title XVIII (including section 1860D-19).

10          “(3) AGREEMENT TO ESTABLISH INFORMATION AND  
11          ENROLLMENT SITES AT SOCIAL SECURITY FIELD OF-  
12          FICES.—Enter into an agreement with the Commissioner of  
13          Social Security to use all Social Security field offices lo-  
14          cated in the State as information and enrollment sites for  
15          making the eligibility determinations required under para-  
16          graphs (1) and (2).

17          “(b) FEDERAL SUBSIDY OF ADMINISTRATIVE COSTS.—

18          “(1) ENHANCED MATCH FOR ELIGIBILITY DETER-  
19          MINATIONS.—Subject to paragraphs (2) and (4), with re-  
20          spect to calendar quarters beginning on or after January  
21          1, 2004, the amounts expended by a State in carrying out  
22          subsection (a) are expenditures reimbursable under section  
23          1903(a)(7) except that, in applying such section with re-  
24          spect to such expenditures incurred for—

25                  “(A) such calendar quarters occurring in fiscal  
26                  year 2004 or 2005, ‘75 percent’ shall be substituted for  
27                  ‘50 per centum’;

28                  “(B) calendar quarters occurring in fiscal year  
29                  2006, ‘70 percent’ shall be substituted for ‘50 per cen-  
30                  tum’;

31                  “(C) calendar quarters occurring in fiscal year  
32                  2007, ‘65 percent’ shall be substituted for ‘50 per cen-  
33                  tum’; and

34                  “(D) calendar quarters occurring in fiscal year  
35                  2008 or any fiscal year thereafter, ‘60 percent’ shall be  
36                  substituted for ‘50 per centum’.

1           “(2) 100 PERCENT MATCH FOR ELIGIBILITY DETER-  
2           MINATIONS FOR SUBSIDY-ELIGIBLE INDIVIDUALS.—In the  
3           case of amounts expended by a State on or after November  
4           1, 2005, to determine whether an individual is a subsidy-  
5           eligible individual for purposes of section 1860D–19, such  
6           expenditures shall be reimbursed under section 1903(a)(7)  
7           by substituting ‘100 percent’ for ‘50 per centum’.

8           “(3) ENHANCED MATCH FOR UPDATES OR IMPROVE-  
9           MENTS TO ELIGIBILITY DETERMINATION SYSTEMS.—With  
10          respect to calendar quarters occurring in fiscal year 2004,  
11          2005, or 2006, the Secretary, in addition to amounts other-  
12          wise paid under section 1903(a), shall pay to each State  
13          which has a plan approved under this title, for each such  
14          quarter an amount equal to 90 percent of so much of the  
15          sums expended during such quarter as are attributable to  
16          the design, development, acquisition, or installation of im-  
17          proved eligibility determination systems (including hard-  
18          ware and software for such systems) in order to carry out  
19          the requirements of subsection (a) and section  
20          1807A(h)(1). No payment shall be made to a State under  
21          the preceding sentence unless the State’s improved eligi-  
22          bility determination system—

23                   “(A) satisfies such standards for improvement as  
24                   the Secretary may establish; and

25                   “(B) complies, and is compatible, with the stand-  
26                   ards established under part C of title XI and any regu-  
27                   lations promulgated under section 264(c) of the Health  
28                   Insurance Portability and Accountability Act of 1996  
29                   (42 U.S.C. 1320d–2 note).

30          “(4) COORDINATION.—The State shall provide the  
31          Secretary with such information as may be necessary to  
32          properly allocate expenditures described in paragraph (1),  
33          (2), or (3) that may otherwise be made for similar eligi-  
34          bility determinations or expenditures.

35          “(c) FEDERAL PAYMENT OF MEDICARE PART B PREMIUM  
36          FOR STATES PROVIDING PRESCRIPTION DRUG COVERAGE FOR  
37          DUAL ELIGIBLE INDIVIDUALS.—

1           “(1) IN GENERAL.—Subject to paragraph (4), in the  
2 case of a State that provides medical assistance for covered  
3 drugs (as such term is defined in section 1860D(a)(2)) to  
4 dual eligible individuals under this title that satisfies the  
5 minimum standards described in paragraph (2), the Sec-  
6 retary shall be responsible in accordance with section  
7 1841(f)(2) for paying 100 percent of the medicare cost-  
8 sharing described in section 1905(p)(3)(A)(ii) (relating to  
9 premiums under section 1839) for individuals—

10           “(A) who are dual eligible individuals or qualified  
11 medicare beneficiaries; and

12           “(B) whose family income is at least 74 percent,  
13 but not more than 100 percent, of the poverty line (as  
14 defined in section 2110(c)(5)) applicable to a family of  
15 the size involved.

16           “(2) MINIMUM STANDARDS DESCRIBED.—For pur-  
17 poses of paragraph (1), the minimum standards described  
18 in this paragraph are the following:

19           “(A) In providing medical assistance for dual eligi-  
20 ble individuals for such covered drugs, the State satis-  
21 fies the requirements of this title (including limitations  
22 on cost-sharing imposed under section 1916) applicable  
23 to the provision of medical assistance for prescribed  
24 drugs to dual eligible individuals.

25           “(B) In providing medical assistance for dual eligi-  
26 ble individuals for such covered drugs, the State pro-  
27 vides such individuals with beneficiary protections that  
28 the Secretary determines are equivalent to the bene-  
29 ficiary protections applicable under section 1860D-5 to  
30 eligible entities offering a Medicare Prescription Drug  
31 plan under part D of title XVIII.

32           “(C) In providing medical assistance for such indi-  
33 viduals for such covered drugs, the State does not im-  
34 pose a limitation on the number of prescriptions an in-  
35 dividual may have filled.

36           “(3) NONAPPLICATION.—Section 1927(d)(2)(E) shall  
37 not apply to a State for purposes of providing medical as-

1 assistance for covered drugs (as such term is defined in sec-  
2 tion 1860D(a)(2)) to dual eligible individuals that satisfies  
3 the minimum standards described in paragraph (2).

4 “(4) LIMITATION.—Paragraph (1) shall not apply to  
5 any State before January 1, 2006.

6 “(d) FEDERAL PAYMENT OF MEDICARE PART A COST-  
7 SHARING FOR CERTAIN STATES.—

8 “(1) IN GENERAL.—Subject to paragraph (2), in the  
9 case of a State that, as of the date of enactment of the  
10 Prescription Drug and Medicare Improvement Act of 2003,  
11 provides medical assistance for individuals described in sec-  
12 tion 1902(a)(10)(A)(ii)(X), the Secretary shall be respon-  
13 sible in accordance with section 1817(g)(2), for paying 100  
14 percent of the medicare cost-sharing described in subpara-  
15 graphs (B) and (C) of section 1905(p)(3) (relating to  
16 coninsurance and deductibles established under title XVIII)  
17 for the individuals provided medical assistance under sec-  
18 tion 1902(a)(10)(A)(ii)(X), but only—

19 “(A) with respect to such medicare cost-sharing  
20 that is incurred under part A of title XVIII; and

21 “(B) for so long as the State elects to provide  
22 medical assistance under section 1902(a)(10)(A)(ii)(X).

23 “(2) LIMITATION.—Paragraph (1) shall not apply to  
24 any State before January 1, 2006.

25 “(e) TREATMENT OF TERRITORIES.—

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

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

30 “(B) if the State establishes a plan described in  
31 paragraph (2), the amount otherwise determined under  
32 section 1108(f) (as increased under section 1108(g))  
33 for the State shall be further increased by the amount  
34 specified in paragraph (3).

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

1           “(A) provides medical assistance with respect to  
2           the provision of covered drugs (as defined in section  
3           1860D(a)(2)) to individuals described in subparagraph  
4           (A), (B), (C), or (D) of section 1860D–19(a)(3); and

5           “(B) ensures that additional amounts received by  
6           the State that are attributable to the operation of this  
7           subsection are used only for such assistance.

8           “(3) INCREASED AMOUNT.—

9           “(A) IN GENERAL.—The amount specified in this  
10          paragraph for a State for a fiscal year is equal to the  
11          product of—

12          “(i) the aggregate amount specified in sub-  
13          paragraph (B); and

14          “(ii) the amount specified in section  
15          1108(g)(1) for that State, divided by the sum of  
16          the amounts specified in such section for all such  
17          States.

18          “(B) AGGREGATE AMOUNT.—The aggregate  
19          amount specified in this subparagraph for—

20          “(i) the last 3 quarters of fiscal year 2006, is  
21          equal to \$22,500,000;

22          “(ii) fiscal year 2007, is equal to \$30,000,000;  
23          and

24          “(iii) any subsequent fiscal year, is equal to  
25          the aggregate amount specified in this subpara-  
26          graph for the previous fiscal year increased by the  
27          annual percentage increase specified in section  
28          1860D–6(c)(5) for the calendar year beginning in  
29          such fiscal year.

30          “(4) NONAPPLICATION.—Section 1927(d)(2)(E) shall  
31          not apply to a State described in paragraph (1) for pur-  
32          poses of providing medical assistance described in para-  
33          graph (2)(A).

34          “(5) REPORT.—The Secretary shall submit to Con-  
35          gress a report on the application of this subsection and  
36          may include in the report such recommendations as the  
37          Secretary deems appropriate.”.

1           “(f) DEFINITIONS.—For purposes of this section, the  
2 terms ‘qualified medicare beneficiary’, ‘subsidy-eligible indi-  
3 vidual’, and ‘dual eligible individual’ have the meanings given  
4 such terms in subparagraphs (A), (D), and (E), respectively, of  
5 section 1860D–19(a)(4).”.

6           (B) CONFORMING AMENDMENT.—Section 1108(f)  
7 (42 U.S.C. 1308(f)) is amended by inserting “and sec-  
8 tion 1935(e)(1)(B)” after “Subject to subsection (g)”.

9           (3) TRANSFER OF FEDERALLY ASSUMED PORTIONS OF  
10 MEDICARE COST-SHARING.—Section 1841(f) (42 U.S.C.  
11 1395t(f)) is amended—

12           (A) by inserting “(1)” after “(f)”; and

13           (B) by adding at the end the following new para-  
14 graph:

15           “(2) There shall be transferred periodically (but not less  
16 often than once each fiscal year) to the Trust Fund from the  
17 Treasury amounts which the Secretary of Health and Human  
18 Services shall have certified are equivalent to the amounts de-  
19 termined under section 1935(c)(1) with respect to all States for  
20 a fiscal year.”.

21           (4) AMENDMENT TO BEST PRICE.—Section  
22 1927(c)(1)(C)(i) (42 U.S.C. 1396r–8(c)(1)(C)(i)), as  
23 amended by section 111(b), is amended—

24           (A) by striking “and” at the end of subclause  
25 (IV);

26           (B) by striking the period at the end of subclause  
27 (V) and inserting “; and”; and

28           (C) by adding at the end the following new sub-  
29 clause:

30           “(VI) any prices charged which are nego-  
31 tiated under a Medicare Prescription Drug plan  
32 under part D of title XVIII with respect to cov-  
33 ered drugs, under a MedicareAdvantage plan  
34 under part C of such title with respect to such  
35 drugs, or under a qualified retiree prescription  
36 drug plan (as defined in section 1860D–  
37 20(f)(1)) with respect to such drugs, on behalf

1 of eligible beneficiaries (as defined in section  
2 1860D(a)(3)).

3 (c) EXTENSION OF MEDICARE COST-SHARING FOR PART  
4 B PREMIUM FOR QUALIFYING INDIVIDUALS THROUGH 2008.—

5 (1) IN GENERAL.—Section 1902(a)(10)(E)(iv) (42  
6 U.S.C. 1396a(a)(10)(E)(iv)) is amended to read as follows:

7 “(iv) subject to sections 1933 and 1905(p)(4), for  
8 making medical assistance available (but only for pre-  
9 miums payable with respect to months during the pe-  
10 riod beginning with January 1998, and ending with  
11 December 2008) for medicare cost-sharing described in  
12 section 1905(p)(3)(A)(ii) for individuals who would be  
13 qualified medicare beneficiaries described in section  
14 1905(p)(1) but for the fact that their income exceeds  
15 the income level established by the State under section  
16 1905(p)(2) and is at least 120 percent, but less than  
17 135 percent, of the official poverty line (referred to in  
18 such section) for a family of the size involved and who  
19 are not otherwise eligible for medical assistance under  
20 the State plan;”.

21 (2) TOTAL AMOUNT AVAILABLE FOR ALLOCATION.—  
22 Section 1933(c) (42 U.S.C. 1396u-3(c)) is amended—

23 (A) in paragraph (1)—

24 (i) in subparagraph (D), by striking “and” at  
25 the end;

26 (ii) in subparagraph (E)—

27 (I) by striking “fiscal year 2002” and in-  
28 sserting “each of fiscal years 2002 through  
29 2008”; and

30 (II) by striking the period and inserting “;  
31 and”; and

32 (iii) by adding at the end the following new  
33 subparagraph:

34 “(F) the first quarter of fiscal year 2009,  
35 \$100,000,000.”; and

36 (B) in paragraph (2)(A), by striking “the sum of”  
37 and all that follows through “1902(a)(10)(E)(iv)(II) in

1 the State; to” and inserting “twice the total number of  
2 individuals described in section 1902(a)(10)(E)(iv) in  
3 the State; to”.

4 (d) REPORT REGARDING VOLUNTARY ENROLLMENT OF  
5 DUAL ELIGIBLE INDIVIDUALS IN PART D.—Not later than  
6 January 1, 2005, the Secretary shall submit a report to Con-  
7 gress that contains such recommendations for legislation as the  
8 Secretary determines are necessary in order to establish a vol-  
9 untary option for dual eligible individuals (as defined in  
10 1860D–19(a)(4)(E) of the Social Security Act (as added by  
11 section 101)) to enroll under part D of title XVIII of such Act  
12 for prescription drug coverage.

13 **SEC. 105. EXPANSION OF MEMBERSHIP AND DUTIES OF**  
14 **MEDICARE PAYMENT ADVISORY COMMIS-**  
15 **SION (MEDPAC).**

16 (a) EXPANSION OF MEMBERSHIP.—

17 (1) IN GENERAL.—Section 1805(c) (42 U.S.C. 1395b–  
18 6(c)) is amended—

19 (A) in paragraph (1), by striking “17” and insert-  
20 ing “19”; and

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

24 (2) INITIAL TERMS OF ADDITIONAL MEMBERS.—

25 (A) IN GENERAL.—For purposes of staggering the  
26 initial terms of members of the Medicare Payment Ad-  
27 visory Commission under section 1805(c)(3) of the So-  
28 cial Security Act (42 U.S.C. 1395b–6(c)(3)), the initial  
29 terms of the 2 additional members of the Commission  
30 provided for by the amendment under paragraph (1)(A)  
31 are as follows:

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

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

35 (B) COMMENCEMENT OF TERMS.—Such terms  
36 shall begin on January 1, 2005.

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

4 “(D) VOLUNTARY PRESCRIPTION DRUG DELIVERY  
5 PROGRAM.—Specifically, the Commission shall review,  
6 with respect to the voluntary prescription drug delivery  
7 program under part D, competition among eligible enti-  
8 ties offering Medicare Prescription Drug plans and  
9 beneficiary access to such plans and covered drugs,  
10 particularly in rural areas.”.

11 **SEC. 106. STUDY REGARDING VARIATIONS IN SPENDING**  
12 **AND DRUG UTILIZATION.**

13 (a) STUDY.—The Secretary shall study on an ongoing  
14 basis variations in spending and drug utilization under part D  
15 of title XVIII of the Social Security Act for covered drugs to  
16 determine the impact of such variations on premiums imposed  
17 by eligible entities offering Medicare Prescription Drug plans  
18 under that part. In conducting such study, the Secretary shall  
19 examine the impact of geographic adjustments of the monthly  
20 national average premium under section 1860D–15 of such Act  
21 on—

22 (1) maximization of competition under part D of title  
23 XVIII of such Act; and

24 (2) the ability of eligible entities offering Medicare  
25 Prescription Drug plans to contain costs for covered drugs.

26 (b) REPORT.—Beginning with 2007, the Secretary shall  
27 submit annual reports to Congress on the study required under  
28 subsection (a).

29 **Subtitle B—Medicare Prescription**  
30 **Drug Discount Card and Transi-**  
31 **tional Assistance for Low-Income**  
32 **Beneficiaries**

33 **SEC. 111. MEDICARE PRESCRIPTION DRUG DISCOUNT**  
34 **CARD AND TRANSITIONAL ASSISTANCE FOR**  
35 **LOW-INCOME BENEFICIARIES.**

36 (a) IN GENERAL.—Title XVIII is amended by inserting  
37 after section 1806 the following new sections:



1           “(c) PROVIDING INFORMATION TO ELIGIBLE BENE-  
2 FICIARIES.—

3           “(1) PROMOTION OF INFORMED CHOICE.—

4           “(A) BY THE SECRETARY.—In order to promote  
5 informed choice among endorsed prescription drug dis-  
6 count card programs, the Secretary shall provide for  
7 the dissemination of information which compares the  
8 costs and benefits of such programs. Such dissemina-  
9 tion shall be coordinated with the dissemination of edu-  
10 cational information on other medicare options.

11           “(B) BY PRESCRIPTION DRUG CARD SPONSORS.—  
12 Each prescription drug card sponsor shall make avail-  
13 able to each eligible beneficiary (through the Internet  
14 and otherwise) information—

15           “(i) that the Secretary identifies as being nec-  
16 essary to promote informed choice among endorsed  
17 prescription drug discount card programs by eligi-  
18 ble beneficiaries, including information on enroll-  
19 ment fees, negotiated prices for prescription drugs  
20 charged to beneficiaries, and services relating to  
21 prescription drugs offered under the program;

22           “(ii) on how any formulary used by such spon-  
23 sor functions.

24           “(2) USE OF MEDICARE TOLL-FREE NUMBER.—The  
25 Secretary shall provide through the 1-800-MEDICARE toll  
26 free telephone number for the receipt and response to in-  
27 quiries and complaints concerning the medicare prescrip-  
28 tion drug discount card endorsement program established  
29 under this section and prescription drug discount card pro-  
30 grams endorsed under such program.

31           “(d) BENEFICIARY PROTECTIONS.—

32           “(1) IN GENERAL.—Each prescription drug discount  
33 card program endorsed under this section shall meet such  
34 requirements as the Secretary identifies to protect and pro-  
35 mote the interest of eligible beneficiaries, including require-  
36 ments that—

1           “(A) relate to appeals by eligible beneficiaries and  
2           marketing practices; and

3           “(B) ensure that beneficiaries are not charged  
4           more than the lower of the negotiated retail price or  
5           the usual and customary price.

6           “(2) ENSURING PHARMACY ACCESS.—Each prescrip-  
7           tion drug card sponsor offering a prescription drug dis-  
8           count card program endorsed under this section shall se-  
9           cure the participation in its network of a sufficient number  
10          of pharmacies that dispense (other than by mail order)  
11          drugs directly to patients to ensure convenient access (as  
12          determined by the Secretary and including adequate emer-  
13          gency access) for enrolled beneficiaries. Such standards  
14          shall take into account reasonable distances to pharmacy  
15          services in both urban and rural areas.

16          “(3) QUALITY ASSURANCE.—Each prescription drug  
17          card sponsor offering a prescription drug discount card  
18          program endorsed under this section shall have in place  
19          adequate procedures for assuring that quality service is  
20          provided to eligible beneficiaries enrolled in a prescription  
21          drug discount card program offered by such sponsor.

22          “(4) CONFIDENTIALITY OF ENROLLEE RECORDS.—In-  
23          sofar as a prescription drug card sponsor maintains indi-  
24          vidually identifiable medical records or other health infor-  
25          mation regarding eligible beneficiaries enrolled in a pre-  
26          scription drug discount card program endorsed under this  
27          section, the prescription drug card sponsor shall have in  
28          place procedures to safeguard the privacy of any individ-  
29          ually identifiable beneficiary information in a manner that  
30          the Secretary determines is consistent with the Federal reg-  
31          ulations (concerning the privacy of individually identifiable  
32          health information) promulgated under section 264(c) of  
33          the Health Insurance Portability and Accountability Act of  
34          1996.

35          “(5) NO OTHER FEES.—A prescription drug card  
36          sponsor may not charge any fee to an eligible beneficiary  
37          under a prescription drug discount card program endorsed

1 under this section other than an enrollment fee charged  
2 under subsection (b)(2)(A).

3 “(6) PRICES.—

4 “(A) AVOIDANCE OF HIGH PRICED DRUGS.—A  
5 prescription drug card sponsor may not recommend  
6 switching an eligible beneficiary to a drug with a higher  
7 negotiated price absent a recommendation by a licensed  
8 health professional that there is a clinical indication  
9 with respect to the patient for such a switch.

10 “(B) PRICE STABILITY.—Negotiated prices  
11 charged for prescription drugs covered under a pre-  
12 scription drug discount card program endorsed under  
13 this section may not change more frequently than once  
14 every 60 days.

15 “(e) PRESCRIPTION DRUG BENEFITS.—

16 “(1) IN GENERAL.—Each prescription drug card spon-  
17 sor may only provide benefits that relate to prescription  
18 drugs (as defined in subsection (i)(2)) under a prescription  
19 drug discount card program endorsed under this section.

20 “(2) SAVINGS TO ELIGIBLE BENEFICIARIES.—

21 “(A) IN GENERAL.—Subject to subparagraph (D),  
22 each prescription drug card sponsor shall provide eligi-  
23 ble beneficiaries who enroll in a prescription drug dis-  
24 count card program offered by such sponsor that is en-  
25 dorsed under this section with access to negotiated  
26 prices used by the sponsor with respect to prescription  
27 drugs dispensed to eligible beneficiaries.

28 “(B) INAPPLICABILITY OF MEDICAID BEST PRICE  
29 RULES.—The requirements of section 1927 relating to  
30 manufacturer best price shall not apply to the nego-  
31 tiated prices for prescription drugs made available  
32 under a prescription drug discount card program en-  
33 dorsed under this section.

34 “(C) GUARANTEED ACCESS TO NEGOTIATED  
35 PRICES.—The Secretary, in consultation with the In-  
36 spector General of the Department of Health and  
37 Human Services, shall establish procedures to ensure

1           that eligible beneficiaries have access to the negotiated  
2           prices for prescription drugs provided under subpara-  
3           graph (A).

4           “(D) APPLICATION OF FORMULARY RESTRIC-  
5           TIONS.—A drug prescribed for an eligible beneficiary  
6           that would otherwise be a covered drug under this sec-  
7           tion shall not be so considered under a prescription  
8           drug discount card program if the program excludes  
9           the drug under a formulary.

10          “(3) BENEFICIARY SERVICES.—Each prescription drug  
11          discount card program endorsed under this section shall  
12          provide pharmaceutical support services, such as education,  
13          counseling, and services to prevent adverse drug inter-  
14          actions.

15          “(4) DISCOUNT CARDS.—Each prescription drug card  
16          sponsor shall issue a card to eligible beneficiaries enrolled  
17          in a prescription drug discount card program offered by  
18          such sponsor that the beneficiary may use to obtain bene-  
19          fits under the program.

20          “(f) SUBMISSION OF APPLICATIONS FOR ENDORSEMENT  
21          AND APPROVAL.—

22          “(1) SUBMISSION OF APPLICATIONS FOR ENDORSE-  
23          MENT.—Each prescription drug card sponsor that seeks en-  
24          dorsement of a prescription drug discount card program under  
25          this section shall submit to the Secretary, at such time and in  
26          such manner as the Secretary may specify, such information as  
27          the Secretary may require.

28          “(2) APPROVAL.—The Secretary shall review the in-  
29          formation submitted under paragraph (1) and shall deter-  
30          mine whether to endorse the prescription drug discount  
31          card program to which such information relates. The Sec-  
32          retary may not approve a program unless the program and  
33          prescription drug card sponsor offering the program comply  
34          with the requirements under this section.

35          “(g) REQUIREMENTS ON DEVELOPMENT AND APPLICA-  
36          TION OF FORMULARIES.—If a prescription drug card sponsor

1 offering a prescription drug discount card program uses a for-  
2 mulary, the following requirements must be met:

3 “(1) PHARMACY AND THERAPEUTIC (P&T) COM-  
4 MITTEE.—

5 “(A) IN GENERAL.—The eligible entity must es-  
6 tablish a pharmacy and therapeutic committee that de-  
7 velops and reviews the formulary.

8 “(B) COMPOSITION.—A pharmacy and therapeutic  
9 committee shall include at least 1 academic expert, at  
10 least 1 practicing physician, and at least 1 practicing  
11 pharmacist, all of whom have expertise in the care of  
12 elderly or disabled persons, and a majority of the mem-  
13 bers of such committee shall consist of individuals who  
14 are a practicing physician or a practicing pharmacist  
15 (or both).

16 “(2) FORMULARY DEVELOPMENT.—In developing and  
17 reviewing the formulary, the committee shall base clinical  
18 decisions on the strength of scientific evidence and stand-  
19 ards of practice, including assessing peer-reviewed medical  
20 literature, such as randomized clinical trials,  
21 pharmacoeconomic studies, outcomes research data, and  
22 such other information as the committee determines to be  
23 appropriate.

24 “(3) INCLUSION OF DRUGS IN ALL THERAPEUTIC CAT-  
25 EGORIES AND CLASSES.—

26 “(A) IN GENERAL.—The formulary must include  
27 drugs within each therapeutic category and class of  
28 covered outpatient drugs (as defined by the Secretary),  
29 although not necessarily for all drugs within such cat-  
30 egories and classes.

31 “(B) REQUIREMENT.—In defining therapeutic cat-  
32 egories and classes of covered outpatient drugs pursu-  
33 ant to subparagraph (A), the Secretary shall use the  
34 compendia referred to section 1927(g)(1)(B)(i) or other  
35 recognized sources for categorizing drug therapeutic  
36 categories and classes.

1           “(4) PROVIDER EDUCATION.—The committee shall es-  
2           tablish policies and procedures to educate and inform  
3           health care providers concerning the formulary.

4           “(5) NOTICE BEFORE REMOVING DRUGS FROM FOR-  
5           MULARY.—Any removal of a drug from a formulary shall  
6           take effect only after appropriate notice is made available  
7           to beneficiaries and pharmacies.

8           “(h) FRAUD AND ABUSE PREVENTION.—

9           “(1) IN GENERAL.—The Secretary shall provide ap-  
10           propriate oversight to ensure compliance of endorsed pro-  
11           grams with the requirements of this section, including ver-  
12           ification of the negotiated prices and services provided.

13           “(2) DISQUALIFICATION FOR ABUSIVE PRACTICES.—  
14           The Secretary may implement intermediate sanctions and  
15           may revoke the endorsement of a program that the Sec-  
16           retary determines no longer meets the requirements of this  
17           section or that has engaged in false or misleading mar-  
18           keting practices.

19           “(3) AUTHORITY WITH RESPECT TO CIVIL MONEY  
20           PENALTIES.—The Secretary may impose a civil money pen-  
21           alty in an amount not to exceed \$10,000 for any violation  
22           of this section. The provisions of section 1128A (other than  
23           subsections (a) and (b)) shall apply to a civil money penalty  
24           under the previous sentence in the same manner as such  
25           provisions apply to a penalty or proceeding under section  
26           1128A(a).

27           “(4) REPORTING TO SECRETARY.—Each prescription  
28           drug card sponsor offering a prescription drug discount  
29           card program endorsed under this section shall report in-  
30           formation relating to program performance, use of pre-  
31           scription drugs by eligible beneficiaries enrolled in the pro-  
32           gram, financial information of the sponsor, and such other  
33           information as the Secretary may specify. The Secretary  
34           may not disclose any proprietary data reported under this  
35           paragraph.

1           “(5) DRUG UTILIZATION REVIEW.—The Secretary may  
2 use claims data from parts A and B for purposes of con-  
3 ducting a drug utilization review program.

4           “(i) DEFINITIONS.—In this section:

5           “(1) ELIGIBLE BENEFICIARY.—

6           “(A) IN GENERAL.—The term ‘eligible beneficiary’  
7 means an individual who—

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

10           “(ii) is not a dual eligible individual (as de-  
11 fined in subparagraph (B)).

12           “(B) DUAL ELIGIBLE INDIVIDUAL.—

13           “(i) IN GENERAL.—The term ‘dual eligible in-  
14 dividual’ means an individual who is—

15           “(I) enrolled under title XIX or under a  
16 waiver under section 1115 of the requirements  
17 of such title for medical assistance that is not  
18 less than the medical assistance provided to an  
19 individual described in section  
20 1902(a)(10)(A)(i) and includes covered out-  
21 patient drugs (as such term is defined for pur-  
22 poses of section 1927); and

23           “(II) entitled to benefits under part A and  
24 enrolled under part B.

25           “(ii) INCLUSION OF MEDICALLY NEEDY.—  
26 Such term includes an individual described in sec-  
27 tion 1902(a)(10)(C).

28           “(2) PRESCRIPTION DRUG.—

29           “(A) IN GENERAL.—Except as provided in sub-  
30 paragraph (B), the term ‘prescription drug’ means—

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

34           “(ii) a biological product or insulin described  
35 in subparagraph (B) or (C) of such section,  
36 and such term includes a vaccine licensed under section  
37 351 of the Public Health Service Act and any use of

1 a covered outpatient drug for a medically accepted indi-  
2 cation (as defined in section 1927(k)(6)).

3 “(B) EXCLUSIONS.—The term ‘prescription drug’  
4 does not include drugs or classes of drugs, or their  
5 medical uses, which may be excluded from coverage or  
6 otherwise restricted under section 1927(d)(2), other  
7 than subparagraph (E) thereof (relating to smoking  
8 cessation agents), or under section 1927(d)(3).

9 “(3) NEGOTIATED PRICE.—The term ‘negotiated  
10 price’ includes all discounts, direct or indirect subsidies, re-  
11 bates, price concessions, and direct or indirect remunera-  
12 tions.

13 “(4) PRESCRIPTION DRUG CARD SPONSOR.—The term  
14 ‘prescription drug card sponsor’ means any entity with  
15 demonstrated experience and expertise in operating a pre-  
16 scription drug discount card program, an insurance pro-  
17 gram that provides coverage for prescription drugs, or a  
18 similar program that the Secretary determines to be appro-  
19 priate to provide eligible beneficiaries with the benefits  
20 under a prescription drug discount card program endorsed  
21 by the Secretary under this section, including—

22 “(A) a pharmaceutical benefit management com-  
23 pany;

24 “(B) a wholesale or retail pharmacist delivery sys-  
25 tem;

26 “(C) an insurer (including an insurer that offers  
27 medicare supplemental policies under section 1882);

28 “(D) any other entity; or

29 “(E) any combination of the entities described in  
30 subparagraphs (A) through (D).

31 “TRANSITIONAL PRESCRIPTION DRUG ASSISTANCE CARD  
32 PROGRAM FOR ELIGIBLE LOW-INCOME BENEFICIARIES

33 “SEC. 1807A. (a) ESTABLISHMENT.—

34 “(1) IN GENERAL.—There is established a program  
35 under which the Secretary shall award contracts to pre-  
36 scription drug card sponsors offering a prescription drug  
37 discount card that has been endorsed by the Secretary

1 under section 1807 under which such sponsors shall offer  
2 a prescription drug assistance card program to eligible low-  
3 income beneficiaries in accordance with the requirements of  
4 this section.

5 “(2) APPLICATION OF DISCOUNT CARD PROVISIONS.—  
6 Except as otherwise provided in this section, the provisions  
7 of section 1807 shall apply to the program established  
8 under this section.

9 “(b) ELIGIBILITY, ELECTION OF PROGRAM, AND ENROLL-  
10 MENT FEES.—

11 “(1) ELIGIBILITY AND ELECTION OF PROGRAM.—

12 “(A) IN GENERAL.—Subject to the succeeding pro-  
13 visions of this paragraph, the enrollment procedures es-  
14 tablished under section 1807(b)(1)(A)(ii) shall apply  
15 for purposes of this section.

16 “(B) ENROLLMENT OF ANY ELIGIBLE LOW-IN-  
17 COME BENEFICIARY.—Each prescription drug card  
18 sponsor offering a prescription drug assistance card  
19 program under this section shall permit any eligible  
20 low-income beneficiary to enroll in such program if it  
21 serves the geographic area in which the beneficiary re-  
22 sides.

23 “(C) SIMULTANEOUS ENROLLMENT IN PRESCRIP-  
24 TION DRUG DISCOUNT CARD PROGRAM.—An eligible  
25 low-income beneficiary who enrolls in a prescription  
26 drug assistance card program offered by a prescription  
27 drug card sponsor under this section shall be simulta-  
28 neously enrolled in a prescription drug discount card  
29 program offered by such sponsor.

30 “(2) WAIVER OF ENROLLMENT FEES.—

31 “(A) IN GENERAL.—A prescription drug card  
32 sponsor may not charge an enrollment fee to any eligi-  
33 ble low-income beneficiary enrolled in a prescription  
34 drug discount card program offered by such sponsor.

35 “(B) PAYMENT BY SECRETARY.—Under a contract  
36 awarded under subsection (f)(2), the Secretary shall  
37 pay to each prescription drug card sponsor an amount

1 equal to any enrollment fee charged under section  
2 1807(b)(2)(A) on behalf of each eligible low-income  
3 beneficiary enrolled in a prescription drug discount  
4 card program under paragraph (1)(C) offered by such  
5 sponsor.

6 “(c) ADDITIONAL BENEFICIARY PROTECTIONS.—

7 “(1) PROVIDING INFORMATION TO ELIGIBLE LOW-IN-  
8 COME BENEFICIARIES.—In addition to the information pro-  
9 vided to eligible beneficiaries under section 1807(c), the  
10 prescription drug card sponsor shall—

11 “(A) periodically notify each eligible low-income  
12 beneficiary enrolled in a prescription drug assistance  
13 card program offered by such sponsor of the amount of  
14 coverage for prescription drugs remaining under sub-  
15 section (d)(2)(A); and

16 “(B) notify each eligible low-income beneficiary en-  
17 rolled in a prescription drug assistance card program  
18 offered by such sponsor of the grievance and appeals  
19 processes under the program.

20 “(2) CONVENIENT ACCESS IN LONG-TERM CARE FA-  
21 CILITIES.—For purposes of determining whether convenient  
22 access has been provided under section 1807(d)(2) with re-  
23 spect to eligible low-income beneficiaries enrolled in a pre-  
24 scription drug assistance card program, the Secretary may  
25 only make a determination that such access has been pro-  
26 vided if an appropriate arrangement is in place for eligible  
27 low-income beneficiaries who are in a long-term care facility  
28 (as defined by the Secretary) to receive prescription drug  
29 benefits under the program.

30 “(3) COORDINATION OF BENEFITS.—

31 “(A) IN GENERAL.—The Secretary shall establish  
32 procedures under which eligible low-income bene-  
33 ficiaries who are enrolled for coverage described in sub-  
34 paragraph (B) and enrolled in a prescription drug as-  
35 sistance card program have access to the prescription  
36 drug benefits available under such program.

1                   “(B) COVERAGE DESCRIBED.—Coverage described  
2                   in this subparagraph is as follows:

3                   “(i) Coverage of prescription drugs under a  
4                   State pharmaceutical assistance program.

5                   “(ii) Enrollment in a Medicare+ Choice plan  
6                   under part C.

7                   “(4) GRIEVANCE MECHANISM.—Each prescription  
8                   drug card sponsor with a contract under this section shall  
9                   provide in accordance with section 1852(f) meaningful pro-  
10                  cedures for hearing and resolving grievances between the  
11                  prescription drug card sponsor (including any entity or in-  
12                  dividual through which the prescription drug card sponsor  
13                  provides covered benefits) and enrollees in a prescription  
14                  drug assistance card program offered by such sponsor.

15                  “(5) APPLICATION OF COVERAGE DETERMINATION  
16                  AND RECONSIDERATION PROVISIONS.—

17                  “(A) IN GENERAL.—The requirements of para-  
18                  graphs (1) through (3) of section 1852(g) shall apply  
19                  with respect to covered benefits under a prescription  
20                  drug assistance card program under this section in the  
21                  same manner as such requirements apply to a  
22                  Medicare+ Choice organization with respect to benefits  
23                  it offers under a Medicare+ Choice plan under part C.

24                  “(B) REQUEST FOR REVIEW OF TIERED FOR-  
25                  MULARY DETERMINATIONS.—In the case of a prescrip-  
26                  tion drug assistance card program offered by a pre-  
27                  scription drug card sponsor that provides for tiered  
28                  pricing for drugs included within a formulary and pro-  
29                  vides lower prices for preferred drugs included within  
30                  the formulary, an eligible low-income beneficiary who is  
31                  enrolled in the program may request coverage of a non-  
32                  preferred drug under the terms applicable for preferred  
33                  drugs if the prescribing physician determines that the  
34                  preferred drug for treatment of the same condition is  
35                  not as effective for the eligible low-income beneficiary  
36                  or has adverse effects for the eligible low-income bene-  
37                  ficiary.

1           “(C) FORMULARY DETERMINATIONS.—An eligible  
2 low-income beneficiary who is enrolled in a prescription  
3 drug assistance card program offered by a prescription  
4 drug card sponsor may appeal to obtain coverage for a  
5 covered drug that is not on a formulary of the entity  
6 if the prescribing physician determines that the for-  
7 mulary drug for treatment of the same condition is not  
8 as effective for the eligible low-income beneficiary or  
9 has adverse effects for the eligible low-income bene-  
10 ficiary.

11           “(6) APPEALS.—

12           “(A) IN GENERAL.—Subject to subparagraph (B),  
13 a prescription drug card sponsor shall meet the require-  
14 ments of paragraphs (4) and (5) of section 1852(g)  
15 with respect to drugs not included on any formulary in  
16 a similar manner (as determined by the Secretary) as  
17 such requirements apply to a Medicare+ Choice organi-  
18 zation with respect to benefits it offers under a  
19 Medicare+ Choice plan under part C.

20           “(B) FORMULARY DETERMINATIONS.—An eligible  
21 low-income beneficiary who is enrolled in a prescription  
22 drug assistance card program offered by a prescription  
23 drug card sponsor may appeal to obtain coverage for a  
24 covered drug that is not on a formulary of the entity  
25 if the prescribing physician determines that the for-  
26 mulary drug for treatment of the same condition is not  
27 as effective for the eligible low-income beneficiary or  
28 has adverse effects for the eligible low-income bene-  
29 ficiary.

30           “(C) APPEALS AND EXCEPTIONS TO APPLICA-  
31 TION.—The prescription drug card sponsor must have,  
32 as part of the appeals process under this paragraph, a  
33 process for timely appeals for denials of coverage based  
34 on the application of the formulary.

35           “(d) PRESCRIPTION DRUG BENEFITS.—

36           “(1) IN GENERAL.—Subject to paragraph (5), all the  
37 benefits available under a prescription drug discount card

1 program offered by a prescription drug card sponsor and  
2 endorsed under section 1807 shall be available to eligible  
3 low-income beneficiaries enrolled in a prescription drug as-  
4 sistance card program offered by such sponsor.

5 “(2) ASSISTANCE FOR ELIGIBLE LOW-INCOME BENE-  
6 FICIARIES.—

7 “(A) \$600 ANNUAL ASSISTANCE.—Subject to sub-  
8 paragraphs (B) and (C) and paragraph (5), each pre-  
9 scription drug card sponsor with a contract under this  
10 section shall provide coverage for the first \$600 of ex-  
11 penses for prescription drugs incurred during each cal-  
12 endar year by an eligible low-income beneficiary en-  
13 rolled in a prescription drug assistance card program  
14 offered by such sponsor.

15 “(B) COINSURANCE.—

16 “(i) IN GENERAL.—The prescription drug card  
17 sponsor shall determine an amount of coinsurance  
18 to collect from each eligible low-income beneficiary  
19 enrolled in a prescription drug assistance card pro-  
20 gram offered by such sponsor for which coverage is  
21 available under subparagraph (A).

22 “(ii) AMOUNT.—The amount of coinsurance  
23 collected under clause (i) shall be at least 10 per-  
24 cent of the negotiated price of each prescription  
25 drug dispensed to an eligible low-income bene-  
26 ficiary.

27 “(iii) CONSTRUCTION.—Amounts collected  
28 under clause (i) shall not be counted against the  
29 total amount of coverage available under subpara-  
30 graph (A).

31 “(C) REDUCTION FOR LATE ENROLLMENT.—For  
32 each month during a calendar quarter in which an eli-  
33 gible low-income beneficiary is not enrolled in a pre-  
34 scription drug assistance card program offered by a  
35 prescription drug card sponsor with a contract under  
36 this section, the amount of assistance available under  
37 subparagraph (A) shall be reduced by \$50.

1           “(D) CREDITING OF UNUSED BENEFITS TOWARD  
2           FUTURE YEARS.—The dollar amount of coverage de-  
3           scribed in subparagraph (A) shall be increased by any  
4           amount of coverage described in such subparagraph  
5           that was not used during the previous calendar year.

6           “(E) WAIVER TO ENSURE PROVISION OF BEN-  
7           EFIT.—The Secretary may waive such requirements of  
8           this section and section 1807 as may be necessary to  
9           ensure that each eligible low-income beneficiaries has  
10          access to the assistance described in subparagraph (A).

11          “(3) ADDITIONAL DISCOUNTS.—A prescription drug  
12          card sponsor with a contract under this section shall pro-  
13          vide each eligible low-income beneficiary enrolled in a pre-  
14          scription drug assistance program offered by the sponsor  
15          with access to negotiated prices that reflect a minimum av-  
16          erage discount of at least 20 percent of the average whole-  
17          sale price for prescription drugs covered under that pro-  
18          gram.

19          “(4) ASSISTANCE CARDS.—Each prescription drug  
20          card sponsor shall permit eligible low-income beneficiaries  
21          enrolled in a prescription drug assistance card program of-  
22          fered by such sponsor to use the discount card issued under  
23          section 1807(e)(4) to obtain benefits under the program.

24          “(5) APPLICATION OF FORMULARY RESTRICTIONS.—A  
25          drug prescribed for an eligible low-income beneficiary that  
26          would otherwise be a covered drug under this section shall  
27          not be so considered under a prescription drug assistance  
28          card program if the program excludes the drug under a for-  
29          mulary and such exclusion is not successfully resolved  
30          under paragraph (4), (5), or (6) of subsection (c).

31          “(e) REQUIREMENTS FOR PRESCRIPTION DRUG CARD  
32          SPONSORS THAT OFFER PRESCRIPTION DRUG ASSISTANCE  
33          CARD PROGRAMS.—

34                  “(1) IN GENERAL.—Each prescription drug card spon-  
35                  sor shall—

36                          “(A) process claims made by eligible low-income  
37                          beneficiaries;

1           “(B) negotiate with brand name and generic pre-  
2           scription drug manufacturers and others for low prices  
3           on prescription drugs;

4           “(C) track individual beneficiary expenditures in a  
5           format and periodicity specified by the Secretary; and

6           “(D) perform such other functions as the Sec-  
7           retary may assign.

8           “(2) DATA EXCHANGES.—Each prescription drug card  
9           sponsor shall receive data exchanges in a format specified  
10          by the Secretary and shall maintain real-time beneficiary  
11          files.

12          “(3) PUBLIC DISCLOSURE OF PHARMACEUTICAL  
13          PRICES FOR EQUIVALENT DRUGS.—The prescription drug  
14          card sponsor offering the prescription drug assistance card  
15          program shall provide that each pharmacy or other dis-  
16          penser that arranges for the dispensing of a covered drug  
17          shall inform the eligible low-income beneficiary at the time  
18          of purchase of the drug of any differential between the  
19          price of the prescribed drug to the enrollee and the price  
20          of the lowest priced generic drug covered under the plan  
21          that is therapeutically equivalent and bioequivalent and  
22          available at such pharmacy or other dispenser.

23          “(f) SUBMISSION OF BIDS AND AWARDING OF CON-  
24          TRACTS.—

25          “(1) SUBMISSION OF BIDS.—Each prescription drug  
26          card sponsor that seeks to offer a prescription drug assist-  
27          ance card program under this section shall submit to the  
28          Secretary, at such time and in such manner as the Sec-  
29          retary may specify, such information as the Secretary may  
30          require.

31          “(2) AWARDING OF CONTRACTS.—The Secretary shall  
32          review the information submitted under paragraph (1) and  
33          shall determine whether to award a contract to the pre-  
34          scription drug card sponsor offering the program to which  
35          such information relates. The Secretary may not approve a  
36          program unless the program and prescription drug card

1 sponsor offering the program comply with the requirements  
2 under this section.

3 “(3) NUMBER OF CONTRACTS.—There shall be no  
4 limit on the number of prescription drug card sponsors that  
5 may be awarded contracts under paragraph (2).

6 “(4) CONTRACT PROVISIONS.—

7 “(A) DURATION.—A contract awarded under  
8 paragraph (2) shall be for the lifetime of the program  
9 under this section.

10 “(B) WITHDRAWAL.—A prescription drug card  
11 sponsor that desires to terminate the contract awarded  
12 under paragraph (2) may terminate such contract with-  
13 out penalty if such sponsor gives notice—

14 “(i) to the Secretary 90 days prior to the ter-  
15 mination of such contract; and

16 “(ii) to each eligible low-income beneficiary  
17 that is enrolled in a prescription drug assistance  
18 card program offered by such sponsor 60 days  
19 prior to such termination.

20 “(C) SERVICE AREA.—The service area under the  
21 contract shall be the same as the area served by the  
22 prescription drug card sponsor under section 1807.

23 “(5) SIMULTANEOUS APPROVAL OF DISCOUNT CARD  
24 AND ASSISTANCE PROGRAMS.—A prescription drug card  
25 sponsor may submit an application for endorsement under  
26 section 1807 as part of the bid submitted under paragraph  
27 (1) and the Secretary may approve such application at the  
28 same time as the Secretary awards a contract under this  
29 section.

30 “(g) PAYMENTS TO PRESCRIPTION DRUG CARD SPON-  
31 SORS.—

32 “(1) IN GENERAL.—The Secretary shall pay to each  
33 prescription drug card sponsor offering a prescription drug  
34 assistance card program in which an eligible low-income  
35 beneficiary is enrolled an amount equal to the amount  
36 agreed to by the Secretary and the sponsor in the contract  
37 awarded under subsection (f)(2).

1           “(2) PAYMENT FROM PART B TRUST FUND.—The  
2 costs of providing benefits under this section shall be pay-  
3 able from the Federal Supplementary Medical Insurance  
4 Trust Fund established under section 1841.

5           “(h) ELIGIBILITY DETERMINATIONS MADE BY STATES;  
6 PRESUMPTIVE ELIGIBILITY.—States shall perform the func-  
7 tions described in section 1935(a)(1).

8           “(i) APPROPRIATIONS.—There are appropriated from the  
9 Federal Supplementary Medical Insurance Trust Fund estab-  
10 lished under section 1841 such sums as may be necessary to  
11 carry out the program under this section.

12           “(j) DEFINITIONS.—In this section:

13           “(1) ELIGIBLE BENEFICIARY; NEGOTIATED PRICE;  
14 PRESCRIPTION DRUG.—The terms ‘eligible beneficiary’, ‘ne-  
15 gotiated price’, and ‘prescription drug’ have the meanings  
16 given those terms in section 1807(i).

17           “(2) ELIGIBLE LOW-INCOME BENEFICIARY.—

18           “(A) IN GENERAL.—Subject to subparagraphs (B)  
19 and (C), the term ‘eligible low-income beneficiary’  
20 means an individual who—

21           “(i) is an eligible beneficiary (as defined in  
22 section 1807(i)); and

23           “(ii) is described in clause (iii) or (iv) of sec-  
24 tion 1902(a)(10)(E) or in section 1905(p)(1).

25           “(3) PRESCRIPTION DRUG CARD SPONSOR.—The term  
26 ‘prescription drug card sponsor’ has the meaning given that  
27 term in section 1807(i), except that such sponsor shall also  
28 be an entity that the Secretary determines is—

29           “(A) is appropriate to provide eligible low-income  
30 beneficiaries with the benefits under a prescription  
31 drug assistance card program under this section; and

32           “(B) is able to manage the monetary assistance  
33 made available under subsection (d)(2);

34           “(C) agrees to submit to audits by the Secretary;  
35 and

36           “(D) provides such other assurances as the Sec-  
37 retary may require.

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

3           (b) EXCLUSION OF PRICES FROM DETERMINATION OF  
4           BEST PRICE.—Section 1927(c)(1)(C)(i) (42 U.S.C. 1396r-  
5           8(c)(1)(C)(i)) is amended—

6           (1) by striking “and” at the end of subclause (III);

7           (2) by striking the period at the end of subclause (IV)  
8           and inserting “; and”; and

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

10                   “(V) any negotiated prices charged under  
11                   the medicare prescription drug discount card  
12                   endorsement program under section 1807 or  
13                   under the transitional prescription drug assist-  
14                   ance card program for eligible low-income bene-  
15                   ficiaries under section 1807A.”.

16           (c) EXCLUSION OF PRESCRIPTION DRUG ASSISTANCE  
17           CARD COSTS FROM DETERMINATION OF PART B MONTHLY  
18           PREMIUM.—Section 1839(g) of the Social Security Act (42  
19           U.S.C. 1395r(g)) is amended—

20           (1) by striking “attributable to the application of sec-  
21           tion” and inserting “attributable to—

22                   “(1) the application of section”;

23           (2) by striking the period and inserting “; and”; and

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

25                   “(2) the prescription drug assistance card program  
26                   under section 1807A.”.

27           (d) REGULATIONS.—

28           (1) AUTHORITY FOR INTERIM FINAL REGULATIONS.—

29           The Secretary may promulgate initial regulations imple-  
30           menting sections 1807 and 1807A of the Social Security  
31           Act (as added by this section) in interim final form without  
32           prior opportunity for public comment.

33           (2) FINAL REGULATIONS.—A final regulation reflect-  
34           ing public comments must be published within 1 year of the  
35           interim final regulation promulgated under paragraph (1).

36           (3) EXEMPTION FROM THE PAPERWORK REDUCTION  
37           ACT.—The promulgation of the regulations under this sub-

1 section and the administration the programs established by  
2 sections 1807 and 1807A of the Social Security Act (as  
3 added by this section) shall be made without regard to  
4 chapter 35 of title 44, United States Code (commonly  
5 known as the “Paperwork Reduction Act”).

6 (e) IMPLEMENTATION; TRANSITION.—

7 (1) IMPLEMENTATION.—The Secretary shall imple-  
8 ment the amendments made by this section in a manner  
9 that discounts are available to eligible beneficiaries under  
10 section 1807 of the Social Security Act and assistance is  
11 available to eligible low-income beneficiaries under section  
12 1807A of such Act not later than January 1, 2004.

13 (2) TRANSITION.—The Secretary shall provide for an  
14 appropriate transition and discontinuation of the programs  
15 under section 1807 and 1807A of the Social Security Act.  
16 Such transition and discontinuation shall ensure that such  
17 programs continue to operate until the date on which the  
18 first enrollment period under part D ends.

19 **TITLE II—MEDICAREADVANTAGE**  
20 **Subtitle A—MedicareAdvantage**  
21 **Competition**

22 **SEC. 201. ELIGIBILITY, ELECTION, AND ENROLLMENT.**

23 Section 1851 (42 U.S.C. 1395w-21) is amended to read  
24 as follows:

25 “ELIGIBILITY, ELECTION, AND ENROLLMENT

26 “SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS  
27 THROUGH MEDICAREADVANTAGE PLANS.—

28 “(1) IN GENERAL.—Subject to the provisions of this  
29 section, each MedicareAdvantage eligible individual (as de-  
30 fined in paragraph (3)) is entitled to elect to receive bene-  
31 fits under this title—

32 “(A) through—

33 “(i) the original Medicare fee-for-service pro-  
34 gram under parts A and B; and

35 “(ii) the voluntary prescription drug delivery  
36 program under part D; or

1           “(B) through enrollment in a MedicareAdvantage  
2           plan under this part.

3           “(2) TYPES OF MEDICAREADVANTAGE PLANS THAT  
4           MAY BE AVAILABLE.—A MedicareAdvantage plan may be  
5           any of the following types of plans of health insurance:

6           “(A) COORDINATED CARE PLANS.—Coordinated  
7           care plans which provide health care services, including  
8           health maintenance organization plans (with or without  
9           point of service options) and plans offered by provider-  
10          sponsored organizations (as defined in section  
11          1855(d)).

12          “(B) COMBINATION OF MSA PLAN AND CONTRIBU-  
13          TIONS TO MEDICAREADVANTAGE MSA.—An MSA plan,  
14          as defined in section 1859(b)(3), and a contribution  
15          into a MedicareAdvantage medical savings account  
16          (MSA).

17          “(C) PRIVATE FEE-FOR-SERVICE PLANS.—A  
18          MedicareAdvantage private fee-for-service plan, as de-  
19          fined in section 1859(b)(2).

20          “(3) MEDICAREADVANTAGE ELIGIBLE INDIVIDUAL.—

21          “(A) IN GENERAL.—Subject to subparagraph (B),  
22          in this title, the term ‘MedicareAdvantage eligible indi-  
23          vidual’ means an individual who is entitled to (or en-  
24          rolled for) benefits under part A, enrolled under part  
25          B, and enrolled under part D.

26          “(B) SPECIAL RULE FOR END-STAGE RENAL DIS-  
27          EASE.—Such term shall not include an individual medi-  
28          cally determined to have end-stage renal disease, except  
29          that—

30                  “(i) an individual who develops end-stage renal  
31                  disease while enrolled in a Medicare+ Choice or a  
32                  MedicareAdvantage plan may continue to be en-  
33                  rolled in that plan; and

34                  “(ii) in the case of such an individual who is  
35                  enrolled in a Medicare+ Choice plan or a  
36                  MedicareAdvantage plan under clause (i) (or subse-  
37                  quently under this clause), if the enrollment is dis-

1 continued under circumstances described in section  
2 1851(e)(4)(A), then the individual will be treated  
3 as a 'MedicareAdvantage eligible individual' for  
4 purposes of electing to continue enrollment in an-  
5 other MedicareAdvantage plan.

6 “(b) SPECIAL RULES.—

7 “(1) RESIDENCE REQUIREMENT.—

8 “(A) IN GENERAL.—Except as the Secretary may  
9 otherwise provide and except as provided in subpara-  
10 graph (C), an individual is eligible to elect a  
11 MedicareAdvantage plan offered by a  
12 MedicareAdvantage organization only if the plan serves  
13 the geographic area in which the individual resides.

14 “(B) CONTINUATION OF ENROLLMENT PER-  
15 MITTED.—Pursuant to rules specified by the Secretary,  
16 the Secretary shall provide that a plan may offer to all  
17 individuals residing in a geographic area the option to  
18 continue enrollment in the plan, notwithstanding that  
19 the individual no longer resides in the service area of  
20 the plan, so long as the plan provides that individuals  
21 exercising this option have, as part of the basic benefits  
22 described in section 1852(a)(1)(A), reasonable access  
23 within that geographic area to the full range of basic  
24 benefits, subject to reasonable cost-sharing liability in  
25 obtaining such benefits.

26 “(C) CONTINUATION OF ENROLLMENT PERMITTED  
27 WHERE SERVICE CHANGED.—Notwithstanding subpara-  
28 graph (A) and in addition to subparagraph (B), if a  
29 MedicareAdvantage organization eliminates from its  
30 service area a MedicareAdvantage payment area that  
31 was previously within its service area, the organization  
32 may elect to offer individuals residing in all or portions  
33 of the affected area who would otherwise be ineligible  
34 to continue enrollment the option to continue enroll-  
35 ment in a MedicareAdvantage plan it offers so long  
36 as—



1 selection), use of preventive care, access to care, and  
2 the financial status of the Trust Funds under this title.

3 “(C) REPORTS.—The Secretary shall submit to  
4 Congress periodic reports on the numbers of individuals  
5 enrolled in such plans and on the evaluation being con-  
6 ducted under subparagraph (B).

7 “(c) PROCESS FOR EXERCISING CHOICE.—

8 “(1) IN GENERAL.—The Secretary shall establish a  
9 process through which elections described in subsection (a)  
10 are made and changed, including the form and manner in  
11 which such elections are made and changed. Such elections  
12 shall be made or changed only during coverage election pe-  
13 riods specified under subsection (e) and shall become effec-  
14 tive as provided in subsection (f).

15 “(2) COORDINATION THROUGH MEDICAREADVANTAGE  
16 ORGANIZATIONS.—

17 “(A) ENROLLMENT.—Such process shall permit  
18 an individual who wishes to elect a MedicareAdvantage  
19 plan offered by a MedicareAdvantage organization to  
20 make such election through the filing of an appropriate  
21 election form with the organization.

22 “(B) DISENROLLMENT.—Such process shall per-  
23 mit an individual, who has elected a  
24 MedicareAdvantage plan offered by a  
25 MedicareAdvantage organization and who wishes to ter-  
26 minate such election, to terminate such election  
27 through the filing of an appropriate election form with  
28 the organization.

29 “(3) DEFAULT.—

30 “(A) INITIAL ELECTION.—

31 “(i) IN GENERAL.—Subject to clause (ii), an  
32 individual who fails to make an election during an  
33 initial election period under subsection (e)(1) is  
34 deemed to have chosen the original medicare fee-  
35 for-service program option.

36 “(ii) SEAMLESS CONTINUATION OF COV-  
37 ERAGE.—The Secretary may establish procedures

1 under which an individual who is enrolled in a  
2 Medicare+ Choice plan or another health plan  
3 (other than a MedicareAdvantage plan) offered by  
4 a MedicareAdvantage organization at the time of  
5 the initial election period and who fails to elect to  
6 receive coverage other than through the organiza-  
7 tion is deemed to have elected the  
8 MedicareAdvantage plan offered by the organiza-  
9 tion (or, if the organization offers more than 1  
10 such plan, such plan or plans as the Secretary  
11 identifies under such procedures).

12 “(B) CONTINUING PERIODS.—An individual who  
13 has made (or is deemed to have made) an election  
14 under this section is considered to have continued to  
15 make such election until such time as—

16 “(i) the individual changes the election under  
17 this section; or

18 “(ii) the MedicareAdvantage plan with respect  
19 to which such election is in effect is discontinued  
20 or, subject to subsection (b)(1)(B), no longer serves  
21 the area in which the individual resides.

22 “(d) PROVIDING INFORMATION TO PROMOTE INFORMED  
23 CHOICE.—

24 “(1) IN GENERAL.—The Secretary shall provide for  
25 activities under this subsection to broadly disseminate in-  
26 formation to medicare beneficiaries (and prospective medi-  
27 care beneficiaries) on the coverage options provided under  
28 this section in order to promote an active, informed selec-  
29 tion among such options.

30 “(2) PROVISION OF NOTICE.—

31 “(A) OPEN SEASON NOTIFICATION.—At least 15  
32 days before the beginning of each annual, coordinated  
33 election period (as defined in subsection (e)(3)(B)), the  
34 Secretary shall mail to each MedicareAdvantage eligible  
35 individual residing in an area the following:

36 “(i) GENERAL INFORMATION.—The general in-  
37 formation described in paragraph (3).

1                   “(ii) LIST OF PLANS AND COMPARISON OF  
2                   PLAN OPTIONS.—A list identifying the  
3                   MedicareAdvantage plans that are (or will be)  
4                   available to residents of the area and information  
5                   described in paragraph (4) concerning such plans.  
6                   Such information shall be presented in a compara-  
7                   tive form.

8                   “(iii) ADDITIONAL INFORMATION.—Any other  
9                   information that the Secretary determines will as-  
10                  sist the individual in making the election under this  
11                  section.

12                  The mailing of such information shall be coordinated,  
13                  to the extent practicable, with the mailing of any an-  
14                  nual notice under section 1804.

15                  “(B) NOTIFICATION TO NEWLY ELIGIBLE  
16                  MEDICAREADVANTAGE ELIGIBLE INDIVIDUALS.—To the  
17                  extent practicable, the Secretary shall, not later than  
18                  30 days before the beginning of the initial  
19                  MedicareAdvantage enrollment period for an individual  
20                  described in subsection (e)(1), mail to the individual  
21                  the information described in subparagraph (A).

22                  “(C) FORM.—The information disseminated under  
23                  this paragraph shall be written and formatted using  
24                  language that is easily understandable by medicare  
25                  beneficiaries.

26                  “(D) PERIODIC UPDATING.—The information de-  
27                  scribed in subparagraph (A) shall be updated on at  
28                  least an annual basis to reflect changes in the avail-  
29                  ability of MedicareAdvantage plans, the benefits under  
30                  such plans, and the MedicareAdvantage monthly basic  
31                  beneficiary premium, MedicareAdvantage monthly ben-  
32                  eficiary premium for enhanced medical benefits, and  
33                  MedicareAdvantage monthly beneficiary obligation for  
34                  qualified prescription drug coverage for such plans.

35                  “(3) GENERAL INFORMATION.—General information  
36                  under this paragraph, with respect to coverage under this  
37                  part during a year, shall include the following:

1           “(A) BENEFITS UNDER THE ORIGINAL MEDICARE  
2 FEE-FOR-SERVICE PROGRAM OPTION.—A general de-  
3 scription of the benefits covered under parts A and B  
4 of the original medicare fee-for-service program,  
5 including—

6           “(i) covered items and services;

7           “(ii) beneficiary cost-sharing, such as  
8 deductibles, coinsurance, and copayment amounts;  
9 and

10           “(iii) any beneficiary liability for balance bill-  
11 ing.

12           “(B) CATASTROPHIC COVERAGE AND COMBINED  
13 DEDUCTIBLE.—A description of the catastrophic cov-  
14 erage and unified deductible applicable under the plan.

15           “(C) OUTPATIENT PRESCRIPTION DRUG COVERAGE  
16 BENEFITS.—The information required under section  
17 1860D-4 with respect to coverage for prescription  
18 drugs under the plan.

19           “(D) ELECTION PROCEDURES.—Information and  
20 instructions on how to exercise election options under  
21 this section.

22           “(E) RIGHTS.—A general description of proce-  
23 dural rights (including grievance and appeals proce-  
24 dures) of beneficiaries under the original medicare fee-  
25 for-service program (including such rights under part  
26 D) and the MedicareAdvantage program and the right  
27 to be protected against discrimination based on health  
28 status-related factors under section 1852(b).

29           “(F) INFORMATION ON MEDIGAP AND MEDICARE  
30 SELECT.—A general description of the benefits, enroll-  
31 ment rights, and other requirements applicable to medi-  
32 care supplemental policies under section 1882 and pro-  
33 visions relating to medicare select policies described in  
34 section 1882(t).

35           “(G) POTENTIAL FOR CONTRACT TERMINATION.—  
36 The fact that a MedicareAdvantage organization may  
37 terminate its contract, refuse to renew its contract, or

1           reduce the service area included in its contract, under  
2           this part, and the effect of such a termination, non-  
3           renewal, or service area reduction may have on individ-  
4           uals enrolled with the MedicareAdvantage plan under  
5           this part.

6           “(4) INFORMATION COMPARING PLAN OPTIONS.—In-  
7           formation under this paragraph, with respect to a  
8           MedicareAdvantage plan for a year, shall include the fol-  
9           lowing:

10           “(A) BENEFITS.—The benefits covered under the  
11           plan, including the following:

12           “(i) Covered items and services beyond those  
13           provided under the original medicare fee-for-service  
14           program option.

15           “(ii) Beneficiary cost-sharing for any items  
16           and services described in clause (i) and paragraph  
17           (3)(A)(i), including information on the unified de-  
18           ductible under section 1852(a)(1)(C).

19           “(iii) The maximum limitations on out-of-  
20           pocket expenses under section 1852(a)(1)(C).

21           “(iv) In the case of an MSA plan, differences  
22           in cost-sharing, premiums, and balance billing  
23           under such a plan compared to under other  
24           MedicareAdvantage plans.

25           “(v) In the case of a MedicareAdvantage pri-  
26           vate fee-for-service plan, differences in cost-sharing,  
27           premiums, and balance billing under such a plan  
28           compared to under other MedicareAdvantage plans.

29           “(vi) The extent to which an enrollee may ob-  
30           tain benefits through out-of-network health care  
31           providers.

32           “(vii) The extent to which an enrollee may se-  
33           lect among in-network providers and the types of  
34           providers participating in the plan’s network.

35           “(viii) The organization’s coverage of emer-  
36           gency and urgently needed care.

1           “(ix) The comparative information described  
2           in section 1860D-4(b)(2) relating to prescription  
3           drug coverage under the plan.

4           “(B) PREMIUMS.—

5           “(i) IN GENERAL.—The MedicareAdvantage  
6           monthly basic beneficiary premium and  
7           MedicareAdvantage monthly beneficiary premium  
8           for enhanced medical benefits, if any, for the plan  
9           or, in the case of an MSA plan, the  
10          MedicareAdvantage monthly MSA premium.

11          “(ii) REDUCTIONS.—The reduction in part B  
12          premiums, if any.

13          “(iii) NATURE OF THE PREMIUM FOR EN-  
14          HANCED MEDICAL BENEFITS.—Whether the  
15          MedicareAdvantage monthly premium for enhanced  
16          benefits is optional or mandatory.

17          “(C) SERVICE AREA.—The service area of the  
18          plan.

19          “(D) QUALITY AND PERFORMANCE.—Plan quality  
20          and performance indicators for the benefits under the  
21          plan (and how such indicators compare to quality and  
22          performance indicators under the original medicare fee-  
23          for-service program under parts A and B and under  
24          the voluntary prescription drug delivery program under  
25          part D in the area involved), including—

26                 “(i) disenrollment rates for medicare enrollees  
27                 electing to receive benefits through the plan for the  
28                 previous 2 years (excluding disenrollment due to  
29                 death or moving outside the plan’s service area);

30                 “(ii) information on medicare enrollee satisfac-  
31                 tion;

32                 “(iii) information on health outcomes; and

33                 “(iv) the recent record regarding compliance of  
34                 the plan with requirements of this part (as deter-  
35                 mined by the Secretary).

36          “(5) MAINTAINING A TOLL-FREE NUMBER AND INTER-  
37          NET SITE.—The Secretary shall maintain a toll-free num-

1 ber for inquiries regarding MedicareAdvantage options and  
2 the operation of this part in all areas in which  
3 MedicareAdvantage plans are offered and an Internet site  
4 through which individuals may electronically obtain infor-  
5 mation on such options and MedicareAdvantage plans.

6 “(6) USE OF NON-FEDERAL ENTITIES.—The Secretary  
7 may enter into contracts with non-Federal entities to carry  
8 out activities under this subsection.

9 “(7) PROVISION OF INFORMATION.—A  
10 MedicareAdvantage organization shall provide the Sec-  
11 retary with such information on the organization and each  
12 MedicareAdvantage plan it offers as may be required for  
13 the preparation of the information referred to in paragraph  
14 (2)(A).

15 “(e) COVERAGE ELECTION PERIODS.—

16 “(1) INITIAL CHOICE UPON ELIGIBILITY TO MAKE  
17 ELECTION IF MEDICAREADVANTAGE PLANS AVAILABLE TO  
18 INDIVIDUAL.—If, at the time an individual first becomes el-  
19 igible to elect to receive benefits under part B or D (which-  
20 ever is later), there is 1 or more MedicareAdvantage plans  
21 offered in the area in which the individual resides, the indi-  
22 vidual shall make the election under this section during a  
23 period specified by the Secretary such that if the individual  
24 elects a MedicareAdvantage plan during the period, cov-  
25 erage under the plan becomes effective as of the first date  
26 on which the individual may receive such coverage.

27 “(2) OPEN ENROLLMENT AND DISENROLLMENT OP-  
28 PORTUNITIES.—Subject to paragraph (5), the following  
29 rules shall apply:

30 “(A) CONTINUOUS OPEN ENROLLMENT AND  
31 DISENROLLMENT THROUGH 2005.—At any time during  
32 the period beginning January 1, 1998, and ending on  
33 December 31, 2005, a Medicare+ Choice eligible indi-  
34 vidual may change the election under subsection (a)(1).

35 “(B) CONTINUOUS OPEN ENROLLMENT AND  
36 DISENROLLMENT FOR FIRST 6 MONTHS DURING 2006.—

1           “(i) IN GENERAL.—Subject to clause (ii) and  
2           subparagraph (D), at any time during the first 6  
3           months of 2006, or, if the individual first becomes  
4           a MedicareAdvantage eligible individual during  
5           2006, during the first 6 months during 2006 in  
6           which the individual is a MedicareAdvantage eligi-  
7           ble individual, a MedicareAdvantage eligible indi-  
8           vidual may change the election under subsection  
9           (a)(1).

10           “(ii) LIMITATION OF 1 CHANGE.—An indi-  
11           vidual may exercise the right under clause (i) only  
12           once. The limitation under this clause shall not  
13           apply to changes in elections effected during an an-  
14           nual, coordinated election period under paragraph  
15           (3) or during a special enrollment period under the  
16           first sentence of paragraph (4).

17           “(C) CONTINUOUS OPEN ENROLLMENT AND  
18           DISENROLLMENT FOR FIRST 3 MONTHS IN SUBSE-  
19           QUENT YEARS.—

20           “(i) IN GENERAL.—Subject to clause (ii) and  
21           subparagraph (D), at any time during the first 3  
22           months of 2007 and each subsequent year, or, if  
23           the individual first becomes a MedicareAdvantage  
24           eligible individual during 2007 or any subsequent  
25           year, during the first 3 months of such year in  
26           which the individual is a MedicareAdvantage eligi-  
27           ble individual, a MedicareAdvantage eligible indi-  
28           vidual may change the election under subsection  
29           (a)(1).

30           “(ii) LIMITATION OF 1 CHANGE DURING OPEN  
31           ENROLLMENT PERIOD EACH YEAR.—An individual  
32           may exercise the right under clause (i) only once  
33           during the applicable 3-month period described in  
34           such clause in each year. The limitation under this  
35           clause shall not apply to changes in elections ef-  
36           fected during an annual, coordinated election pe-

1                   riod under paragraph (3) or during a special enroll-  
2                   ment period under paragraph (4).

3                   “(D) CONTINUOUS OPEN ENROLLMENT FOR INSTI-  
4                   TUTIONALIZED INDIVIDUALS.—At any time during  
5                   2006 or any subsequent year, in the case of a  
6                   MedicareAdvantage eligible individual who is institu-  
7                   tionalized (as defined by the Secretary), the individual  
8                   may elect under subsection (a)(1)—

9                   “(i) to enroll in a MedicareAdvantage plan; or  
10                   “(ii) to change the MedicareAdvantage plan in  
11                   which the individual is enrolled.

12                   “(3) ANNUAL, COORDINATED ELECTION PERIOD.—

13                   “(A) IN GENERAL.—Subject to paragraph (5),  
14                   each individual who is eligible to make an election  
15                   under this section may change such election during an  
16                   annual, coordinated election period.

17                   “(B) ANNUAL, COORDINATED ELECTION PE-  
18                   RIOD.—For purposes of this section, the term ‘annual,  
19                   coordinated election period’ means, with respect to a  
20                   year before 2003 and after 2006, the month of Novem-  
21                   ber before such year and with respect to 2003, 2004,  
22                   2005, and 2006, the period beginning on November 15  
23                   and ending on December 31 of the year before such  
24                   year.

25                   “(C) MEDICAREADVANTAGE HEALTH INFORMA-  
26                   TION FAIRS.—During the fall season of each year (be-  
27                   ginning with 2006), in conjunction with the annual co-  
28                   ordinated election period defined in subparagraph (B),  
29                   the Secretary shall provide for a nationally coordinated  
30                   educational and publicity campaign to inform  
31                   MedicareAdvantage eligible individuals about  
32                   MedicareAdvantage plans and the election process pro-  
33                   vided under this section.

34                   “(D) SPECIAL INFORMATION CAMPAIGN IN 2005.—  
35                   During the period beginning on November 15, 2005,  
36                   and ending on December 31, 2005, the Secretary shall  
37                   provide for an educational and publicity campaign to

1 inform MedicareAdvantage eligible individuals about  
2 the availability of MedicareAdvantage plans, and eligi-  
3 ble organizations with risk-sharing contracts under sec-  
4 tion 1876, offered in different areas and the election  
5 process provided under this section.

6 “(4) SPECIAL ELECTION PERIODS.—Effective on and  
7 after January 1, 2006, an individual may discontinue an  
8 election of a MedicareAdvantage plan offered by a  
9 MedicareAdvantage organization other than during an an-  
10 nual, coordinated election period and make a new election  
11 under this section if—

12 “(A)(i) the certification of the organization or plan  
13 under this part has been terminated, or the organiza-  
14 tion or plan has notified the individual of an impending  
15 termination of such certification; or

16 “(ii) the organization has terminated or otherwise  
17 discontinued providing the plan in the area in which  
18 the individual resides, or has notified the individual of  
19 an impending termination or discontinuation of such  
20 plan;

21 “(B) the individual is no longer eligible to elect the  
22 plan because of a change in the individual’s place of  
23 residence or other change in circumstances (specified  
24 by the Secretary, but not including termination of the  
25 individual’s enrollment on the basis described in clause  
26 (i) or (ii) of subsection (g)(3)(B));

27 “(C) the individual demonstrates (in accordance  
28 with guidelines established by the Secretary) that—

29 “(i) the organization offering the plan sub-  
30 stantially violated a material provision of the orga-  
31 nization’s contract under this part in relation to  
32 the individual (including the failure to provide an  
33 enrollee on a timely basis medically necessary care  
34 for which benefits are available under the plan or  
35 the failure to provide such covered care in accord-  
36 ance with applicable quality standards); or

1                   “(ii) the organization (or an agent or other en-  
2                   tity acting on the organization’s behalf) materially  
3                   misrepresented the plan’s provisions in marketing  
4                   the plan to the individual; or

5                   “(D) the individual meets such other exceptional  
6                   conditions as the Secretary may provide.

7                   Effective on and after January 1, 2006, an individual who,  
8                   upon first becoming eligible for benefits under part A at  
9                   age 65, enrolls in a MedicareAdvantage plan under this  
10                  part, the individual may discontinue the election of such  
11                  plan, and elect coverage under the original fee-for-service  
12                  plan, at any time during the 12-month period beginning on  
13                  the effective date of such enrollment.

14                  “(5) SPECIAL RULES FOR MSA PLANS.—Notwith-  
15                  standing the preceding provisions of this subsection, an  
16                  individual—

17                         “(A) may elect an MSA plan only during—

18                                 “(i) an initial open enrollment period described  
19                                 in paragraph (1);

20                                 “(ii) an annual, coordinated election period de-  
21                                 scribed in paragraph (3)(B); or

22                                 “(iii) the month of November 1998;

23                         “(B) subject to subparagraph (C), may not dis-  
24                         continue an election of an MSA plan except during the  
25                         periods described in clause (ii) or (iii) of subparagraph  
26                         (A) and under the first sentence of paragraph (4); and

27                                 “(C) who elects an MSA plan during an annual,  
28                                 coordinated election period, and who never previously  
29                                 had elected such a plan, may revoke such election, in  
30                                 a manner determined by the Secretary, by not later  
31                                 than December 15 following the date of the election.

32                  “(6) OPEN ENROLLMENT PERIODS.—Subject to para-  
33                  graph (5), a MedicareAdvantage organization—

34                         “(A) shall accept elections or changes to elections  
35                         during the initial enrollment periods described in para-  
36                         graph (1), during the period beginning on November  
37                         15, 2005, and ending on December 31, 2005, and dur-

1           ing the annual, coordinated election period under para-  
2           graph (3) for each subsequent year, and during special  
3           election periods described in the first sentence of para-  
4           graph (4); and

5           “(B) may accept other changes to elections at  
6           such other times as the organization provides.

7           “(f) EFFECTIVENESS OF ELECTIONS AND CHANGES OF  
8           ELECTIONS.—

9           “(1) DURING INITIAL COVERAGE ELECTION PERIOD.—  
10          An election of coverage made during the initial coverage  
11          election period under subsection (e)(1)(A) shall take effect  
12          upon the date the individual becomes entitled to (or en-  
13          rolled for) benefits under part A, enrolled under part B,  
14          and enrolled under part D, except as the Secretary may  
15          provide (consistent with sections 1838 and 1860D-2)) in  
16          order to prevent retroactive coverage.

17          “(2) DURING CONTINUOUS OPEN ENROLLMENT PERI-  
18          ODS.—An election or change of coverage made under sub-  
19          section (e)(2) shall take effect with the first day of the first  
20          calendar month following the date on which the election or  
21          change is made.

22          “(3) ANNUAL, COORDINATED ELECTION PERIOD.—An  
23          election or change of coverage made during an annual, co-  
24          ordinated election period (as defined in subsection  
25          (e)(3)(B)) in a year shall take effect as of the first day of  
26          the following year.

27          “(4) OTHER PERIODS.—An election or change of cov-  
28          erage made during any other period under subsection (e)(4)  
29          shall take effect in such manner as the Secretary provides  
30          in a manner consistent (to the extent practicable) with pro-  
31          tecting continuity of health benefit coverage.

32          “(g) GUARANTEED ISSUE AND RENEWAL.—

33          “(1) IN GENERAL.—Except as provided in this sub-  
34          section, a MedicareAdvantage organization shall provide  
35          that at any time during which elections are accepted under  
36          this section with respect to a MedicareAdvantage plan of-  
37          fered by the organization, the organization will accept with-

1 out restrictions individuals who are eligible to make such  
2 election.

3 “(2) PRIORITY.—If the Secretary determines that a  
4 MedicareAdvantage organization, in relation to a  
5 MedicareAdvantage plan it offers, has a capacity limit and  
6 the number of MedicareAdvantage eligible individuals who  
7 elect the plan under this section exceeds the capacity limit,  
8 the organization may limit the election of individuals of the  
9 plan under this section but only if priority in election is  
10 provided—

11 “(A) first to such individuals as have elected the  
12 plan at the time of the determination; and

13 “(B) then to other such individuals in such a man-  
14 ner that does not discriminate, on a basis described in  
15 section 1852(b), among the individuals (who seek to  
16 elect the plan).

17 The preceding sentence shall not apply if it would result in  
18 the enrollment of enrollees substantially nonrepresentative,  
19 as determined in accordance with regulations of the Sec-  
20 retary, of the medicare population in the service area of the  
21 plan.

22 “(3) LIMITATION ON TERMINATION OF ELECTION.—

23 “(A) IN GENERAL.—Subject to subparagraph (B),  
24 a MedicareAdvantage organization may not for any  
25 reason terminate the election of any individual under  
26 this section for a MedicareAdvantage plan it offers.

27 “(B) BASIS FOR TERMINATION OF ELECTION.—A  
28 MedicareAdvantage organization may terminate an in-  
29 dividual’s election under this section with respect to a  
30 MedicareAdvantage plan it offers if—

31 “(i) any MedicareAdvantage monthly basic  
32 beneficiary premium, MedicareAdvantage monthly  
33 beneficiary obligation for qualified prescription  
34 drug coverage, or MedicareAdvantage monthly ben-  
35 eficiary premium for required or optional enhanced  
36 medical benefits required with respect to such plan  
37 are not paid on a timely basis (consistent with

1 standards under section 1856 that provide for a  
2 grace period for late payment of such premiums);

3 “(ii) the individual has engaged in disruptive  
4 behavior (as specified in such standards); or

5 “(iii) the plan is terminated with respect to all  
6 individuals under this part in the area in which the  
7 individual resides.

8 “(C) CONSEQUENCE OF TERMINATION.—

9 “(i) TERMINATIONS FOR CAUSE.—Any indi-  
10 vidual whose election is terminated under clause (i)  
11 or (ii) of subparagraph (B) is deemed to have elect-  
12 ed to receive benefits under the original medicare  
13 fee-for-service program option.

14 “(ii) TERMINATION BASED ON PLAN TERMI-  
15 NATION OR SERVICE AREA REDUCTION.—Any indi-  
16 vidual whose election is terminated under subpara-  
17 graph (B)(iii) shall have a special election period  
18 under subsection (e)(4)(A) in which to change cov-  
19 erage to coverage under another  
20 MedicareAdvantage plan. Such an individual who  
21 fails to make an election during such period is  
22 deemed to have chosen to change coverage to the  
23 original medicare fee-for-service program option.

24 “(D) ORGANIZATION OBLIGATION WITH RESPECT  
25 TO ELECTION FORMS.—Pursuant to a contract under  
26 section 1857858., each MedicareAdvantage organiza-  
27 tion receiving an election form under subsection (c)(2)  
28 shall transmit to the Secretary (at such time and in  
29 such manner as the Secretary may specify) a copy of  
30 such form or such other information respecting the  
31 election as the Secretary may specify.

32 “(h) APPROVAL OF MARKETING MATERIAL AND APPLICA-  
33 TION FORMS.—

34 “(1) SUBMISSION.—No marketing material or applica-  
35 tion form may be distributed by a MedicareAdvantage or-  
36 ganization to (or for the use of) MedicareAdvantage eligible  
37 individuals unless—

1           “(A) at least 45 days (or 10 days in the case de-  
2           scribed in paragraph (5)) before the date of distribu-  
3           tion the organization has submitted the material or  
4           form to the Secretary for review; and

5           “(B) the Secretary has not disapproved the dis-  
6           tribution of such material or form.

7           “(2) REVIEW.—The standards established under sec-  
8           tion 1856 shall include guidelines for the review of any ma-  
9           terial or form submitted and under such guidelines the Sec-  
10          retary shall disapprove (or later require the correction of)  
11          such material or form if the material or form is materially  
12          inaccurate or misleading or otherwise makes a material  
13          misrepresentation.

14          “(3) DEEMED APPROVAL (1-STOP SHOPPING).—In the  
15          case of material or form that is submitted under paragraph  
16          (1)(A) to the Secretary or a regional office of the Depart-  
17          ment of Health and Human Services and the Secretary or  
18          the office has not disapproved the distribution of marketing  
19          material or form under paragraph (1)(B) with respect to  
20          a MedicareAdvantage plan in an area, the Secretary is  
21          deemed not to have disapproved such distribution in all  
22          other areas covered by the plan and organization except  
23          with regard to that portion of such material or form that  
24          is specific only to an area involved.

25          “(4) PROHIBITION OF CERTAIN MARKETING PRAC-  
26          TICES.—Each MedicareAdvantage organization shall con-  
27          form to fair marketing standards, in relation to  
28          MedicareAdvantage plans offered under this part, included  
29          in the standards established under section 1856. Such  
30          standards—

31                 “(A) shall not permit a MedicareAdvantage orga-  
32                 nization to provide for cash or other monetary rebates  
33                 as an inducement for enrollment or otherwise (other  
34                 than as an additional benefit described in section  
35                 1854(g)(1)(C)(i)); and

36                 “(B) may include a prohibition against a  
37                 MedicareAdvantage organization (or agent of such an

1 organization) completing any portion of any election  
2 form used to carry out elections under this section on  
3 behalf of any individual.

4 “(5) SPECIAL TREATMENT OF MARKETING MATERIAL  
5 FOLLOWING MODEL MARKETING LANGUAGE.—In the case  
6 of marketing material of an organization that uses, without  
7 modification, proposed model language specified by the Sec-  
8 retary, the period specified in paragraph (1)(A) shall be re-  
9 duced from 45 days to 10 days.

10 “(i) EFFECT OF ELECTION OF MEDICAREADVANTAGE  
11 PLAN OPTION.—

12 “(1) PAYMENTS TO ORGANIZATIONS.—Subject to sec-  
13 tions 1852(a)(5), 1853(h), 1853(i), 1886(d)(11), and  
14 1886(h)(3)(D), payments under a contract with a  
15 MedicareAdvantage organization under section 1853(a)  
16 with respect to an individual electing a MedicareAdvantage  
17 plan offered by the organization shall be instead of the  
18 amounts which (in the absence of the contract) would oth-  
19 erwise be payable under parts A, B, and D for items and  
20 services furnished to the individual.

21 “(2) ONLY ORGANIZATION ENTITLED TO PAYMENT.—  
22 Subject to sections 1853(f), 1853(h), 1853(i), 1857(f)(2),  
23 1886(d)(11), and 1886(h)(3)(D), only the  
24 MedicareAdvantage organization shall be entitled to receive  
25 payments from the Secretary under this title for services  
26 furnished to the individual.”.

27 **SEC. 202. BENEFITS AND BENEFICIARY PROTECTIONS.**

28 Section 1852 (42 U.S.C. 1395w-22) is amended to read  
29 as follows:

30 “BENEFITS AND BENEFICIARY PROTECTIONS

31 “SEC. 1852. (a) BASIC BENEFITS.—

32 “(1) IN GENERAL.—Except as provided in section  
33 1859(b)(3) for MSA plans, each MedicareAdvantage plan  
34 shall provide to members enrolled under this part, through  
35 providers and other persons that meet the applicable re-  
36 quirements of this title and part A of title XI—

1           “(A) those items and services (other than hospice  
2           care) for which benefits are available under parts A  
3           and B to individuals residing in the area served by the  
4           plan;

5           “(B) except as provided in paragraph (2)(D),  
6           qualified prescription drug coverage under part D to  
7           individuals residing in the area served by the plan;

8           “(C) a maximum limitation on out-of-pocket ex-  
9           penses and a unified deductible; and

10           “(D) additional benefits required under section  
11           1854(d)(1).

12           “(2) SATISFACTION OF REQUIREMENT.—

13           “(A) IN GENERAL.—A MedicareAdvantage plan  
14           (other than an MSA plan) offered by a  
15           MedicareAdvantage organization satisfies paragraph  
16           (1)(A), with respect to benefits for items and services  
17           furnished other than through a provider or other per-  
18           son that has a contract with the organization offering  
19           the plan, if the plan provides payment in an amount so  
20           that—

21           “(i) the sum of such payment amount and any  
22           cost-sharing provided for under the plan; is equal  
23           to at least

24           “(ii) the total dollar amount of payment for  
25           such items and services as would otherwise be au-  
26           thorized under parts A and B (including any bal-  
27           ance billing permitted under such parts).

28           “(B) REFERENCE TO RELATED PROVISIONS.—For  
29           provisions relating to—

30           “(i) limitations on balance billing against  
31           MedicareAdvantage organizations for noncontract  
32           providers, see sections 1852(k) and 1866(a)(1)(O);  
33           and

34           “(ii) limiting actuarial value of enrollee liabil-  
35           ity for covered benefits, see section 1854(f).

36           “(C) ELECTION OF UNIFORM COVERAGE POL-  
37           ICY.—In the case of a MedicareAdvantage organization

1 that offers a MedicareAdvantage plan in an area in  
2 which more than 1 local coverage policy is applied with  
3 respect to different parts of the area, the organization  
4 may elect to have the local coverage policy for the part  
5 of the area that is most beneficial to  
6 MedicareAdvantage enrollees (as identified by the Sec-  
7 retary) apply with respect to all MedicareAdvantage en-  
8 rollees enrolled in the plan.

9 “(D) SPECIAL RULE FOR PRIVATE FEE-FOR-SERV-  
10 ICE PLANS.—

11 “(i) IN GENERAL.—A private fee-for-service  
12 plan may elect not to provide qualified prescription  
13 drug coverage under part D to individuals residing  
14 in the area served by the plan.

15 “(ii) AVAILABILITY OF DRUG COVERAGE FOR  
16 ENROLLEES.—If a beneficiary enrolls in a plan  
17 making the election described in clause (i), the ben-  
18 eficiary may enroll for drug coverage under part D  
19 with an eligible entity under such part.

20 “(3) ENHANCED MEDICAL BENEFITS.—

21 “(A) BENEFITS INCLUDED SUBJECT TO SEC-  
22 RETARY’S APPROVAL.—Each MedicareAdvantage orga-  
23 nization may provide to individuals enrolled under this  
24 part, other than under an MSA plan (without affording  
25 those individuals an option to decline the coverage), en-  
26 hanced medical benefits that the Secretary may ap-  
27 prove. The Secretary shall approve any such enhanced  
28 medical benefits unless the Secretary determines that  
29 including such enhanced medical benefits would sub-  
30 stantially discourage enrollment by MedicareAdvantage  
31 eligible individuals with the organization.

32 “(B) AT ENROLLEES’ OPTION.—A  
33 MedicareAdvantage organization may not provide,  
34 under an MSA plan, enhanced medical benefits that  
35 cover the deductible described in section 1859(b)(2)(B).  
36 In applying the previous sentence, health benefits de-

1 scribed in section 1882(u)(2)(B) shall not be treated as  
2 covering such deductible.

3 “(C) APPLICATION TO MEDICAREADVANTAGE PRI-  
4 VATE FEE-FOR-SERVICE PLANS.—Nothing in this para-  
5 graph shall be construed as preventing a  
6 MedicareAdvantage private fee-for-service plan from of-  
7 fering enhanced medical benefits that include payment  
8 for some or all of the balance billing amounts permitted  
9 consistent with section 1852(k) and coverage of addi-  
10 tional services that the plan finds to be medically nec-  
11 essary.

12 “(D) RULE FOR APPROVAL OF MEDICAL AND PRE-  
13 SCRIPTIION DRUG BENEFITS.—Notwithstanding the pre-  
14 ceding provisions of this paragraph, the Secretary may  
15 not approve any enhanced medical benefit that provides  
16 for the coverage of any prescription drug (other than  
17 that relating to prescription drugs covered under the  
18 original medicare fee-for-service program option).

19 “(4) ORGANIZATION AS SECONDARY PAYER.—Notwith-  
20 standing any other provision of law, a MedicareAdvantage  
21 organization may (in the case of the provision of items and  
22 services to an individual under a MedicareAdvantage plan  
23 under circumstances in which payment under this title is  
24 made secondary pursuant to section 1862(b)(2)) charge or  
25 authorize the provider of such services to charge, in accord-  
26 ance with the charges allowed under a law, plan, or policy  
27 described in such section—

28 “(A) the insurance carrier, employer, or other en-  
29 tity which under such law, plan, or policy is to pay for  
30 the provision of such services; or

31 “(B) such individual to the extent that the indi-  
32 vidual has been paid under such law, plan, or policy for  
33 such services.

34 “(5) NATIONAL COVERAGE DETERMINATIONS AND  
35 LEGISLATIVE CHANGES IN BENEFITS.—If there is a na-  
36 tional coverage determination or legislative change in bene-  
37 fits required to be provided under this part made in the pe-

1           riod beginning on the date of an announcement under sec-  
2           tion 1853(b) and ending on the date of the next announce-  
3           ment under such section and the Secretary projects that  
4           the determination will result in a significant change in the  
5           costs to a MedicareAdvantage organization of providing the  
6           benefits that are the subject of such national coverage de-  
7           termination and that such change in costs was not incor-  
8           porated in the determination of the benchmark amount an-  
9           nounced under section 1853(b)(1)(A) at the beginning of  
10          such period, then, unless otherwise required by law—

11                 “(A) such determination or legislative change in  
12                 benefits shall not apply to contracts under this part  
13                 until the first contract year that begins after the end  
14                 of such period; and

15                 “(B) if such coverage determination or legislative  
16                 change provides for coverage of additional benefits or  
17                 coverage under additional circumstances, section  
18                 1851(i)(1) shall not apply to payment for such addi-  
19                 tional benefits or benefits provided under such addi-  
20                 tional circumstances until the first contract year that  
21                 begins after the end of such period.

22          The projection under the previous sentence shall be based  
23          on an analysis by the Secretary of the actuarial costs asso-  
24          ciated with the coverage determination or legislative change  
25          in benefits.

26                 “(6) AUTHORITY TO PROHIBIT RISK SELECTION.—The  
27                 Secretary shall have the authority to disapprove any  
28                 MedicareAdvantage plan that the Secretary determines is  
29                 designed to attract a population that is healthier than the  
30          average population residing in the service area of the plan.

31                 “(7) UNIFIED DEDUCTIBLE DEFINED.—In this part,  
32                 the term ‘unified deductible’ means an annual deductible  
33                 amount that is applied in lieu of the inpatient hospital de-  
34                 ductible under section 1813(b)(1) and the deductible under  
35                 section 1833(b). Nothing in this part shall be construed as  
36                 preventing a MedicareAdvantage organization from requir-  
37                 ing coinsurance or a copayment for inpatient hospital serv-

1 ices after the unified deductible is satisfied, subject to the  
2 limitation on enrollee liability under section 1854(f).

3 “(b) ANTIDISCRIMINATION.—

4 “(1) BENEFICIARIES.—

5 “(A) IN GENERAL.—A MedicareAdvantage organi-  
6 zation may not deny, limit, or condition the coverage  
7 or provision of benefits under this part, for individuals  
8 permitted to be enrolled with the organization under  
9 this part, based on any health status-related factor de-  
10 scribed in section 2702(a)(1) of the Public Health  
11 Service Act.

12 “(B) CONSTRUCTION.—Except as provided under  
13 section 1851(a)(3)(B), subparagraph (A) shall not be  
14 construed as requiring a MedicareAdvantage organiza-  
15 tion to enroll individuals who are determined to have  
16 end-stage renal disease.

17 “(2) PROVIDERS.—A MedicareAdvantage organization  
18 shall not discriminate with respect to participation, reim-  
19 bursement, or indemnification as to any provider who is  
20 acting within the scope of the provider’s license or certifi-  
21 cation under applicable State law, solely on the basis of  
22 such license or certification. This paragraph shall not be  
23 construed to prohibit a plan from including providers only  
24 to the extent necessary to meet the needs of the plan’s en-  
25 rollees or from establishing any measure designed to main-  
26 tain quality and control costs consistent with the respon-  
27 sibilities of the plan.

28 “(c) DISCLOSURE REQUIREMENTS.—

29 “(1) DETAILED DESCRIPTION OF PLAN PROVISIONS.—

30 A MedicareAdvantage organization shall disclose, in clear,  
31 accurate, and standardized form to each enrollee with a  
32 MedicareAdvantage plan offered by the organization under  
33 this part at the time of enrollment and at least annually  
34 thereafter, the following information regarding such plan:

35 “(A) SERVICE AREA.—The plan’s service area.

36 “(B) BENEFITS.—Benefits offered under the plan,  
37 including information described section 1852(a)(1) (re-

1           lating to benefits under the original medicare fee-for-  
2           service program option, the maximum limitation in out-  
3           of-pocket expenses and the unified deductible, and  
4           qualified prescription drug coverage under part D, re-  
5           spectively) and exclusions from coverage and, if it is an  
6           MSA plan, a comparison of benefits under such a plan  
7           with benefits under other MedicareAdvantage plans.

8           “(C) ACCESS.—The number, mix, and distribution  
9           of plan providers, out-of-network coverage (if any) pro-  
10          vided by the plan, and any point-of-service option (in-  
11          cluding the MedicareAdvantage monthly beneficiary  
12          premium for enhanced medical benefits for such op-  
13          tion).

14          “(D) OUT-OF-AREA COVERAGE.—Out-of-area cov-  
15          erage provided by the plan.

16          “(E) EMERGENCY COVERAGE.—Coverage of emer-  
17          gency services, including—

18                  “(i) the appropriate use of emergency services,  
19                  including use of the 911 telephone system or its  
20                  local equivalent in emergency situations and an ex-  
21                  planation of what constitutes an emergency situa-  
22                  tion;

23                  “(ii) the process and procedures of the plan  
24                  for obtaining emergency services; and

25                  “(iii) the locations of—

26                          “(I) emergency departments; and

27                          “(II) other settings, in which plan physi-  
28                          cians and hospitals provide emergency services  
29                          and post-stabilization care.

30          “(F) ENHANCED MEDICAL BENEFITS.—Enhanced  
31          medical benefits available from the organization offer-  
32          ing the plan, including—

33                  “(i) whether the enhanced medical benefits are  
34                  optional;

35                  “(ii) the enhanced medical benefits covered;  
36                  and

1                   “(iii) the MedicareAdvantage monthly bene-  
2                   ficiary premium for enhanced medical benefits.

3                   “(G) PRIOR AUTHORIZATION RULES.—Rules re-  
4                   garding prior authorization or other review require-  
5                   ments that could result in nonpayment.

6                   “(H) PLAN GRIEVANCE AND APPEALS PROCE-  
7                   DURES.—All plan appeal or grievance rights and proce-  
8                   dures.

9                   “(I) QUALITY ASSURANCE PROGRAM.—A descrip-  
10                  tion of the organization’s quality assurance program  
11                  under subsection (e).

12                  “(2) DISCLOSURE UPON REQUEST.—Upon request of  
13                  a MedicareAdvantage eligible individual, a  
14                  MedicareAdvantage organization must provide the following  
15                  information to such individual:

16                  “(A) The general coverage information and gen-  
17                  eral comparative plan information made available under  
18                  clauses (i) and (ii) of section 1851(d)(2)(A).

19                  “(B) Information on procedures used by the orga-  
20                  nization to control utilization of services and expendi-  
21                  tures.

22                  “(C) Information on the number of grievances, re-  
23                  considerations, and appeals and on the disposition in  
24                  the aggregate of such matters.

25                  “(D) An overall summary description as to the  
26                  method of compensation of participating physicians.

27                  “(E) The information described in subparagraphs  
28                  (A) through (C) in relation to the qualified prescription  
29                  drug coverage provided by the organization.

30                  “(d) ACCESS TO SERVICES.—

31                  “(1) IN GENERAL.—A MedicareAdvantage organiza-  
32                  tion offering a MedicareAdvantage plan may select the pro-  
33                  viders from whom the benefits under the plan are provided  
34                  so long as—

35                  “(A) the organization makes such benefits avail-  
36                  able and accessible to each individual electing the plan  
37                  within the plan service area with reasonable prompt-

1           ness and in a manner which assures continuity in the  
2           provision of benefits;

3           “(B) when medically necessary the organization  
4           makes such benefits available and accessible 24 hours  
5           a day and 7 days a week;

6           “(C) the plan provides for reimbursement with re-  
7           spect to services which are covered under subpara-  
8           graphs (A) and (B) and which are provided to such an  
9           individual other than through the organization, if—

10           “(i) the services were not emergency services  
11           (as defined in paragraph (3)), but—

12           “(I) the services were medically necessary  
13           and immediately required because of an unfore-  
14           seen illness, injury, or condition; and

15           “(II) it was not reasonable given the cir-  
16           cumstances to obtain the services through the  
17           organization;

18           “(ii) the services were renal dialysis services  
19           and were provided other than through the organiza-  
20           tion because the individual was temporarily out of  
21           the plan’s service area; or

22           “(iii) the services are maintenance care or  
23           post-stabilization care covered under the guidelines  
24           established under paragraph (2);

25           “(D) the organization provides access to appro-  
26           priate providers, including credentialed specialists, for  
27           medically necessary treatment and services; and

28           “(E) coverage is provided for emergency services  
29           (as defined in paragraph (3)) without regard to prior  
30           authorization or the emergency care provider’s contrac-  
31           tual relationship with the organization.

32           “(2) GUIDELINES RESPECTING COORDINATION OF  
33           POST-STABILIZATION CARE.—A MedicareAdvantage plan  
34           shall comply with such guidelines as the Secretary may pre-  
35           scribe relating to promoting efficient and timely coordina-  
36           tion of appropriate maintenance and post-stabilization care

1 of an enrollee after the enrollee has been determined to be  
2 stable under section 1867.

3 “(3) DEFINITION OF EMERGENCY SERVICES.—In this  
4 subsection—

5 “(A) IN GENERAL.—The term ‘emergency services’  
6 means, with respect to an individual enrolled with an  
7 organization, covered inpatient and outpatient services  
8 that—

9 “(i) are furnished by a provider that is quali-  
10 fied to furnish such services under this title; and

11 “(ii) are needed to evaluate or stabilize an  
12 emergency medical condition (as defined in sub-  
13 paragraph (B)).

14 “(B) EMERGENCY MEDICAL CONDITION BASED ON  
15 PRUDENT LAYPERSON.—The term ‘emergency medical  
16 condition’ means a medical condition manifesting itself  
17 by acute symptoms of sufficient severity (including se-  
18 vere pain) such that a prudent layperson, who pos-  
19 sesses an average knowledge of health and medicine,  
20 could reasonably expect the absence of immediate med-  
21 ical attention to result in—

22 “(i) placing the health of the individual (or,  
23 with respect to a pregnant woman, the health of  
24 the woman or her unborn child) in serious jeop-  
25 ardy;

26 “(ii) serious impairment to bodily functions; or

27 “(iii) serious dysfunction of any bodily organ  
28 or part.

29 “(4) ASSURING ACCESS TO SERVICES IN  
30 MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE  
31 PLANS.—In addition to any other requirements under  
32 this part, in the case of a MedicareAdvantage private  
33 fee-for-service plan, the organization offering the plan  
34 must demonstrate to the Secretary that the organiza-  
35 tion has sufficient number and range of health care  
36 professionals and providers willing to provide services  
37 under the terms of the plan. The Secretary shall find

1 that an organization has met such requirement with re-  
2 spect to any category of health care professional or pro-  
3 vider if, with respect to that category of provider—

4 “(A) the plan has established payment rates  
5 for covered services furnished by that category of  
6 provider that are not less than the payment rates  
7 provided for under part A, B, or D for such serv-  
8 ices; or

9 “(B) the plan has contracts or agreements  
10 with a sufficient number and range of providers  
11 within such category to provide covered services  
12 under the terms of the plan,

13 or a combination of both. The previous sentence shall  
14 not be construed as restricting the persons from whom  
15 enrollees under such a plan may obtain covered bene-  
16 fits.

17 “(e) QUALITY ASSURANCE PROGRAM.—

18 “(1) IN GENERAL.—Each MedicareAdvantage organi-  
19 zation must have arrangements, consistent with any regula-  
20 tion, for an ongoing quality assurance program for health  
21 care services it provides to individuals enrolled with  
22 MedicareAdvantage plans of the organization.

23 “(2) ELEMENTS OF PROGRAM.—

24 “(A) IN GENERAL.—The quality assurance pro-  
25 gram of an organization with respect to a  
26 MedicareAdvantage plan (other than a  
27 MedicareAdvantage private fee-for-service plan or a  
28 nonnetwork MSA plan) it offers shall—

29 “(i) stress health outcomes and provide for the  
30 collection, analysis, and reporting of data (in ac-  
31 cordance with a quality measurement system that  
32 the Secretary recognizes) that will permit measure-  
33 ment of outcomes and other indices of the quality  
34 of MedicareAdvantage plans and organizations;

35 “(ii) monitor and evaluate high volume and  
36 high risk services and the care of acute and chronic  
37 conditions;

1                   “(iii) provide access to disease management  
2                   and chronic care services;

3                   “(iv) provide access to preventive benefits and  
4                   information for enrollees on such benefits;

5                   “(v) evaluate the continuity and coordination  
6                   of care that enrollees receive;

7                   “(vi) be evaluated on an ongoing basis as to  
8                   its effectiveness;

9                   “(vii) include measures of consumer satisfac-  
10                  tion;

11                  “(viii) provide the Secretary with such access  
12                  to information collected as may be appropriate to  
13                  monitor and ensure the quality of care provided  
14                  under this part;

15                  “(ix) provide review by physicians and other  
16                  health care professionals of the process followed in  
17                  the provision of such health care services;

18                  “(x) provide for the establishment of written  
19                  protocols for utilization review, based on current  
20                  standards of medical practice;

21                  “(xi) have mechanisms to detect both under-  
22                  utilization and overutilization of services;

23                  “(xii) after identifying areas for improvement,  
24                  establish or alter practice parameters;

25                  “(xiii) take action to improve quality and as-  
26                  sesses the effectiveness of such action through sys-  
27                  tematic followup; and

28                  “(xiv) make available information on quality  
29                  and outcomes measures to facilitate beneficiary  
30                  comparison and choice of health coverage options  
31                  (in such form and on such quality and outcomes  
32                  measures as the Secretary determines to be appro-  
33                  priate).

34                  Such program shall include a separate focus (with re-  
35                  spect to all the elements described in this subpara-  
36                  graph) on racial and ethnic minorities.

1           “(B) ELEMENTS OF PROGRAM FOR ORGANIZA-  
2           TIONS OFFERING MEDICAREADVANTAGE PRIVATE FEE-  
3           FOR-SERVICE PLANS, AND NONNETWORK MSA PLANS.—  
4           The quality assurance program of an organization with  
5           respect to a MedicareAdvantage private fee-for-service  
6           plan or a nonnetwork MSA plan it offers shall—

7                   “(i) meet the requirements of clauses (i)  
8                   through (viii) of subparagraph (A);

9                   “(ii) insofar as it provides for the establish-  
10                  ment of written protocols for utilization review,  
11                  base such protocols on current standards of med-  
12                  ical practice; and

13                  “(iii) have mechanisms to evaluate utilization  
14                  of services and inform providers and enrollees of  
15                  the results of such evaluation.

16           Such program shall include a separate focus (with re-  
17           spect to all the elements described in this subpara-  
18           graph) on racial and ethnic minorities.

19           “(C) DEFINITION OF NONNETWORK MSA PLAN.—  
20           In this subsection, the term ‘nonnetwork MSA plan’  
21           means an MSA plan offered by a MedicareAdvantage  
22           organization that does not provide benefits required to  
23           be provided by this part, in whole or in part, through  
24           a defined set of providers under contract, or under an-  
25           other arrangement, with the organization.

26           “(3) EXTERNAL REVIEW.—

27                   “(A) IN GENERAL.—Each MedicareAdvantage or-  
28                  ganization shall, for each MedicareAdvantage plan it  
29                  operates, have an agreement with an independent qual-  
30                  ity review and improvement organization approved by  
31                  the Secretary to perform functions of the type de-  
32                  scribed in paragraphs (4)(B) and (14) of section  
33                  1154(a) with respect to services furnished by  
34                  MedicareAdvantage plans for which payment is made  
35                  under this title. The previous sentence shall not apply  
36                  to a MedicareAdvantage private fee-for-service plan or

1 a nonnetwork MSA plan that does not employ utiliza-  
2 tion review.

3 “(B) NONDUPLICATION OF ACCREDITATION.—Ex-  
4 cept in the case of the review of quality complaints, and  
5 consistent with subparagraph (C), the Secretary shall  
6 ensure that the external review activities conducted  
7 under subparagraph (A) are not duplicative of review  
8 activities conducted as part of the accreditation proc-  
9 ess.

10 “(C) WAIVER AUTHORITY.—The Secretary may  
11 waive the requirement described in subparagraph (A)  
12 in the case of an organization if the Secretary deter-  
13 mines that the organization has consistently main-  
14 tained an excellent record of quality assurance and  
15 compliance with other requirements under this part.

16 “(4) TREATMENT OF ACCREDITATION.—

17 “(A) IN GENERAL.—The Secretary shall provide  
18 that a MedicareAdvantage organization is deemed to  
19 meet all the requirements described in any specific  
20 clause of subparagraph (B) if the organization is ac-  
21 credited (and periodically reaccredited) by a private ac-  
22 crediting organization under a process that the Sec-  
23 retary has determined assures that the accrediting or-  
24 ganization applies and enforces standards that meet or  
25 exceed the standards established under section 1856 to  
26 carry out the requirements in such clause.

27 “(B) REQUIREMENTS DESCRIBED.—The provi-  
28 sions described in this subparagraph are the following:

29 “(i) Paragraphs (1) and (2) of this subsection  
30 (relating to quality assurance programs).

31 “(ii) Subsection (b) (relating to antidiscrimi-  
32 nation).

33 “(iii) Subsection (d) (relating to access to  
34 services).

35 “(iv) Subsection (h) (relating to confidentiality  
36 and accuracy of enrollee records).

1                   “(v) Subsection (i) (relating to information on  
2                   advance directives).

3                   “(vi) Subsection (j) (relating to provider par-  
4                   ticipation rules).

5                   “(C) TIMELY ACTION ON APPLICATIONS.—The  
6                   Secretary shall determine, within 210 days after the  
7                   date the Secretary receives an application by a private  
8                   accrediting organization and using the criteria specified  
9                   in section 1865(b)(2), whether the process of the pri-  
10                  vate accrediting organization meets the requirements  
11                  with respect to any specific clause in subparagraph (B)  
12                  with respect to which the application is made. The Sec-  
13                  retary may not deny such an application on the basis  
14                  that it seeks to meet the requirements with respect to  
15                  only one, or more than one, such specific clause.

16                  “(D) CONSTRUCTION.—Nothing in this paragraph  
17                  shall be construed as limiting the authority of the Sec-  
18                  retary under section 1857, including the authority to  
19                  terminate contracts with MedicareAdvantage organiza-  
20                  tions under subsection (c)(2) of such section.

21                  “(5) REPORT TO CONGRESS.—

22                  “(A) IN GENERAL.—The Secretary shall submit to  
23                  Congress a biennial report regarding how quality assur-  
24                  ance programs conducted under this subsection focus  
25                  on racial and ethnic minorities.

26                  “(B) CONTENTS OF REPORT.—Each such report  
27                  shall include the following:

28                         “(i) A description of the means by which such  
29                         programs focus on such racial and ethnic minori-  
30                         ties.

31                         “(ii) An evaluation of the impact of such pro-  
32                         grams on eliminating health disparities and on im-  
33                         proving health outcomes, continuity and coordina-  
34                         tion of care, management of chronic conditions,  
35                         and consumer satisfaction.

1                   “(iii) Recommendations on ways to reduce  
2                   clinical outcome disparities among racial and ethnic  
3                   minorities.

4                   “(f) GRIEVANCE MECHANISM.—Each MedicareAdvantage  
5                   organization must provide meaningful procedures for hearing  
6                   and resolving grievances between the organization (including  
7                   any entity or individual through which the organization pro-  
8                   vides health care services) and enrollees with  
9                   MedicareAdvantage plans of the organization under this part.

10                   “(g) COVERAGE DETERMINATIONS, RECONSIDERATIONS,  
11                   AND APPEALS.—

12                   “(1) DETERMINATIONS BY ORGANIZATION.—

13                   “(A) IN GENERAL.—A MedicareAdvantage organi-  
14                   zation shall have a procedure for making determina-  
15                   tions regarding whether an individual enrolled with the  
16                   plan of the organization under this part is entitled to  
17                   receive a health service under this section and the  
18                   amount (if any) that the individual is required to pay  
19                   with respect to such service. Subject to paragraph (3),  
20                   such procedures shall provide for such determination to  
21                   be made on a timely basis.

22                   “(B) EXPLANATION OF DETERMINATION.—Such a  
23                   determination that denies coverage, in whole or in part,  
24                   shall be in writing and shall include a statement in un-  
25                   derstandable language of the reasons for the denial and  
26                   a description of the reconsideration and appeals proc-  
27                   esses.

28                   “(2) RECONSIDERATIONS.—

29                   “(A) IN GENERAL.—The organization shall pro-  
30                   vide for reconsideration of a determination described in  
31                   paragraph (1)(B) upon request by the enrollee involved.  
32                   The reconsideration shall be within a time period speci-  
33                   fied by the Secretary, but shall be made, subject to  
34                   paragraph (3), not later than 60 days after the date of  
35                   the receipt of the request for reconsideration.

36                   “(B) PHYSICIAN DECISION ON CERTAIN RECON-  
37                   SIDERATIONS.—A reconsideration relating to a deter-

1           mination to deny coverage based on a lack of medical  
2           necessity shall be made only by a physician with appro-  
3           priate expertise in the field of medicine which neces-  
4           sitates treatment who is other than a physician in-  
5           volved in the initial determination.

6           “(3) EXPEDITED DETERMINATIONS AND RECONSIDER-  
7           ATIONS.—

8           “(A) RECEIPT OF REQUESTS.—

9           “(i) ENROLLEE REQUESTS.—An enrollee in a  
10          MedicareAdvantage plan may request, either in  
11          writing or orally, an expedited determination under  
12          paragraph (1) or an expedited reconsideration  
13          under paragraph (2) by the MedicareAdvantage or-  
14          ganization.

15          “(ii) PHYSICIAN REQUESTS.—A physician, re-  
16          gardless whether the physician is affiliated with the  
17          organization or not, may request, either in writing  
18          or orally, such an expedited determination or recon-  
19          sideration.

20          “(B) ORGANIZATION PROCEDURES.—

21          “(i) IN GENERAL.—The MedicareAdvantage  
22          organization shall maintain procedures for expe-  
23          diting organization determinations and reconsider-  
24          ations when, upon request of an enrollee, the orga-  
25          nization determines that the application of the nor-  
26          mal timeframe for making a determination (or a  
27          reconsideration involving a determination) could se-  
28          riously jeopardize the life or health of the enrollee  
29          or the enrollee’s ability to regain maximum func-  
30          tion.

31          “(ii) EXPEDITION REQUIRED FOR PHYSICIAN  
32          REQUESTS.—In the case of a request for an expe-  
33          dited determination or reconsideration made under  
34          subparagraph (A)(ii), the organization shall expe-  
35          dite the determination or reconsideration if the re-  
36          quest indicates that the application of the normal  
37          timeframe for making a determination (or a recon-

1           sideration involving a determination) could seri-  
2           ously jeopardize the life or health of the enrollee or  
3           the enrollee's ability to regain maximum function.

4           “(iii) TIMELY RESPONSE.—In cases described  
5           in clauses (i) and (ii), the organization shall notify  
6           the enrollee (and the physician involved, as appro-  
7           priate) of the determination or reconsideration  
8           under time limitations established by the Secretary,  
9           but not later than 72 hours of the time of receipt  
10          of the request for the determination or reconsider-  
11          ation (or receipt of the information necessary to  
12          make the determination or reconsideration), or  
13          such longer period as the Secretary may permit in  
14          specified cases.

15          “(4) INDEPENDENT REVIEW OF CERTAIN COVERAGE  
16          DENIALS.—The Secretary shall contract with an inde-  
17          pendent, outside entity to review and resolve in a timely  
18          manner reconsiderations that affirm denial of coverage, in  
19          whole or in part. The provisions of section 1869(c)(5) shall  
20          apply to independent outside entities under contract with  
21          the Secretary under this paragraph.

22          “(5) APPEALS.—An enrollee with a  
23          MedicareAdvantage plan of a MedicareAdvantage organiza-  
24          tion under this part who is dissatisfied by reason of the en-  
25          rollee's failure to receive any health service to which the en-  
26          rollee believes the enrollee is entitled and at no greater  
27          charge than the enrollee believes the enrollee is required to  
28          pay is entitled, if the amount in controversy is \$100 or  
29          more, to a hearing before the Secretary to the same extent  
30          as is provided in section 205(b), and in any such hearing  
31          the Secretary shall make the organization a party. If the  
32          amount in controversy is \$1,000 or more, the individual or  
33          organization shall, upon notifying the other party, be enti-  
34          tled to judicial review of the Secretary's final decision as  
35          provided in section 205(g), and both the individual and the  
36          organization shall be entitled to be parties to that judicial  
37          review. In applying subsections (b) and (g) of section 205

1 as provided in this paragraph, and in applying section  
2 205(l) thereto, any reference therein to the Commissioner  
3 of Social Security or the Social Security Administration  
4 shall be considered a reference to the Secretary or the De-  
5 partment of Health and Human Services, respectively.

6 “(h) CONFIDENTIALITY AND ACCURACY OF ENROLLEE  
7 RECORDS.—Insofar as a MedicareAdvantage organization  
8 maintains medical records or other health information regard-  
9 ing enrollees under this part, the MedicareAdvantage organiza-  
10 tion shall establish procedures—

11 “(1) to safeguard the privacy of any individually iden-  
12 tifiable enrollee information;

13 “(2) to maintain such records and information in a  
14 manner that is accurate and timely; and

15 “(3) to assure timely access of enrollees to such  
16 records and information.

17 “(i) INFORMATION ON ADVANCE DIRECTIVES.—Each  
18 MedicareAdvantage organization shall meet the requirement of  
19 section 1866(f) (relating to maintaining written policies and  
20 procedures respecting advance directives).

21 “(j) RULES REGARDING PROVIDER PARTICIPATION.—

22 “(1) PROCEDURES.—Insofar as a MedicareAdvantage  
23 organization offers benefits under a MedicareAdvantage  
24 plan through agreements with physicians, the organization  
25 shall establish reasonable procedures relating to the partici-  
26 pation (under an agreement between a physician and the  
27 organization) of physicians under such a plan. Such proce-  
28 dures shall include—

29 “(A) providing notice of the rules regarding par-  
30 ticipation;

31 “(B) providing written notice of participation deci-  
32 sions that are adverse to physicians; and

33 “(C) providing a process within the organization  
34 for appealing such adverse decisions, including the  
35 presentation of information and views of the physician  
36 regarding such decision.

1           “(2) CONSULTATION IN MEDICAL POLICIES.—A  
2 MedicareAdvantage organization shall consult with physi-  
3 cians who have entered into participation agreements with  
4 the organization regarding the organization’s medical pol-  
5 icy, quality, and medical management procedures.

6           “(3) PROHIBITING INTERFERENCE WITH PROVIDER  
7 ADVICE TO ENROLLEES.—

8           “(A) IN GENERAL.—Subject to subparagraphs (B)  
9 and (C), a MedicareAdvantage organization (in relation  
10 to an individual enrolled under a MedicareAdvantage  
11 plan offered by the organization under this part) shall  
12 not prohibit or otherwise restrict a covered health care  
13 professional (as defined in subparagraph (D)) from ad-  
14 vising such an individual who is a patient of the profes-  
15 sional about the health status of the individual or med-  
16 ical care or treatment for the individual’s condition or  
17 disease, regardless of whether benefits for such care or  
18 treatment are provided under the plan, if the profes-  
19 sional is acting within the lawful scope of practice.

20           “(B) CONSCIENCE PROTECTION.—Subparagraph  
21 (A) shall not be construed as requiring a  
22 MedicareAdvantage plan to provide, reimburse for, or  
23 provide coverage of a counseling or referral service if  
24 the MedicareAdvantage organization offering the  
25 plan—

26           “(i) objects to the provision of such service on  
27 moral or religious grounds; and

28           “(ii) in the manner and through the written  
29 instrumentalities such MedicareAdvantage organi-  
30 zation deems appropriate, makes available informa-  
31 tion on its policies regarding such service to pro-  
32 spective enrollees before or during enrollment and  
33 to enrollees within 90 days after the date that the  
34 organization or plan adopts a change in policy re-  
35 garding such a counseling or referral service.

36           “(C) CONSTRUCTION.—Nothing in subparagraph  
37 (B) shall be construed to affect disclosure requirements

1 under State law or under the Employee Retirement In-  
2 come Security Act of 1974.

3 “(D) HEALTH CARE PROFESSIONAL DEFINED.—  
4 For purposes of this paragraph, the term ‘health care  
5 professional’ means a physician (as defined in section  
6 1861(r)) or other health care professional if coverage  
7 for the professional’s services is provided under the  
8 MedicareAdvantage plan for the services of the profes-  
9 sional. Such term includes a podiatrist, optometrist,  
10 chiropractor, psychologist, dentist, licensed pharmacist,  
11 physician assistant, physical or occupational therapist  
12 and therapy assistant, speech-language pathologist, au-  
13 diologist, registered or licensed practical nurse (includ-  
14 ing nurse practitioner, clinical nurse specialist, certified  
15 registered nurse anesthetist, and certified nurse-mid-  
16 wife), licensed certified social worker, registered res-  
17 piratory therapist, and certified respiratory therapy  
18 technician.

19 “(4) LIMITATIONS ON PHYSICIAN INCENTIVE PLANS.—

20 “(A) IN GENERAL.—No MedicareAdvantage orga-  
21 nization may operate any physician incentive plan (as  
22 defined in subparagraph (B)) unless the following re-  
23 quirements are met:

24 “(i) No specific payment is made directly or  
25 indirectly under the plan to a physician or physi-  
26 cian group as an inducement to reduce or limit  
27 medically necessary services provided with respect  
28 to a specific individual enrolled with the organiza-  
29 tion.

30 “(ii) If the plan places a physician or physi-  
31 cian group at substantial financial risk (as deter-  
32 mined by the Secretary) for services not provided  
33 by the physician or physician group, the  
34 organization—

35 “(I) provides stop-loss protection for the  
36 physician or group that is adequate and appro-  
37 priate, based on standards developed by the

1 Secretary that take into account the number of  
2 physicians placed at such substantial financial  
3 risk in the group or under the plan and the  
4 number of individuals enrolled with the organi-  
5 zation who receive services from the physician  
6 or group; and

7 “(II) conducts periodic surveys of both in-  
8 dividuals enrolled and individuals previously en-  
9 rolled with the organization to determine the  
10 degree of access of such individuals to services  
11 provided by the organization and satisfaction  
12 with the quality of such services.

13 “(iii) The organization provides the Secretary  
14 with descriptive information regarding the plan,  
15 sufficient to permit the Secretary to determine  
16 whether the plan is in compliance with the require-  
17 ments of this subparagraph.

18 “(B) PHYSICIAN INCENTIVE PLAN DEFINED.—In  
19 this paragraph, the term ‘physician incentive plan’  
20 means any compensation arrangement between a  
21 MedicareAdvantage organization and a physician or  
22 physician group that may directly or indirectly have the  
23 effect of reducing or limiting services provided with re-  
24 spect to individuals enrolled with the organization  
25 under this part.

26 “(5) LIMITATION ON PROVIDER INDEMNIFICATION.—A  
27 MedicareAdvantage organization may not provide (directly  
28 or indirectly) for a health care professional, provider of  
29 services, or other entity providing health care services (or  
30 group of such professionals, providers, or entities) to in-  
31 demnify the organization against any liability resulting  
32 from a civil action brought for any damage caused to an  
33 enrollee with a MedicareAdvantage plan of the organization  
34 under this part by the organization’s denial of medically  
35 necessary care.

36 “(6) SPECIAL RULES FOR MEDICAREADVANTAGE PRI-  
37 VATE FEE-FOR-SERVICE PLANS.—For purposes of applying

1 this part (including subsection (k)(1)) and section  
2 1866(a)(1)(O), a hospital (or other provider of services), a  
3 physician or other health care professional, or other entity  
4 furnishing health care services is treated as having an  
5 agreement or contract in effect with a MedicareAdvantage  
6 organization (with respect to an individual enrolled in a  
7 MedicareAdvantage private fee-for-service plan it offers),  
8 if—

9 “(A) the provider, professional, or other entity fur-  
10 nishes services that are covered under the plan to such  
11 an enrollee; and

12 “(B) before providing such services, the provider,  
13 professional, or other entity —

14 “(i) has been informed of the individual’s en-  
15 rollment under the plan; and

16 “(ii) either—

17 “(I) has been informed of the terms and  
18 conditions of payment for such services under  
19 the plan; or

20 “(II) is given a reasonable opportunity to  
21 obtain information concerning such terms and  
22 conditions,

23 in a manner reasonably designed to effect informed  
24 agreement by a provider.

25 The previous sentence shall only apply in the absence of an  
26 explicit agreement between such a provider, professional, or  
27 other entity and the MedicareAdvantage organization.

28 “(k) TREATMENT OF SERVICES FURNISHED BY CERTAIN  
29 PROVIDERS.—

30 “(1) IN GENERAL.—Except as provided in paragraph  
31 (2), a physician or other entity (other than a provider of  
32 services) that does not have a contract establishing pay-  
33 ment amounts for services furnished to an individual en-  
34 rolled under this part with a MedicareAdvantage organiza-  
35 tion described in section 1851(a)(2)(A) shall accept as pay-  
36 ment in full for covered services under this title that are  
37 furnished to such an individual the amounts that the physi-

1           cian or other entity could collect if the individual were not  
2           so enrolled. Any penalty or other provision of law that ap-  
3           plies to such a payment with respect to an individual enti-  
4           tled to benefits under this title (but not enrolled with a  
5           MedicareAdvantage organization under this part) also ap-  
6           plies with respect to an individual so enrolled.

7           “(2) APPLICATION TO MEDICAREADVANTAGE PRIVATE  
8           FEE-FOR-SERVICE PLANS.—

9                   “(A) BALANCE BILLING LIMITS UNDER  
10                   MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE  
11                   PLANS IN CASE OF CONTRACT PROVIDERS.—

12                   “(i) IN GENERAL.—In the case of an indi-  
13                   vidual enrolled in a MedicareAdvantage private fee-  
14                   for-service plan under this part, a physician, pro-  
15                   vider of services, or other entity that has a contract  
16                   (including through the operation of subsection  
17                   (j)(6)) establishing a payment rate for services fur-  
18                   nished to the enrollee shall accept as payment in  
19                   full for covered services under this title that are  
20                   furnished to such an individual an amount not to  
21                   exceed (including any deductibles, coinsurance, co-  
22                   payments, or balance billing otherwise permitted  
23                   under the plan) an amount equal to 115 percent of  
24                   such payment rate.

25                   “(ii) PROCEDURES TO ENFORCE LIMITS.—The  
26                   MedicareAdvantage organization that offers such a  
27                   plan shall establish procedures, similar to the pro-  
28                   cedures described in section 1848(g)(1)(A), in  
29                   order to carry out clause (i).

30                   “(iii) ASSURING ENFORCEMENT.—If the  
31                   MedicareAdvantage organization fails to establish  
32                   and enforce procedures required under clause (ii),  
33                   the organization is subject to intermediate sanc-  
34                   tions under section 1857(g).

35                   “(B) ENROLLEE LIABILITY FOR NONCONTRACT  
36                   PROVIDERS.—For provisions—

1           “(i) establishing a minimum payment rate in  
2           the case of noncontract providers under a  
3           MedicareAdvantage private fee-for-service plan, see  
4           section 1852(a)(2); or

5           “(ii) limiting enrollee liability in the case of  
6           covered services furnished by such providers, see  
7           paragraph (1) and section 1866(a)(1)(O).

8           “(C) INFORMATION ON BENEFICIARY LIABILITY.—

9           “(i) IN GENERAL.—Each MedicareAdvantage  
10           organization that offers a MedicareAdvantage pri-  
11           vate fee-for-service plan shall provide that enrollees  
12           under the plan who are furnished services for which  
13           payment is sought under the plan are provided an  
14           appropriate explanation of benefits (consistent with  
15           that provided under parts A, B, and D, and, if ap-  
16           plicable, under medicare supplemental policies) that  
17           includes a clear statement of the amount of the en-  
18           rollee’s liability (including any liability for balance  
19           billing consistent with this subsection) with respect  
20           to payments for such services.

21           “(ii) ADVANCE NOTICE BEFORE RECEIPT OF  
22           INPATIENT HOSPITAL SERVICES AND CERTAIN  
23           OTHER SERVICES.—In addition, such organization  
24           shall, in its terms and conditions of payments to  
25           hospitals for inpatient hospital services and for  
26           other services identified by the Secretary for which  
27           the amount of the balance billing under subpara-  
28           graph (A) could be substantial, require the hospital  
29           to provide to the enrollee, before furnishing such  
30           services and if the hospital imposes balance billing  
31           under subparagraph (A)—

32                   “(I) notice of the fact that balance billing  
33                   is permitted under such subparagraph for such  
34                   services; and

35                   “(II) a good faith estimate of the likely  
36                   amount of such balance billing (if any), with

1                   respect to such services, based upon the pre-  
2                   senting condition of the enrollee.

3           “(I) RETURN TO HOME SKILLED NURSING FACILITIES  
4 FOR COVERED POST-HOSPITAL EXTENDED CARE SERVICES.—

5                   “(1) ENSURING RETURN TO HOME SNF.—

6                   “(A) IN GENERAL.—In providing coverage of post-  
7                   hospital extended care services, a MedicareAdvantage  
8 plan shall provide for such coverage through a home skilled  
9 nursing facility if the following conditions are met:

10                   “(i) ENROLLEE ELECTION.—The enrollee  
11                   elects to receive such coverage through such facil-  
12                   ity.

13                   “(ii) SNF AGREEMENT.—The facility has a  
14                   contract with the MedicareAdvantage organization  
15                   for the provision of such services, or the facility  
16                   agrees to accept substantially similar payment  
17                   under the same terms and conditions that apply to  
18                   similarly situated skilled nursing facilities that are  
19                   under contract with the MedicareAdvantage organi-  
20                   zation for the provision of such services and  
21                   through which the enrollee would otherwise receive  
22                   such services.

23                   “(B) MANNER OF PAYMENT TO HOME SNF.—The  
24                   organization shall provide payment to the home skilled  
25                   nursing facility consistent with the contract or the  
26                   agreement described in subparagraph (A)(ii), as the  
27                   case may be.

28                   “(2) NO LESS FAVORABLE COVERAGE.—The coverage  
29                   provided under paragraph (1) (including scope of services,  
30                   cost-sharing, and other criteria of coverage) shall be no less  
31                   favorable to the enrollee than the coverage that would be  
32                   provided to the enrollee with respect to a skilled nursing fa-  
33                   cility the post-hospital extended care services of which are  
34                   otherwise covered under the MedicareAdvantage plan.

35                   “(3) RULE OF CONSTRUCTION.—Nothing in this sub-  
36                   section shall be construed to do the following:

1           “(A) To require coverage through a skilled nursing  
2 facility that is not otherwise qualified to provide bene-  
3 fits under part A for medicare beneficiaries not enrolled  
4 in a MedicareAdvantage plan.

5           “(B) To prevent a skilled nursing facility from re-  
6 fusing to accept, or imposing conditions upon the ac-  
7 ceptance of, an enrollee for the receipt of post-hospital  
8 extended care services.

9           “(4) DEFINITIONS.—In this subsection:

10           “(A) HOME SKILLED NURSING FACILITY.—The  
11 term ‘home skilled nursing facility’ means, with respect  
12 to an enrollee who is entitled to receive post-hospital  
13 extended care services under a MedicareAdvantage  
14 plan, any of the following skilled nursing facilities:

15           “(i) SNF RESIDENCE AT TIME OF ADMIS-  
16 SION.—The skilled nursing facility in which the en-  
17 rollee resided at the time of admission to the hos-  
18 pital preceding the receipt of such post-hospital ex-  
19 tended care services.

20           “(ii) SNF IN CONTINUING CARE RETIREMENT  
21 COMMUNITY.—A skilled nursing facility that is pro-  
22 viding such services through a continuing care re-  
23 tirement community (as defined in subparagraph  
24 (B)) which provided residence to the enrollee at the  
25 time of such admission.

26           “(iii) SNF RESIDENCE OF SPOUSE AT TIME OF  
27 DISCHARGE.—The skilled nursing facility in which  
28 the spouse of the enrollee is residing at the time of  
29 discharge from such hospital.

30           “(B) CONTINUING CARE RETIREMENT COMMU-  
31 NITY.—The term ‘continuing care retirement commu-  
32 nity’ means, with respect to an enrollee in a  
33 MedicareAdvantage plan, an arrangement under which  
34 housing and health-related services are provided (or ar-  
35 ranged) through an organization for the enrollee under  
36 an agreement that is effective for the life of the en-  
37 rollee or for a specified period.”.

1     **SEC. 203. PAYMENTS TO MEDICAREADVANTAGE ORGA-**  
2                     **NIZATIONS.**

3             Section 1853 (42 U.S.C. 1395w-23) is amended to read  
4 as follows:

5             “PAYMENTS TO MEDICAREADVANTAGE ORGANIZATIONS

6             “SEC. 1853. (a) PAYMENTS TO ORGANIZATIONS.—

7                 “(1) MONTHLY PAYMENTS.—

8                     “(A) IN GENERAL.—Under a contract under sec-  
9                     tion 1857 and subject to subsections (f), (h), and (j)  
10                    and section 1859(e)(4), the Secretary shall make, to  
11                    each MedicareAdvantage organization, with respect to  
12                    coverage of an individual for a month under this part  
13                    in a MedicareAdvantage payment area, separate  
14                    monthly payments with respect to—

15                         “(i) benefits under the original medicare fee-  
16                         for-service program under parts A and B in accord-  
17                         ance with subsection (d); and

18                         “(ii) benefits under the voluntary prescription  
19                         drug program under part D in accordance with sec-  
20                         tion 1858A and the other provisions of this part.

21                     “(B) SPECIAL RULE FOR END-STAGE RENAL DIS-  
22                     EASE.—The Secretary shall establish separate rates of  
23                     payment to a MedicareAdvantage organization with re-  
24                     spect to classes of individuals determined to have end-  
25                     stage renal disease and enrolled in a  
26                     MedicareAdvantage plan of the organization. Such  
27                     rates of payment shall be actuarially equivalent to rates  
28                     paid to other enrollees in the MedicareAdvantage pay-  
29                     ment area (or such other area as specified by the Sec-  
30                     retary). In accordance with regulations, the Secretary  
31                     shall provide for the application of the seventh sentence  
32                     of section 1881(b)(7) to payments under this section  
33                     covering the provision of renal dialysis treatment in the  
34                     same manner as such sentence applies to composite  
35                     rate payments described in such sentence. In estab-  
36                     lishing such rates, the Secretary shall provide for ap-  
37                     propriate adjustments to increase each rate to reflect

1 the demonstration rate (including the risk adjustment  
2 methodology associated with such rate) of the social  
3 health maintenance organization end-stage renal dis-  
4 ease capitation demonstrations (established by section  
5 2355 of the Deficit Reduction Act of 1984, as amended  
6 by section 13567(b) of the Omnibus Budget Reconcili-  
7 ation Act of 1993), and shall compute such rates by  
8 taking into account such factors as renal treatment mo-  
9 dality, age, and the underlying cause of the end-stage  
10 renal disease.

11 “(2) ADJUSTMENT TO REFLECT NUMBER OF ENROLL-  
12 EES.—

13 “(A) IN GENERAL.—The amount of payment  
14 under this subsection may be retroactively adjusted to  
15 take into account any difference between the actual  
16 number of individuals enrolled with an organization  
17 under this part and the number of such individuals es-  
18 timated to be so enrolled in determining the amount of  
19 the advance payment.

20 “(B) SPECIAL RULE FOR CERTAIN ENROLLEES.—

21 “(i) IN GENERAL.—Subject to clause (ii), the  
22 Secretary may make retroactive adjustments under  
23 subparagraph (A) to take into account individuals  
24 enrolled during the period beginning on the date on  
25 which the individual enrolls with a  
26 MedicareAdvantage organization under a plan oper-  
27 ated, sponsored, or contributed to by the individ-  
28 ual’s employer or former employer (or the employer  
29 or former employer of the individual’s spouse) and  
30 ending on the date on which the individual is en-  
31 rolled in the organization under this part, except  
32 that for purposes of making such retroactive ad-  
33 justments under this subparagraph, such period  
34 may not exceed 90 days.

35 “(ii) EXCEPTION.—No adjustment may be  
36 made under clause (i) with respect to any indi-  
37 vidual who does not certify that the organization

1 provided the individual with the disclosure state-  
2 ment described in section 1852(c) at the time the  
3 individual enrolled with the organization.

4 “(C) EQUALIZATION OF FEDERAL CONTRIBU-  
5 TION.—In applying subparagraph (A), the Secretary  
6 shall ensure that the payment to the  
7 MedicareAdvantage organization for each individual en-  
8 rolled with the organization shall equal the  
9 MedicareAdvantage benchmark amount for the pay-  
10 ment area in which that individual resides (as deter-  
11 mined under paragraph (4)), as adjusted—

12 “(i) by multiplying the benchmark amount for  
13 that payment area by the ratio of—

14 “(I) the payment amount determined  
15 under subsection (d)(4); to

16 “(II) the weighted service area benchmark  
17 amount determined under subsection (d)(2);  
18 and

19 “(ii) using such risk adjustment factor as  
20 specified by the Secretary under subsection  
21 (b)(1)(B).

22 “(3) COMPREHENSIVE RISK ADJUSTMENT METHOD-  
23 OLOGY.—

24 “(A) APPLICATION OF METHODOLOGY.—The Sec-  
25 retary shall apply the comprehensive risk adjustment  
26 methodology described in subparagraph (B) to 100 per-  
27 cent of the amount of payments to plans under sub-  
28 section (d)(4)(B).

29 “(B) COMPREHENSIVE RISK ADJUSTMENT METH-  
30 ODOLOGY DESCRIBED.—The comprehensive risk adjust-  
31 ment methodology described in this subparagraph is  
32 the risk adjustment methodology that would apply with  
33 respect to MedicareAdvantage plans offered by  
34 MedicareAdvantage organizations in 2005, except that  
35 if such methodology does not apply to groups of bene-  
36 ficiaries who are aged or disabled and groups of bene-  
37 ficiaries who have end-stage renal disease, the Sec-

1           retary shall revise such methodology to apply to such  
2           groups.

3           “(C) UNIFORM APPLICATION TO ALL TYPES OF  
4           PLANS.—Subject to section 1859(e)(4), the comprehen-  
5           sive risk adjustment methodology established under this  
6           paragraph shall be applied uniformly without regard to  
7           the type of plan.

8           “(D) DATA COLLECTION.—In order to carry out  
9           this paragraph, the Secretary shall require  
10          MedicareAdvantage organizations to submit such data  
11          and other information as the Secretary deems nec-  
12          essary.

13          “(E) IMPROVEMENT OF PAYMENT ACCURACY.—  
14          Notwithstanding any other provision of this paragraph,  
15          the Secretary may revise the comprehensive risk adjust-  
16          ment methodology described in subparagraph (B) from  
17          time to time to improve payment accuracy.

18          “(4) ANNUAL CALCULATION OF BENCHMARK  
19          AMOUNTS.—For each year, the Secretary shall calculate a  
20          benchmark amount for each MedicareAdvantage payment  
21          area for each month for such year with respect to coverage  
22          of the benefits available under the original medicare fee-for-serv-  
23          ice program option equal to the greater of the following amounts  
24          (adjusted as appropriate for the application of the risk adjust-  
25          ment methodology under paragraph (3)):

26                 “(A) MINIMUM AMOUNT.— $\frac{1}{12}$  of the annual  
27                 Medicare+ Choice capitation rate determined under  
28                 subsection (c)(1)(B) for the payment area for the year.

29                 “(B) LOCAL FEE-FOR-SERVICE RATE.—The local  
30                 fee-for-service rate for such area for the year (as cal-  
31                 culated under paragraph (5)).

32          “(5) ANNUAL CALCULATION OF LOCAL FEE-FOR-SERV-  
33          ICE RATES.—

34                 “(A) IN GENERAL.—Subject to subparagraphs (B)  
35                 and (C), the term ‘local fee-for-service rate’ means the  
36                 amount of payment for a month in a  
37                 MedicareAdvantage payment area for benefits under

1           this title and associated claims processing costs for an  
2           individual who has elected to receive benefits under the  
3           original medicare fee-for-service program option and  
4           not enrolled in a MedicareAdvantage plan under this  
5           part. The Secretary shall annually calculate such  
6           amount in a manner similar to the manner in which  
7           the Secretary calculated the adjusted average per cap-  
8           ita cost under section 1876.

9           “(B) REMOVAL OF MEDICAL EDUCATION COSTS  
10          FROM CALCULATION OF LOCAL FEE-FOR-SERVICE  
11          RATE.—

12           “(i) IN GENERAL.—In calculating the local  
13          fee-for-service rate under subparagraph (A) for a  
14          year, the amount of payment described in such sub-  
15          paragraph shall be adjusted to exclude from such  
16          payment the payment adjustments described in  
17          clause (ii).

18           “(ii) PAYMENT ADJUSTMENTS DESCRIBED.—

19           “(I) IN GENERAL.—Subject to subclause  
20          (II), the payment adjustments described in this  
21          subparagraph are payment adjustments which  
22          the Secretary estimates are payable during the  
23          year—

24           “(aa) for the indirect costs of medical  
25          education under section 1886(d)(5)(B); and

26           “(bb) for direct graduate medical edu-  
27          cation costs under section 1886(h).

28           “(II) TREATMENT OF PAYMENTS COVERED  
29          UNDER STATE HOSPITAL REIMBURSEMENT SYS-  
30          TEM.—To the extent that the Secretary esti-  
31          mates that the amount of the local fee-for-serv-  
32          ice rates reflects payments to hospitals reim-  
33          bursed under section 1814(b)(3), the Secretary  
34          shall estimate a payment adjustment that is  
35          comparable to the payment adjustment that  
36          would have been made under clause (i) if the

1 hospitals had not been reimbursed under such  
2 section.

3 “(b) ANNUAL ANNOUNCEMENT OF PAYMENT FACTORS.—

4 “(1) ANNUAL ANNOUNCEMENT.—Beginning in 2005,  
5 at the same time as the Secretary publishes the risk adjust-  
6 ers under section 1860D–11, the Secretary shall annually  
7 announce (in a manner intended to provide notice to inter-  
8 ested parties) the following payment factors:

9 “(A) The benchmark amount for each  
10 MedicareAdvantage payment area (as calculated under  
11 subsection (a)(4)) for the year.

12 “(B) The factors to be used for adjusting pay-  
13 ments under the comprehensive risk adjustment meth-  
14 odology described in subsection (a)(3)(B) with respect  
15 to each MedicareAdvantage payment area for the year.

16 “(2) ADVANCE NOTICE OF METHODOLOGICAL  
17 CHANGES.—At least 45 days before making the announce-  
18 ment under paragraph (1) for a year, the Secretary shall—

19 “(A) provide for notice to MedicareAdvantage or-  
20 ganizations of proposed changes to be made in the  
21 methodology from the methodology and assumptions  
22 used in the previous announcement; and

23 “(B) provide such organizations with an oppor-  
24 tunity to comment on such proposed changes.

25 “(3) EXPLANATION OF ASSUMPTIONS.—In each an-  
26 nouncement made under paragraph (1), the Secretary shall  
27 include an explanation of the assumptions and changes in  
28 methodology used in the announcement in sufficient detail  
29 so that MedicareAdvantage organizations can compute each  
30 payment factor described in paragraph (1).

31 “(c) CALCULATION OF ANNUAL MEDICARE+ CHOICE  
32 CAPITATION RATES.—

33 “(1) IN GENERAL.—For purposes of making payments  
34 under this part for years before 2006 and for purposes of  
35 calculating the annual Medicare+ Choice capitation rates  
36 under paragraph (7) beginning with such year, subject to  
37 paragraph (6)(C), each annual Medicare+ Choice capitation

1 rate, for a Medicare+ Choice payment area before 2006 or  
2 a MedicareAdvantage payment area beginning with such  
3 year for a contract year consisting of a calendar year, is  
4 equal to the largest of the amounts specified in the fol-  
5 lowing subparagraph (A), (B), or (C):

6 “(A) BLENDED CAPITATION RATE.—The sum of—

7 “(i) the area-specific percentage (as specified  
8 under paragraph (2) for the year) of the annual  
9 area-specific Medicare+ Choice capitation rate for  
10 the MedicareAdvantage payment area, as deter-  
11 mined under paragraph (3) for the year; and

12 “(ii) the national percentage (as specified  
13 under paragraph (2) for the year) of the input-  
14 price-adjusted annual national Medicare+ Choice  
15 capitation rate, as determined under paragraph (4)  
16 for the year,

17 multiplied by the budget neutrality adjustment factor  
18 determined under paragraph (5).

19 “(B) MINIMUM AMOUNT.—12 multiplied by the  
20 following amount:

21 “(i) For 1998, \$367 (but not to exceed, in the  
22 case of an area outside the 50 States and the Dis-  
23 trict of Columbia, 150 percent of the annual per  
24 capita rate of payment for 1997 determined under  
25 section 1876(a)(1)(C) for the area).

26 “(ii) For 1999 and 2000, the minimum  
27 amount determined under clause (i) or this clause,  
28 respectively, for the preceding year, increased by  
29 the national per capita Medicare+ Choice growth  
30 percentage described in paragraph (6)(A) applica-  
31 ble to 1999 or 2000, respectively.

32 “(iii)(I) Subject to subclause (II), for 2001,  
33 for any area in a Metropolitan Statistical Area with  
34 a population of more than 250,000, \$525, and for  
35 any other area \$475.

36 “(II) In the case of an area outside the 50  
37 States and the District of Columbia, the amount

1 specified in this clause shall not exceed 120 percent  
2 of the amount determined under clause (ii) for such  
3 area for 2000.

4 “(iv) For 2002 through 2013, the minimum  
5 amount specified in this clause (or clause (iii)) for  
6 the preceding year increased by the national per  
7 capita Medicare+ Choice growth percentage, de-  
8 scribed in paragraph (6)(A) for that succeeding  
9 year.

10 “(v) For 2014 and each succeeding year, the  
11 minimum amount specified in this clause (or clause  
12 (iv)) for the preceding year increased by the per-  
13 centage increase in the Consumer Price Index for  
14 all urban consumers (U.S. urban average) for the  
15 12-month period ending with June of the previous  
16 year.

17 “(C) MINIMUM PERCENTAGE INCREASE.—

18 “(i) For 1998, 102 percent of the annual per  
19 capita rate of payment for 1997 determined under  
20 section 1876(a)(1)(C) for the Medicare+ Choice  
21 payment area.

22 “(ii) For 1999 and 2000, 102 percent of the  
23 annual Medicare+ Choice capitation rate under this  
24 paragraph for the area for the previous year.

25 “(iii) For 2001, 103 percent of the annual  
26 Medicare+ Choice capitation rate under this para-  
27 graph for the area for 2000.

28 “(iv) For 2002 and each succeeding year, 102  
29 percent of the annual Medicare+ Choice capitation  
30 rate under this paragraph for the area for the pre-  
31 vious year.

32 “(2) AREA-SPECIFIC AND NATIONAL PERCENTAGES.—  
33 For purposes of paragraph (1)(A)—

34 “(A) for 1998, the ‘area-specific percentage’ is 90  
35 percent and the ‘national percentage’ is 10 percent;

36 “(B) for 1999, the ‘area-specific percentage’ is 82  
37 percent and the ‘national percentage’ is 18 percent;

1           “(C) for 2000, the ‘area-specific percentage’ is 74  
2 percent and the ‘national percentage’ is 26 percent;

3           “(D) for 2001, the ‘area-specific percentage’ is 66  
4 percent and the ‘national percentage’ is 34 percent;

5           “(E) for 2002, the ‘area-specific percentage’ is 58  
6 percent and the ‘national percentage’ is 42 percent;  
7 and

8           “(F) for a year after 2002, the ‘area-specific per-  
9 centage’ is 50 percent and the ‘national percentage’ is  
10 50 percent.

11           “(3) ANNUAL AREA-SPECIFIC MEDICARE+ CHOICE  
12 CAPITATION RATE.—

13           “(A) IN GENERAL.—For purposes of paragraph  
14 (1)(A), subject to subparagraph (B), the annual area-  
15 specific Medicare+ Choice capitation rate for a  
16 Medicare+ Choice payment area—

17           “(i) for 1998 is, subject to subparagraph (D),  
18 the annual per capita rate of payment for 1997 de-  
19 termined under section 1876(a)(1)(C) for the area,  
20 increased by the national per capita  
21 Medicare+ Choice growth percentage for 1998 (de-  
22 scribed in paragraph (6)(A)); or

23           “(ii) for a subsequent year is the annual area-  
24 specific Medicare+ Choice capitation rate for the  
25 previous year determined under this paragraph for  
26 the area, increased by the national per capita  
27 Medicare+ Choice growth percentage for such sub-  
28 sequent year.

29           “(B) REMOVAL OF MEDICAL EDUCATION FROM  
30 CALCULATION OF ADJUSTED AVERAGE PER CAPITA  
31 COST.—

32           “(i) IN GENERAL.—In determining the area-  
33 specific Medicare+ Choice capitation rate under  
34 subparagraph (A) for a year (beginning with  
35 1998), the annual per capita rate of payment for  
36 1997 determined under section 1876(a)(1)(C) shall  
37 be adjusted to exclude from the rate the applicable

1 percent (specified in clause (ii)) of the payment ad-  
2 justments described in subparagraph (C).

3 “(ii) APPLICABLE PERCENT.—For purposes of  
4 clause (i), the applicable percent for—

5 “(I) 1998 is 20 percent;

6 “(II) 1999 is 40 percent;

7 “(III) 2000 is 60 percent;

8 “(IV) 2001 is 80 percent; and

9 “(V) a succeeding year is 100 percent.

10 “(C) PAYMENT ADJUSTMENT.—

11 “(i) IN GENERAL.—Subject to clause (ii), the  
12 payment adjustments described in this subpara-  
13 graph are payment adjustments which the Sec-  
14 retary estimates were payable during 1997—

15 “(I) for the indirect costs of medical edu-  
16 cation under section 1886(d)(5)(B); and

17 “(II) for direct graduate medical education  
18 costs under section 1886(h).

19 “(ii) TREATMENT OF PAYMENTS COVERED  
20 UNDER STATE HOSPITAL REIMBURSEMENT SYS-  
21 TEM.—To the extent that the Secretary estimates  
22 that an annual per capita rate of payment for 1997  
23 described in clause (i) reflects payments to hos-  
24 pitals reimbursed under section 1814(b)(3), the  
25 Secretary shall estimate a payment adjustment that  
26 is comparable to the payment adjustment that  
27 would have been made under clause (i) if the hos-  
28 pitals had not been reimbursed under such section.

29 “(D) TREATMENT OF AREAS WITH HIGHLY VARI-  
30 ABLE PAYMENT RATES.—In the case of a  
31 Medicare+ Choice payment area for which the annual  
32 per capita rate of payment determined under section  
33 1876(a)(1)(C) for 1997 varies by more than 20 percent  
34 from such rate for 1996, for purposes of this sub-  
35 section the Secretary may substitute for such rate for  
36 1997 a rate that is more representative of the costs of  
37 the enrollees in the area.

1           “(4) INPUT-PRICE-ADJUSTED ANNUAL NATIONAL  
2 MEDICARE+ CHOICE CAPITATION RATE.—

3           “(A) IN GENERAL.—For purposes of paragraph  
4 (1)(A), the input-price-adjusted annual national  
5 Medicare+ Choice capitation rate for a  
6 Medicare+ Choice payment area for a year is equal to  
7 the sum, for all the types of medicare services (as clas-  
8 sified by the Secretary), of the product (for each such  
9 type of service) of—

10           “(i) the national standardized annual  
11 Medicare+ Choice capitation rate (determined  
12 under subparagraph (B)) for the year;

13           “(ii) the proportion of such rate for the year  
14 which is attributable to such type of services; and

15           “(iii) an index that reflects (for that year and  
16 that type of services) the relative input price of  
17 such services in the area compared to the national  
18 average input price of such services.

19 In applying clause (iii), the Secretary may, subject to  
20 subparagraph (C), apply those indices under this title  
21 that are used in applying (or updating) national pay-  
22 ment rates for specific areas and localities.

23           “(B) NATIONAL STANDARDIZED ANNUAL  
24 MEDICARE+ CHOICE CAPITATION RATE.—In subpara-  
25 graph (A)(i), the ‘national standardized annual  
26 Medicare+ Choice capitation rate’ for a year is equal  
27 to—

28           “(i) the sum (for all Medicare+ Choice pay-  
29 ment areas) of the product of—

30           “(I) the annual area-specific  
31 Medicare+ Choice capitation rate for that year  
32 for the area under paragraph (3); and

33           “(II) the average number of medicare  
34 beneficiaries residing in that area in the year,  
35 multiplied by the average of the risk factor  
36 weights used to adjust payments under sub-

1 section (a)(1)(A) for such beneficiaries in such  
2 area; divided by  
3 “(ii) the sum of the products described in  
4 clause (i)(II) for all areas for that year.

5 “(5) PAYMENT ADJUSTMENT BUDGET NEUTRALITY  
6 FACTOR.—For purposes of paragraph (1)(A), for each year,  
7 the Secretary shall determine a budget neutrality adjust-  
8 ment factor so that the aggregate of the payments under  
9 this part (other than those attributable to subsections  
10 (a)(3)(C)(iii) and (i)) shall equal the aggregate payments  
11 that would have been made under this part if payment were  
12 based entirely on area-specific capitation rates.

13 “(6) NATIONAL PER CAPITA MEDICARE+ CHOICE  
14 GROWTH PERCENTAGE DEFINED.—

15 “(A) IN GENERAL.—In this part, the ‘national per  
16 capita Medicare+ Choice growth percentage’ for a year  
17 is the percentage determined by the Secretary, by  
18 March 1st before the beginning of the year involved, to  
19 reflect the Secretary’s estimate of the projected per  
20 capita rate of growth in expenditures under this title  
21 for an individual entitled to (or enrolled for) benefits  
22 under part A and enrolled under part B, reduced by  
23 the number of percentage points specified in subpara-  
24 graph (B) for the year. Separate determinations may  
25 be made for aged enrollees, disabled enrollees, and en-  
26 rollees with end-stage renal disease.

27 “(B) ADJUSTMENT.—The number of percentage  
28 points specified in this subparagraph is—

- 29 “(i) for 1998, 0.8 percentage points;  
30 “(ii) for 1999, 0.5 percentage points;  
31 “(iii) for 2000, 0.5 percentage points;  
32 “(iv) for 2001, 0.5 percentage points;  
33 “(v) for 2002, 0.3 percentage points; and  
34 “(vi) for a year after 2002, 0 percentage  
35 points.

36 “(C) ADJUSTMENT FOR OVER OR UNDER PROJEC-  
37 TION OF NATIONAL PER CAPITA MEDICARE+ CHOICE

1           GROWTH PERCENTAGE.—Beginning with rates cal-  
2           culated for 1999, before computing rates for a year as  
3           described in paragraph (1), the Secretary shall adjust  
4           all area-specific and national Medicare+ Choice capita-  
5           tion rates (and beginning in 2000, the minimum  
6           amount) for the previous year for the differences be-  
7           tween the projections of the national per capita  
8           Medicare+ Choice growth percentage for that year and  
9           previous years and the current estimate of such per-  
10          centage for such years.

11          “(7) TRANSITION TO MEDICAREADVANTAGE COMPETI-  
12          TION.—

13                 “(A) IN GENERAL.—For each year (beginning  
14                 with 2006) payments to MedicareAdvantage plans shall  
15                 not be computed under this subsection, but instead  
16                 shall be based on the payment amount determined  
17                 under subsection (d).

18                 “(B) CONTINUED CALCULATION OF CAPITATION  
19                 RATES.—For each year (beginning with 2006) the Sec-  
20                 retary shall calculate and publish the annual  
21                 Medicare+ Choice capitation rates under this subsection  
22                 and shall use the annual Medicare+ Choice capitation  
23                 rate determined under subsection (c)(1) for purposes of  
24                 determining the benchmark amount under subsection  
25                 (a)(4).

26          “(d) SECRETARY’S DETERMINATION OF PAYMENT  
27          AMOUNT.—

28                 “(1) REVIEW OF PLAN BIDS.—The Secretary shall re-  
29                 view each plan bid submitted under section 1854(a) for the  
30                 coverage of benefits under the original medicare fee-for-  
31                 service program option to ensure that such bids are con-  
32                 sistent with the requirements under this part an are based  
33                 on the assumptions described in section 1854(a)(2)(A)(iii).

34                 “(2) DETERMINATION OF WEIGHTED SERVICE AREA  
35                 BENCHMARK AMOUNTS.—The Secretary shall calculate a  
36                 weighted service area benchmark amount for the benefits  
37                 under the original medicare fee-for-service program option

1 for each plan equal to the weighted average of the bench-  
2 mark amounts for benefits under such original medicare  
3 fee-for-service program option for the payment areas in-  
4 cluded in the service area of the plan using the assump-  
5 tions described in section 1854(a)(2)(A)(iii).

6 “(3) COMPARISON TO BENCHMARK.—The Secretary  
7 shall determine the difference between each plan bid (as  
8 adjusted under paragraph (1)) and the weighted service  
9 area benchmark amount (as determined under paragraph  
10 (2)) for purposes of determining—

11 “(A) the payment amount under paragraph (4);  
12 and

13 “(B) the additional benefits required and  
14 MedicareAdvantage monthly basic beneficiary pre-  
15 miums.

16 “(4) DETERMINATION OF PAYMENT AMOUNT FOR  
17 ORIGINAL MEDICARE FEE-FOR-SERVICE BENEFITS.—

18 “(A) IN GENERAL.—Subject to subparagraph (B),  
19 the Secretary shall determine the payment amount for  
20 MedicareAdvantage plans for the benefits under the  
21 original medicare fee-for-service program option as fol-  
22 lows:

23 “(i) BIDS THAT EQUAL OR EXCEED THE  
24 BENCHMARK.—In the case of a plan bid that  
25 equals or exceeds the weighted service area bench-  
26 mark amount, the amount of each monthly pay-  
27 ment to a MedicareAdvantage organization with re-  
28 spect to each individual enrolled in a plan shall be  
29 the weighted service area benchmark amount.

30 “(ii) BIDS BELOW THE BENCHMARK.—In the  
31 case of a plan bid that is less than the weighted  
32 service area benchmark amount, the amount of  
33 each monthly payment to a MedicareAdvantage or-  
34 ganization with respect to each individual enrolled  
35 in a plan shall be the weighted service area bench-  
36 mark amount reduced by the amount of any pre-

1           mium reduction elected by the plan under section  
2           1854(d)(1)(A)(i).

3           “(B) APPLICATION OF COMPREHENSIVE RISK AD-  
4           JUSTMENT METHODOLOGY.—The Secretary shall adjust  
5           the amounts determined under subparagraph (A) using  
6           the comprehensive risk adjustment methodology appli-  
7           cable under subsection (a)(3).

8           “(6) ADJUSTMENT FOR NATIONAL COVERAGE DETER-  
9           MINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If  
10          the Secretary makes a determination with respect to cov-  
11          erage under this title or there is a change in benefits re-  
12          quired to be provided under this part that the Secretary  
13          projects will result in a significant increase in the costs to  
14          MedicareAdvantage organizations of providing benefits  
15          under contracts under this part (for periods after any pe-  
16          riod described in section 1852(a)(5)), the Secretary shall  
17          appropriately adjust the benchmark amounts or payment  
18          amounts (as determined by the Secretary). Such projection  
19          and adjustment shall be based on an analysis by the Sec-  
20          retary of the actuarial costs associated with the new bene-  
21          fits.

22          “(7) BENEFITS UNDER THE ORIGINAL MEDICARE FEE-  
23          FOR-SERVICE PROGRAM OPTION DEFINED.—For purposes  
24          of this part, the term ‘benefits under the original medicare  
25          fee-for-service program option’ means those items and serv-  
26          ices (other than hospice care) for which benefits are avail-  
27          able under parts A and B to individuals entitled to, or en-  
28          rolled for, benefits under part A and enrolled under part  
29          B, with cost-sharing for those services as required under  
30          parts A and B or an actuarially equivalent level of cost-  
31          sharing as determined in this part.

32          “(e) MEDICAREADVANTAGE PAYMENT AREA DEFINED.—

33          “(1) IN GENERAL.—In this part, except as provided in  
34          paragraph (3), the term ‘MedicareAdvantage payment area’  
35          means a county, or equivalent area specified by the Sec-  
36          retary.

1           “(2) RULE FOR ESRD BENEFICIARIES.—In the case of  
2 individuals who are determined to have end stage renal dis-  
3 ease, the MedicareAdvantage payment area shall be a State  
4 or such other payment area as the Secretary specifies.

5           “(3) GEOGRAPHIC ADJUSTMENT.—

6           “(A) IN GENERAL.—Upon written request of the  
7 chief executive officer of a State for a contract year  
8 (beginning after 2005) made by not later than Feb-  
9 ruary 1 of the previous year, the Secretary shall make  
10 a geographic adjustment to a MedicareAdvantage pay-  
11 ment area in the State otherwise determined under  
12 paragraph (1)—

13           “(i) to a single statewide MedicareAdvantage  
14 payment area;

15           “(ii) to the metropolitan based system de-  
16 scribed in subparagraph (C); or

17           “(iii) to consolidating into a single  
18 MedicareAdvantage payment area noncontiguous  
19 counties (or equivalent areas described in para-  
20 graph (1)) within a State.

21 Such adjustment shall be effective for payments for  
22 months beginning with January of the year following  
23 the year in which the request is received.

24           “(B) BUDGET NEUTRALITY ADJUSTMENT.—In the  
25 case of a State requesting an adjustment under this  
26 paragraph, the Secretary shall initially (and annually  
27 thereafter) adjust the payment rates otherwise estab-  
28 lished under this section for MedicareAdvantage pay-  
29 ment areas in the State in a manner so that the aggre-  
30 gate of the payments under this section in the State  
31 shall not exceed the aggregate payments that would  
32 have been made under this section for  
33 MedicareAdvantage payment areas in the State in the  
34 absence of the adjustment under this paragraph.

35           “(C) METROPOLITAN BASED SYSTEM.—The met-  
36 ropolitan based system described in this subparagraph  
37 is one in which—

1           “(i) all the portions of each metropolitan sta-  
2           tistical area in the State or in the case of a consoli-  
3           dated metropolitan statistical area, all of the por-  
4           tions of each primary metropolitan statistical area  
5           within the consolidated area within the State, are  
6           treated as a single MedicareAdvantage payment  
7           area; and

8           “(ii) all areas in the State that do not fall  
9           within a metropolitan statistical area are treated as  
10          a single MedicareAdvantage payment area.

11          “(D) AREAS.—In subparagraph (C), the terms  
12          ‘metropolitan statistical area’, ‘consolidated metropoli-  
13          tan statistical area’, and ‘primary metropolitan statis-  
14          tical area’ mean any area designated as such by the  
15          Secretary of Commerce.

16          “(f) SPECIAL RULES FOR INDIVIDUALS ELECTING MSA  
17          PLANS.—

18          “(1) IN GENERAL.—If the amount of the  
19          MedicareAdvantage monthly MSA premium (as defined in  
20          section 1854(b)(2)(D)) for an MSA plan for a year is less  
21          than  $\frac{1}{12}$  of the annual Medicare+ Choice capitation rate  
22          applied under this section for the area and year involved,  
23          the Secretary shall deposit an amount equal to 100 percent  
24          of such difference in a MedicareAdvantage MSA established  
25          (and, if applicable, designated) by the individual under  
26          paragraph (2).

27          “(2) ESTABLISHMENT AND DESIGNATION OF  
28          MEDICAREADVANTAGE MEDICAL SAVINGS ACCOUNT AS RE-  
29          QUIREMENT FOR PAYMENT OF CONTRIBUTION.—In the  
30          case of an individual who has elected coverage under an  
31          MSA plan, no payment shall be made under paragraph (1)  
32          on behalf of an individual for a month unless the  
33          individual—

34          “(A) has established before the beginning of the  
35          month (or by such other deadline as the Secretary may  
36          specify) a MedicareAdvantage MSA (as defined in sec-

1           tion 138(b)(2) of the Internal Revenue Code of 1986);  
2           and

3           “(B) if the individual has established more than 1  
4           such MedicareAdvantage MSA, has designated 1 of  
5           such accounts as the individual’s MedicareAdvantage  
6           MSA for purposes of this part.

7           Under rules under this section, such an individual may  
8           change the designation of such account under subpara-  
9           graph (B) for purposes of this part.

10           “(3) LUMP-SUM DEPOSIT OF MEDICAL SAVINGS AC-  
11           COUNT CONTRIBUTION.—In the case of an individual elect-  
12           ing an MSA plan effective beginning with a month in a  
13           year, the amount of the contribution to the  
14           MedicareAdvantage MSA on behalf of the individual for  
15           that month and all successive months in the year shall be  
16           deposited during that first month. In the case of a termi-  
17           nation of such an election as of a month before the end of  
18           a year, the Secretary shall provide for a procedure for the  
19           recovery of deposits attributable to the remaining months  
20           in the year.

21           “(g) PAYMENTS FROM TRUST FUNDS.—Except as pro-  
22           vided in section 1858A(c) (relating to payments for qualified  
23           prescription drug coverage), the payment to a  
24           MedicareAdvantage organization under this section for individ-  
25           uals enrolled under this part with the organization and pay-  
26           ments to a MedicareAdvantage MSA under subsection (e)(1)  
27           shall be made from the Federal Hospital Insurance Trust Fund  
28           and the Federal Supplementary Medical Insurance Trust Fund  
29           in such proportion as the Secretary determines reflects the re-  
30           lative weight that benefits under part A and under part B rep-  
31           resents of the actuarial value of the total benefits under this  
32           title. Monthly payments otherwise payable under this section  
33           for October 2000 shall be paid on the first business day of such  
34           month. Monthly payments otherwise payable under this section  
35           for October 2001 shall be paid on the last business day of Sep-  
36           tember 2001. Monthly payments otherwise payable under this

1 section for October 2006 shall be paid on the first business day  
2 of October 2006.

3 “(h) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL  
4 STAYS.—In the case of an individual who is receiving inpatient  
5 hospital services from a subsection (d) hospital (as defined in  
6 section 1886(d)(1)(B)) as of the effective date of the  
7 individual’s—

8 “(1) election under this part of a MedicareAdvantage  
9 plan offered by a MedicareAdvantage organization—

10 “(A) payment for such services until the date of  
11 the individual’s discharge shall be made under this title  
12 through the MedicareAdvantage plan or the original  
13 medicare fee-for-service program option (as the case  
14 may be) elected before the election with such organiza-  
15 tion,

16 “(B) the elected organization shall not be finan-  
17 cially responsible for payment for such services until  
18 the date after the date of the individual’s discharge;  
19 and

20 “(C) the organization shall nonetheless be paid the  
21 full amount otherwise payable to the organization  
22 under this part; or

23 “(2) termination of election with respect to a  
24 MedicareAdvantage organization under this part—

25 “(A) the organization shall be financially respon-  
26 sible for payment for such services after such date and  
27 until the date of the individual’s discharge;

28 “(B) payment for such services during the stay  
29 shall not be made under section 1886(d) or by any suc-  
30 ceeding MedicareAdvantage organization; and

31 “(C) the terminated organization shall not receive  
32 any payment with respect to the individual under this  
33 part during the period the individual is not enrolled.

34 “(i) SPECIAL RULE FOR HOSPICE CARE.—

35 “(1) INFORMATION.—A contract under this part shall  
36 require the MedicareAdvantage organization to inform each  
37 individual enrolled under this part with a

1 MedicareAdvantage plan offered by the organization about  
2 the availability of hospice care if—

3 “(A) a hospice program participating under this  
4 title is located within the organization’s service area; or

5 “(B) it is common practice to refer patients to  
6 hospice programs outside such service area.

7 “(2) PAYMENT.—If an individual who is enrolled with  
8 a MedicareAdvantage organization under this part makes  
9 an election under section 1812(d)(1) to receive hospice care  
10 from a particular hospice program—

11 “(A) payment for the hospice care furnished to the  
12 individual shall be made to the hospice program elected  
13 by the individual by the Secretary;

14 “(B) payment for other services for which the in-  
15 dividual is eligible notwithstanding the individual’s elec-  
16 tion of hospice care under section 1812(d)(1), including  
17 services not related to the individual’s terminal illness,  
18 shall be made by the Secretary to the  
19 MedicareAdvantage organization or the provider or  
20 supplier of the service instead of payments calculated  
21 under subsection (a); and

22 “(C) the Secretary shall continue to make monthly  
23 payments to the MedicareAdvantage organization in an  
24 amount equal to the value of the additional benefits re-  
25 quired under section 1854(f)(1)(A).”.

26 **SEC. 204. SUBMISSION OF BIDS; PREMIUMS.**

27 Section 1854 (42 U.S.C. 1395w-24) is amended to read  
28 as follows:

29 “SUBMISSION OF BIDS; PREMIUMS

30 “SEC. 1854. (a) SUBMISSION OF BIDS BY  
31 MEDICAREADVANTAGE ORGANIZATIONS.—

32 “(1) IN GENERAL.—Not later than the second Monday  
33 in September and except as provided in paragraph (3),  
34 each MedicareAdvantage organization shall submit to the  
35 Secretary, in such form and manner as the Secretary may  
36 specify, for each MedicareAdvantage plan that the organi-

1 zation intends to offer in a service area in the following  
2 year—

3 “(A) notice of such intent and information on the  
4 service area of the plan;

5 “(B) the plan type for each plan;

6 “(C) if the MedicareAdvantage plan is a coordi-  
7 nated care plan (as described in section 1851(a)(2)(A))  
8 or a private fee-for-service plan (as described in section  
9 1851(a)(2)(C)), the information described in paragraph  
10 (2) with respect to each payment area;

11 “(D) the enrollment capacity (if any) in relation to  
12 the plan and each payment area;

13 “(E) the expected mix, by health status, of en-  
14 rolled individuals; and

15 “(F) such other information as the Secretary may  
16 specify.

17 “(2) INFORMATION REQUIRED FOR COORDINATED  
18 CARE PLANS AND PRIVATE FEE-FOR-SERVICE PLANS.—For  
19 a MedicareAdvantage plan that is a coordinated care plan  
20 (as described in section 1851(a)(2)(A)) or a private fee-for-  
21 service plan (as described in section 1851(a)(2)(C)), the in-  
22 formation described in this paragraph is as follows:

23 “(A) INFORMATION REQUIRED WITH RESPECT TO  
24 BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-  
25 SERVICE PROGRAM OPTION.—Information relating to  
26 the coverage of benefits under the original medicare  
27 fee-for-service program option as follows:

28 “(i) The plan bid, which shall consist of a dol-  
29 lar amount that represents the total amount that  
30 the plan is willing to accept (not taking into ac-  
31 count the application of the comprehensive risk ad-  
32 justment methodology under section 1853(a)(3))  
33 for providing coverage of the benefits under the  
34 original medicare fee-for-service program option to  
35 an individual enrolled in the plan that resides in  
36 the service area of the plan for a month.

1                   “(ii) For the enhanced medical benefits pack-  
2 age offered—

3                   “(I) the adjusted community rate (as de-  
4 fined in subsection (g)(3)) of the package;

5                   “(II) the portion of the actuarial value of  
6 such benefits package (if any) that will be ap-  
7 plied toward satisfying the requirement for ad-  
8 ditional benefits under subsection (g);

9                   “(III) the MedicareAdvantage monthly  
10 beneficiary premium for enhanced medical ben-  
11 efits (as defined in subsection (b)(2)(C));

12                   “(IV) a description of any cost-sharing;

13                   “(V) a description of whether the amount  
14 of the unified deductible has been lowered or  
15 the maximum limitations on out-of-pocket ex-  
16 penses have been decreased (relative to the lev-  
17 els used in calculating the plan bid);

18                   “(VI) such other information as the Sec-  
19 retary considers necessary.

20                   “(iii) The assumptions that the  
21 MedicareAdvantage organization used in preparing  
22 the plan bid with respect to numbers, in each pay-  
23 ment area, of enrolled individuals and the mix, by  
24 health status, of such individuals.

25                   “(B) INFORMATION REQUIRED WITH RESPECT TO  
26 PART D.—The information required to be submitted by  
27 an eligible entity under section 1860D-12, including  
28 the monthly premiums for standard coverage and any  
29 other qualified prescription drug coverage available to  
30 individuals enrolled under part D.

31                   “(C) DETERMINING PLAN COSTS INCLUDED IN  
32 PLAN BID.—For purposes of submitting its plan bid  
33 under subparagraph (A)(i) a MedicareAdvantage plan  
34 offered by a MedicareAdvantage organization satisfies  
35 subparagraphs (A) and (C) of section 1852(a)(1) if the  
36 actuarial value of the deductibles, coinsurance, and co-  
37 payments applicable on average to individuals enrolled

1 in such plan under this part with respect to benefits  
2 under the original medicare fee-for-service program op-  
3 tion on which that bid is based (ignoring any reduction  
4 in cost-sharing offered by such plan as enhanced med-  
5 ical benefits under paragraph (2)(A)(ii) or required  
6 under clause (ii) or (iii) of subsection (g)(1)(C)) equals  
7 the amount specified in subsection (f)(1)(B).

8 “(3) REQUIREMENTS FOR MSA PLANS.—For an MSA  
9 plan described in section 1851(a)(2)(B), the information  
10 described in this paragraph is the information that such a  
11 plan would have been required to submit under this part  
12 if the Prescription Drug and Medicare Improvements Act  
13 of 2003 had not been enacted.

14 “(4) REVIEW.—

15 “(A) IN GENERAL.—Subject to subparagraph (B),  
16 the Secretary shall review the adjusted community  
17 rates (as defined in section 1854(g)(3)), the amounts  
18 of the MedicareAdvantage monthly basic premium and  
19 the MedicareAdvantage monthly beneficiary premium  
20 for enhanced medical benefits filed under this sub-  
21 section and shall approve or disapprove such rates and  
22 amounts so submitted. The Secretary shall review the  
23 actuarial assumptions and data used by the  
24 MedicareAdvantage organization with respect to such  
25 rates and amounts so submitted to determine the ap-  
26 propriateness of such assumptions and data.

27 “(B) MSA EXCEPTION.—The Secretary shall not  
28 review, approve, or disapprove the amounts submitted  
29 under paragraph (3).

30 “(C) CLARIFICATION OF AUTHORITY REGARDING  
31 DISAPPROVAL OF UNREASONABLE BENEFICIARY COST-  
32 SHARING.—Under the authority under subparagraph  
33 (A), the Secretary may disapprove the bid if the Sec-  
34 retary determines that the deductibles, coinsurance, or  
35 copayments applicable under the plan discourage access  
36 to covered services or are likely to result in favorable  
37 selection of MedicareAdvantage eligible individuals.

1           “(5) APPLICATION OF FEHBP STANDARD; PROHIBI-  
2           TION ON PRICE GOUGING.—Each bid amount submitted  
3           under paragraph (1) for a MedicareAdvantage plan must  
4           reasonably and equitably reflect the cost of benefits pro-  
5           vided under that plan.

6           “(b) MONTHLY PREMIUMS CHARGED.—

7           “(1) IN GENERAL.—

8           “(A) COORDINATED CARE AND PRIVATE FEE-FOR-  
9           SERVICE PLANS.—The monthly amount of the premium  
10           charged to an individual enrolled in a  
11           MedicareAdvantage plan (other than an MSA plan) of-  
12           fered by a MedicareAdvantage organization shall be  
13           equal to the sum of the following:

14           “(i) The MedicareAdvantage monthly basic  
15           beneficiary premium (if any).

16           “(ii) The MedicareAdvantage monthly bene-  
17           ficiary premium for enhanced medical benefits (if  
18           any).

19           “(iii) The MedicareAdvantage monthly obliga-  
20           tion for qualified prescription drug coverage (if  
21           any).

22           “(B) MSA PLANS.—The rules under this section  
23           that would have applied with respect to an MSA plan  
24           if the Prescription Drug and Medicare Improvements  
25           Act of 2003 had not been enacted shall continue to  
26           apply to MSA plans after the date of enactment of such  
27           Act.

28           “(2) PREMIUM TERMINOLOGY.—For purposes of this  
29           part:

30           “(A) MEDICAREADVANTAGE MONTHLY BASIC BEN-  
31           EFICIARY PREMIUM.—The term ‘MedicareAdvantage  
32           monthly basic beneficiary premium’ means, with re-  
33           spect to a MedicareAdvantage plan, the amount re-  
34           quired to be charged under subsection (d)(2) for the  
35           plan.

36           “(B) MEDICAREADVANTAGE MONTHLY BENE-  
37           FICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION

1 DRUG COVERAGE.—The term ‘MedicareAdvantage  
2 monthly beneficiary obligation for qualified prescription  
3 drug coverage’ means, with respect to a  
4 MedicareAdvantage plan, the amount determined under  
5 section 1858A(d).

6 “(C) MEDICAREADVANTAGE MONTHLY BENE-  
7 FICIARY PREMIUM FOR ENHANCED MEDICAL BENE-  
8 FITS.—The term ‘MedicareAdvantage monthly bene-  
9 ficiary premium for enhanced medical benefits’ means,  
10 with respect to a MedicareAdvantage plan, the amount  
11 required to be charged under subsection (f)(2) for the  
12 plan, or, in the case of an MSA plan, the amount filed under  
13 subsection (a)(3).

14 “(D) MEDICAREADVANTAGE MONTHLY MSA PRE-  
15 MIUM.—The term ‘MedicareAdvantage monthly MSA  
16 premium’ means, with respect to a MedicareAdvantage  
17 plan, the amount of such premium filed under sub-  
18 section (a)(3) for the plan.

19 “(c) UNIFORM PREMIUM.—The MedicareAdvantage  
20 monthly basic beneficiary premium, the MedicareAdvantage  
21 monthly beneficiary obligation for qualified prescription drug  
22 coverage, the MedicareAdvantage monthly beneficiary premium  
23 for enhanced medical benefits, and the MedicareAdvantage  
24 monthly MSA premium charged under subsection (b) of a  
25 MedicareAdvantage organization under this part may not vary  
26 among individuals enrolled in the plan.

27 “(d) DETERMINATION OF PREMIUM REDUCTIONS, RE-  
28 DUCED COST-SHARING, ADDITIONAL BENEFITS, AND BENE-  
29 FICIARY PREMIUMS.—

30 “(1) BIDS BELOW THE BENCHMARK.—If the Secretary  
31 determines under section 1853(d)(3) that the weighted  
32 service area benchmark amount exceeds the plan bid, the  
33 Secretary shall require the plan to provide additional bene-  
34 fits in accordance with subsection (g).

35 “(2) BIDS ABOVE THE BENCHMARK.—If the Secretary  
36 determines under section 1853(d)(3) that the plan bid ex-  
37 ceeds the weighted service area benchmark amount (deter-

1           mined under section 1853(d)(2)), the amount of such ex-  
2           cess shall be the MedicareAdvantage monthly basic bene-  
3           ficiary premium (as defined in section 1854(b)(2)(A)).

4           “(e) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—  
5           Each MedicareAdvantage organization shall permit the pay-  
6           ment of any MedicareAdvantage monthly basic premium, the  
7           MedicareAdvantage monthly beneficiary obligation for qualified  
8           prescription drug coverage, and the MedicareAdvantage month-  
9           ly beneficiary premium for enhanced medical benefits on a  
10          monthly basis, may terminate election of individuals for a  
11          MedicareAdvantage plan for failure to make premium payments  
12          only in accordance with section 1851(g)(3)(B)(i), and may not  
13          provide for cash or other monetary rebates as an inducement  
14          for enrollment or otherwise (other than as an additional benefit  
15          described in subsection (g)(1)(C)(i)).

16          “(f) LIMITATION ON ENROLLEE LIABILITY.—

17                  “(1) FOR BENEFITS UNDER THE ORIGINAL MEDICARE  
18          FEE-FOR-SERVICE PROGRAM OPTION.—The sum of—

19                          “(A) the MedicareAdvantage monthly basic bene-  
20                          ficiary premium (multiplied by 12) and the actuarial  
21                          value of the deductibles, coinsurance, and copayments  
22                          (determined on the same basis as used in determining  
23                          the plan’s bid under paragraph (2)(C)) applicable on  
24                          average to individuals enrolled under this part with a  
25                          MedicareAdvantage plan described in subparagraph (A)  
26                          or (C) of section 1851(a)(2) of an organization with re-  
27                          spect to required benefits described in section  
28                          1852(a)(1)(A); must equal

29                          “(B) the actuarial value of the deductibles, coin-  
30                          surance, and copayments that would be applicable on  
31                          average to individuals who have elected to receive bene-  
32                          fits under the original medicare fee-for-service program  
33                          option if such individuals were not members of a  
34                          MedicareAdvantage organization for the year (adjusted  
35                          as determined appropriate by the Secretary to account  
36                          for geographic differences and for plan cost and utiliza-  
37                          tion differences).

1           “(2) FOR ENHANCED MEDICAL BENEFITS.—If the  
2 MedicareAdvantage organization provides to its members  
3 enrolled under this part in a MedicareAdvantage plan de-  
4 scribed in subparagraph (A) or (C) of section 1851(a)(2)  
5 with respect to enhanced medical benefits relating to bene-  
6 fits under the original medicare fee-for-service program op-  
7 tion, the sum of the MedicareAdvantage monthly bene-  
8 ficiary premium for enhanced medical benefits (multiplied  
9 by 12) charged and the actuarial value of its deductibles,  
10 coinsurance, and copayments charged with respect to such  
11 benefits for a year must equal the adjusted community rate  
12 (as defined in subsection (g)(3)) for such benefits for the  
13 year minus the actuarial value of any additional benefits  
14 pursuant to clause (ii), (iii), or (iv) of subsection (g)(2)(C)  
15 that the plan specified under subsection (a)(2)(i)(II).

16           “(3) DETERMINATION ON OTHER BASIS.—If the Sec-  
17 retary determines that adequate data are not available to  
18 determine the actuarial value under paragraph (1)(A) or  
19 (2), the Secretary may determine such amount with respect  
20 to all individuals in the same geographic area, the State,  
21 or in the United States, eligible to enroll in the  
22 MedicareAdvantage plan involved under this part or on the  
23 basis of other appropriate data.

24           “(4) SPECIAL RULE FOR PRIVATE FEE-FOR-SERVICE  
25 PLANS.—With respect to a MedicareAdvantage private fee-  
26 for-service plan (other than a plan that is an MSA plan),  
27 in no event may—

28           “(A) the actuarial value of the deductibles, coin-  
29 surance, and copayments applicable on average to indi-  
30 viduals enrolled under this part with such a plan of an  
31 organization with respect to required benefits described  
32 in subparagraphs (A), (C), and (D) of section  
33 1852(a)(1); exceed

34           “(B) the actuarial value of the deductibles, coin-  
35 surance, and copayments that would be applicable on  
36 average to individuals entitled to (or enrolled for) bene-  
37 fits under part A and enrolled under part B if they

1           were not members of a MedicareAdvantage organiza-  
2           tion for the year.

3           “(g) REQUIREMENT FOR ADDITIONAL BENEFITS.—

4           “(1) REQUIREMENT.—

5           “(A) IN GENERAL.—Each MedicareAdvantage or-  
6           ganization (in relation to a MedicareAdvantage plan,  
7           other than an MSA plan, it offers) shall provide that  
8           if there is an excess amount (as defined in subpara-  
9           graph (B)) for the plan for a contract year, subject to  
10          the succeeding provisions of this subsection, the organi-  
11          zation shall provide to individuals such additional bene-  
12          fits described in subparagraph (C) as the organization  
13          may specify in a value which the Secretary determines  
14          is at least equal to the adjusted excess amount (as de-  
15          fined in subparagraph (D)).

16          “(B) EXCESS AMOUNT.—For purposes of this  
17          paragraph, the term ‘excess amount’ means, for an or-  
18          ganization for a plan, is 100 percent of the amount (if  
19          any) by which the weighted service area benchmark  
20          amount (determined under section 1853(d)(2)) exceeds  
21          the plan bid (as adjusted under section 1853(d)(1)).

22          “(C) ADDITIONAL BENEFITS DESCRIBED.—The  
23          additional benefits described in this subparagraph are  
24          as follows:

25                  “(i) Subject to subparagraph (F), a monthly  
26                  part B premium reduction for individuals enrolled  
27                  in the plan.

28                  “(ii) Lowering the amount of the unified de-  
29                  ductible and decreasing the maximum limitations  
30                  on out-of-pocket expenses for individuals enrolled in  
31                  the plan.

32                  “(iii) A reduction in the actuarial value of plan  
33                  cost-sharing for plan enrollees.

34                  “(iv) Subject to subparagraph (E), such addi-  
35                  tional benefits as the organization may specify.

36                  “(v) Contributing to the stabilization fund  
37                  under paragraph (2).

1                   “(vi) Any combination of the reductions and  
2                   benefits described in clauses (i) through (v).

3                   “(D) ADJUSTED EXCESS AMOUNT.—For purposes  
4                   of this paragraph, the term ‘adjusted excess amount’  
5                   means, for an organization for a plan, is the excess  
6                   amount reduced to reflect any amount withheld and re-  
7                   served for the organization for the year under para-  
8                   graph (2).

9                   “(E) RULE FOR APPROVAL OF MEDICAL AND PRE-  
10                  SCRIPTION DRUG BENEFITS.—An organization may not  
11                  specify any additional benefit that provides for the cov-  
12                  erage of any prescription drug (other than that relating  
13                  to prescription drugs covered under the original medi-  
14                  care fee-for-service program option).

15                  “(F) PREMIUM REDUCTIONS.—

16                  “(i) IN GENERAL.—Subject to clause (ii), as  
17                  part of providing any additional benefits required  
18                  under subparagraph (A), a MedicareAdvantage or-  
19                  ganization may elect a reduction in its payments  
20                  under section 1853(a)(1)(A)(i) with respect to a  
21                  MedicareAdvantage plan and the Secretary shall  
22                  apply such reduction to reduce the premium under  
23                  section 1839 of each enrollee in such plan as pro-  
24                  vided in section 1840(i).

25                  “(ii) AMOUNT OF REDUCTION.—The amount  
26                  of the reduction under clause (i) with respect to  
27                  any enrollee in a MedicareAdvantage plan—

28                                 “(I) may not exceed 125 percent of the  
29                                 premium described under section 1839(a)(3);  
30                                 and

31                                 “(II) shall apply uniformly to each enrollee  
32                                 of the MedicareAdvantage plan to which such  
33                                 reduction applies.

34                  “(G) UNIFORM APPLICATION.—This paragraph  
35                  shall be applied uniformly for all enrollees for a plan.

36                  “(H) CONSTRUCTION.—Nothing in this subsection  
37                  shall be construed as preventing a MedicareAdvantage

1 organization from providing enhanced medical benefits  
2 (described in section 1852(a)(3)) that are in addition  
3 to the health care benefits otherwise required to be pro-  
4 vided under this paragraph and from imposing a pre-  
5 mium for such enhanced medical benefits.

6 “(2) STABILIZATION FUND.—A MedicareAdvantage  
7 organization may provide that a part of the value of an ex-  
8 cess amount described in paragraph (1) be withheld and re-  
9 served in the Federal Hospital Insurance Trust Fund and  
10 in the Federal Supplementary Medical Insurance Trust  
11 Fund (in such proportions as the Secretary determines to  
12 be appropriate) by the Secretary for subsequent annual  
13 contract periods, to the extent required to prevent undue  
14 fluctuations in the additional benefits offered in those sub-  
15 sequent periods by the organization in accordance with  
16 such paragraph. Any of such value of the amount reserved  
17 which is not provided as additional benefits described in  
18 paragraph (1)(A) to individuals electing the  
19 MedicareAdvantage plan of the organization in accordance  
20 with such paragraph prior to the end of such periods, shall  
21 revert for the use of such Trust Funds.

22 “(3) ADJUSTED COMMUNITY RATE.—For purposes of  
23 this subsection, subject to paragraph (4), the term ‘ad-  
24 justed community rate’ for a service or services means, at  
25 the election of a MedicareAdvantage organization, either—

26 “(A) the rate of payment for that service or serv-  
27 ices which the Secretary annually determines would  
28 apply to an individual electing a MedicareAdvantage  
29 plan under this part if the rate of payment were deter-  
30 mined under a ‘community rating system’ (as defined  
31 in section 1302(8) of the Public Health Service Act,  
32 other than subparagraph (C)); or

33 “(B) such portion of the weighted aggregate pre-  
34 mium, which the Secretary annually estimates would  
35 apply to such an individual, as the Secretary annually  
36 estimates is attributable to that service or services,

1 but adjusted for differences between the utilization charac-  
2 teristics of the individuals electing coverage under this part  
3 and the utilization characteristics of the other enrollees  
4 with the plan (or, if the Secretary finds that adequate data  
5 are not available to adjust for those differences, the dif-  
6 ferences between the utilization characteristics of individ-  
7 uals selecting other MedicareAdvantage coverage, or  
8 MedicareAdvantage eligible individuals in the area, in the  
9 State, or in the United States, eligible to elect  
10 MedicareAdvantage coverage under this part and the utili-  
11 zation characteristics of the rest of the population in the  
12 area, in the State, or in the United States, respectively).

13 “(4) DETERMINATION BASED ON INSUFFICIENT  
14 DATA.—For purposes of this subsection, if the Secretary  
15 finds that there is insufficient enrollment experience to de-  
16 termine the average amount of payments to be made under  
17 this part at the beginning of a contract period or to deter-  
18 mine (in the case of a newly operated provider-sponsored  
19 organization or other new organization) the adjusted com-  
20 munity rate for the organization, the Secretary may deter-  
21 mine such an average based on the enrollment experience  
22 of other contracts entered into under this part and may de-  
23 termine such a rate using data in the general commercial  
24 marketplace.

25 “(h) PROHIBITION OF STATE IMPOSITION OF PREMIUM  
26 TAXES.—No State may impose a premium tax or similar tax  
27 with respect to payments to MedicareAdvantage organizations  
28 under section 1853.

29 “(i) PERMITTING USE OF SEGMENTS OF SERVICE  
30 AREAS.—The Secretary shall permit a MedicareAdvantage or-  
31 ganization to elect to apply the provisions of this section uni-  
32 formly to separate segments of a service area (rather than uni-  
33 formly to an entire service area) as long as such segments are  
34 composed of 1 or more MedicareAdvantage payment areas.”.

35 (b) STUDY AND REPORT ON CLARIFICATION OF AUTHOR-  
36 ITY REGARDING DISAPPROVAL OF UNREASONABLE BENE-  
37 FICIARY COST-SHARING.—

1 (1) STUDY.—The Secretary, in consultation with bene-  
2 ficiaries, consumer groups, employers, and  
3 Medicare+ Choice organizations, shall conduct a study to  
4 determine the extent to which the cost-sharing structures  
5 under Medicare+ Choice plans under part C of title XVIII  
6 of the Social Security Act discourage access to covered  
7 services or discriminate based on the health status of  
8 Medicare+ Choice eligible individuals (as defined in section  
9 1851(a)(3) of the Social Security Act (42 U.S.C. 1395w-  
10 21(a)(3))).

11 (2) REPORT.—Not later than December 31, 2004, the  
12 Secretary shall submit a report to Congress on the study  
13 conducted under paragraph (1) together with recommenda-  
14 tions for such legislation and administrative actions as the  
15 Secretary considers appropriate.

16 **SEC. 205. SPECIAL RULES FOR PRESCRIPTION DRUG**  
17 **BENEFITS.**

18 Part C of title XVIII (42 U.S.C. 1395w-21 et seq.) is  
19 amended by inserting after section 1857 the following new sec-  
20 tion:

21 “SPECIAL RULES FOR PRESCRIPTION DRUG BENEFITS

22 “SEC. 1858A. (a) AVAILABILITY.—

23 “(1) PLANS REQUIRED TO PROVIDE QUALIFIED PRE-  
24 SCRPTION DRUG COVERAGE TO ENROLLEES.—

25 “(A) IN GENERAL.—Except as provided in sub-  
26 paragraph (B), on and after January 1, 2006, a  
27 MedicareAdvantage organization offering a  
28 MedicareAdvantage plan (except for an MSA plan)  
29 shall make available qualified prescription drug cov-  
30 erage that meets the requirements for such coverage  
31 under this part and part D to each enrollee of the plan.

32 “(B) PRIVATE FEE-FOR-SERVICE PLANS MAY, BUT  
33 ARE NOT REQUIRED TO, PROVIDE QUALIFIED PRE-  
34 SCRPTION DRUG COVERAGE.—Pursuant to section  
35 1852(a)(2)(D), a private fee-for-service plan may elect  
36 not to provide qualified prescription drug coverage

1           under part D to individuals residing in the area served  
2           by the plan.

3           “(2) REFERENCE TO PROVISION PERMITTING ADDI-  
4           TIONAL PRESCRIPTION DRUG COVERAGE.—For the provi-  
5           sions of part D, made applicable to this part pursuant to  
6           paragraph (1), that permit a plan to make available quali-  
7           fied prescription drug coverage that includes coverage of  
8           covered drugs that exceeds the coverage required under  
9           paragraph (1) of section 1860D–6 in an area, but only if  
10          the MedicareAdvantage organization offering the plan also  
11          offers a MedicareAdvantage plan in the area that only pro-  
12          vides the coverage that is required under such paragraph  
13          (1), see paragraph (2) of such section.

14          “(3) RULE FOR APPROVAL OF MEDICAL AND PRE-  
15          SCRIPTION DRUG BENEFITS.—Pursuant to sections  
16          1854(g)(1)(F) and 1852(a)(3)(D), a MedicareAdvantage  
17          organization offering a MedicareAdvantage plan that pro-  
18          vides qualified prescription drug coverage may not make  
19          available coverage of any prescription drugs (other than  
20          that relating to prescription drugs covered under the origi-  
21          nal medicare fee-for-service program option) to an enrollee  
22          as an additional benefit or as an enhanced medical benefit.

23          “(b) COMPLIANCE WITH ADDITIONAL BENEFICIARY PRO-  
24          TECTIONS.—With respect to the offering of qualified prescrip-  
25          tion drug coverage by a MedicareAdvantage organization under  
26          a MedicareAdvantage plan, the organization and plan shall  
27          meet the requirements of section 1860D–5, including require-  
28          ments relating to information dissemination and grievance and  
29          appeals, and such other requirements under part D that the  
30          Secretary determines appropriate in the same manner as such  
31          requirements apply to an eligible entity and a Medicare Pre-  
32          scription Drug plan under part D. The Secretary shall waive  
33          such requirements to the extent the Secretary determines that  
34          such requirements duplicate requirements otherwise applicable  
35          to the organization or the plan under this part.

36          “(c) PAYMENTS FOR PRESCRIPTION DRUGS.—

1           “(1) PAYMENT OF FULL AMOUNT OF PREMIUM TO OR-  
2           GANIZATIONS FOR QUALIFIED PRESCRIPTION DRUG COV-  
3           ERAGE.—

4           “(A) IN GENERAL.—For each year (beginning  
5           with 2006), the Secretary shall pay to each  
6           MedicareAdvantage organization offering a  
7           MedicareAdvantage plan that provides qualified pre-  
8           scription drug coverage, an amount equal to the full  
9           amount of the monthly premium submitted under sec-  
10          tion 1854(a)(2)(B) for the year, as adjusted using the  
11          risk adjusters that apply to the standard prescription  
12          drug coverage published under section 1860D–11.

13          “(B) APPLICATION OF PART D RISK CORRIDOR,  
14          STABILIZATION RESERVE FUND, AND ADMINISTRATIVE  
15          EXPENSES PROVISIONS.—The provisions of subsections  
16          (b), (c), and (d) of section 1860D–16 shall apply to a  
17          MedicareAdvantage organization offering a  
18          MedicareAdvantage plan that provides qualified pre-  
19          scription drug coverage and payments made to such or-  
20          ganization under subparagraph (A) in the same man-  
21          ner as such provisions apply to an eligible entity offer-  
22          ing a Medicare Prescription Drug plan and payments  
23          made to such entity under subsection (a) of section  
24          1860D–16.

25          “(2) PAYMENT FROM PRESCRIPTION DRUG AC-  
26          COUNT.—Payment made to MedicareAdvantage organiza-  
27          tions under this subsection shall be made from the Pre-  
28          scription Drug Account in the Federal Supplementary Med-  
29          ical Insurance Trust Fund under section 1841.

30          “(d) COMPUTATION OF MEDICAREADVANTAGE MONTHLY  
31          BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION  
32          DRUG COVERAGE.—In the case of a MedicareAdvantage eligi-  
33          ble individual receiving qualified prescription drug coverage  
34          under a MedicareAdvantage plan during a year after 2005, the  
35          MedicareAdvantage monthly beneficiary obligation for qualified  
36          prescription drug coverage of such individual in the year shall  
37          be determined in the same manner as the monthly beneficiary

1 obligation is determined under section 1860D–17 for eligible  
2 beneficiaries enrolled in a Medicare Prescription Drug plan, ex-  
3 cept that, for purposes of this subparagraph, any reference to  
4 the monthly plan premium approved by the Secretary under sec-  
5 tion 1860D–13 shall be treated as a reference to the monthly  
6 premium for qualified prescription drug coverage submitted by  
7 the MedicareAdvantage organization offering the plan under  
8 section 1854(a)(2)(A) and approved by the Secretary.

9 “(e) COLLECTION OF MEDICAREADVANTAGE MONTHLY  
10 BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION  
11 DRUG COVERAGE.—The provisions of section 1860D–18, in-  
12 cluding subsection (b) of such section, shall apply to the  
13 amount of the MedicareAdvantage monthly beneficiary obliga-  
14 tion for qualified prescription drug coverage (as determined  
15 under subsection (d)) required to be paid by a  
16 MedicareAdvantage eligible individual enrolled in a  
17 MedicareAdvantage plan in the same manner as such provi-  
18 sions apply to the amount of the monthly beneficiary obligation  
19 required to be paid by an eligible beneficiary enrolled in a  
20 Medicare Prescription Drug plan under part D.

21 “(f) AVAILABILITY OF PREMIUM SUBSIDY AND COST-  
22 SHARING REDUCTIONS FOR LOW-INCOME ENROLLEES AND  
23 REINSURANCE PAYMENTS.—For provisions—

24 “(1) providing premium subsidies and cost-sharing re-  
25 ductions for low-income individuals receiving qualified pre-  
26 scription drug coverage through a MedicareAdvantage plan,  
27 see section 1860D–19; and

28 “(2) providing a MedicareAdvantage organization with  
29 reinsurance payments for certain expenses incurred in pro-  
30 viding qualified prescription drug coverage through a  
31 MedicareAdvantage plan, see section 1860D–20.”.

32 (b) TREATMENT OF REDUCTION FOR PURPOSES OF DE-  
33 TERMINING GOVERNMENT CONTRIBUTION UNDER PART B.—  
34 Section 1844(c) (42 U.S.C. 1395w) is amended by striking  
35 “section 1854(f)(1)(E)” and inserting “section  
36 1854(d)(1)(A)(i)”.

1     **SEC. 206. FACILITATING EMPLOYER PARTICIPATION.**

2             Section 1858(h) (as added by section 211) is amended by  
3     inserting “(including subsection (i) of such section)” after “sec-  
4     tion 1857”.

5     **SEC. 207. CONFORMING AMENDMENTS.**

6             (a) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS  
7     FOR MEDICAREADVANTAGE ORGANIZATIONS; PROVIDER-SPON-  
8     SORED ORGANIZATIONS.—Section 1855 (42 U.S.C. 1395w–25)  
9     is amended—

10            (1) in subsection (b), in the matter preceding para-  
11            graph (1), by inserting “subparagraphs (A), (B), and (D)  
12            of” before “section 1852(A)(1)”; and

13            (2) by striking “Medicare+ Choice” and inserting  
14            “MedicareAdvantage” each place it appears.

15            (b) ESTABLISHMENT OF PSO STANDARDS.—Section 1856  
16     (42 U.S.C. 1395w–26) is amended by striking  
17     “Medicare+ Choice” and inserting “MedicareAdvantage” each  
18     place it appears.

19            (c) CONTRACTS WITH MEDICAREADVANTAGE ORGANIZA-  
20     TIONS.—Section 1857 (42 U.S.C. 1395w–27) is amended—

21            (1) in subsection (g)(1)—

22            (A) in subparagraph (B), by striking “amount of  
23            the Medicare+ Choice monthly basic and supplemental  
24            beneficiary premiums” and inserting “amounts of the  
25            MedicareAdvantage monthly basic premium and  
26            MedicareAdvantage monthly beneficiary premium for  
27            enhanced medical benefits”;

28            (B) in subparagraph (F), by striking “or” after  
29            the semicolon at the end;

30            (C) in subparagraph (G), by adding “or” after the  
31            semicolon at the end; and

32            (D) by inserting after subparagraph (G) the fol-  
33            lowing new subparagraph:

34            “(H)(i) charges any individual an amount in ex-  
35            cess of the MedicareAdvantage monthly beneficiary ob-  
36            ligation for qualified prescription drug coverage under  
37            section 1858A(d);

1           “(ii) provides coverage for prescription drugs that  
2           is not qualified prescription drug coverage;

3           “(iii) offers prescription drug coverage, but does  
4           not make standard prescription drug coverage avail-  
5           able; or

6           “(iv) provides coverage for prescription drugs  
7           (other than that relating to prescription drugs covered  
8           under the original medicare fee-for-service program op-  
9           tion described in section 1851(a)(1)(A)(i)) as an en-  
10          hanced medical benefit under section 1852(a)(3)(D) or  
11          as an additional benefit under section 1854(g)(1)(F),”;  
12          and

13          (2) by striking “Medicare+ Choice” and inserting  
14          “MedicareAdvantage” each place it appears.

15          (d) DEFINITIONS; MISCELLANEOUS PROVISIONS.—Section  
16          1859 (42 U.S.C. 1395w-28) is amended—

17                 (1) by striking subsection (c) and inserting the fol-  
18                 lowing new subsection:

19                 “(c) OTHER REFERENCES TO OTHER TERMS.—

20                         “(1) ENHANCED MEDICAL BENEFITS.—The term ‘en-  
21                         hanced medical benefits’ is defined in section  
22                         1852(a)(3)(E).

23                         “(2) MEDICAREADVANTAGE ELIGIBLE INDIVIDUAL.—  
24                         The term ‘MedicareAdvantage eligible individual’ is defined  
25                         in section 1851(a)(3).

26                         “(3) MEDICAREADVANTAGE PAYMENT AREA.—The  
27                         term ‘MedicareAdvantage payment area’ is defined in sec-  
28                         tion 1853(d).

29                         “(4) NATIONAL PER CAPITA MEDICARE+ CHOICE  
30                         GROWTH PERCENTAGE.—The ‘national per capita  
31                         Medicare+ Choice growth percentage’ is defined in section  
32                         1853(c)(6).

33                         “(5) MEDICAREADVANTAGE MONTHLY BASIC BENE-  
34                         FICIARY PREMIUM; MEDICAREADVANTAGE MONTHLY BENE-  
35                         FICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG  
36                         COVERAGE; MEDICAREADVANTAGE MONTHLY BENEFICIARY  
37                         PREMIUM FOR ENHANCED MEDICAL BENEFITS.—The terms

1 'MedicareAdvantage monthly basic beneficiary premium',  
2 'MedicareAdvantage monthly beneficiary obligation for  
3 qualified prescription drug coverage', and  
4 'MedicareAdvantage monthly beneficiary premium for en-  
5 hanced medical benefits' are defined in section 1854(b)(2).

6 "(6) QUALIFIED PRESCRIPTION DRUG COVERAGE.—  
7 The term 'qualified prescription drug coverage' has the  
8 meaning given such term in section 1860D(9).

9 "(7) STANDARD PRESCRIPTION DRUG COVERAGE.—  
10 The term 'standard prescription drug coverage' has the  
11 meaning given such term in section 1860D(10)."; and

12 (2) by striking "Medicare+ Choice" and inserting  
13 "MedicareAdvantage" each place it appears.

14 (e) CONFORMING AMENDMENTS EFFECTIVE BEFORE  
15 2006.—

16 (1) EXTENSION OF MSAs.—Section 1851(b)(4) (42  
17 U.S.C. 1395w-21(b)(4)) is amended by striking "January  
18 1, 2003" and inserting "January 1, 2004".

19 (2) CONTINUOUS OPEN ENROLLMENT AND  
20 DISENROLLMENT THROUGH 2005.—Section 1851(e) of the  
21 Social Security Act (42 U.S.C. 1395w-21(e)) is amended—

22 (A) in paragraph (2)(A), by striking "THROUGH  
23 2004" and "December 31,2004" and inserting  
24 "THROUGH 2005" and "December 31, 2005", respec-  
25 tively;

26 (B) in the heading of paragraph (2)(B), by strik-  
27 ing "DURING 2005" and inserting "DURING 2006";

28 (C) in paragraphs (2)(B)(i) and (2)(C)(i), by  
29 striking "2005" and inserting "2006" each place it ap-  
30 pears;

31 (D) in paragraph (2)(D), by striking "2004" and  
32 inserting "2005"; and

33 (E) in paragraph (4), by striking "2005" and in-  
34 serting "2006" each place it appears.

35 (3) EFFECTIVE DATE.—The amendments made by  
36 this subsection shall take effect on the date of enactment  
37 of this Act.

1 (e) OTHER CONFORMING AMENDMENTS.—

2 (1) CONFORMING MEDICARE CROSS-REFERENCES.—

3 (A) Section 1839(a)(2) (42 U.S.C. 1395r(a)(2)) is  
4 amended by striking “section 1854(f)(1)(E)” and in-  
5 serting “section 1854(g)(1)(C)(i)”.

6 (B) Section 1840(i) (42 U.S.C. 1395s(i)) is  
7 amended by striking “section 1854(f)(1)(E)” and in-  
8 serting “section 1854(g)(1)(C)(i)”.

9 (C) Section 1844(c) (42 U.S.C. 1395w(c)) is  
10 amended by striking “section 1854(f)(1)(E)” and in-  
11 serting “section 1854(g)(1)(C)(i)”.

12 (D) Section 1876(k)(3)(A) (42 U.S.C.  
13 1395mm(k)(3)(A)) is amended by inserting “(as in ef-  
14 fect immediately before the enactment of the Prescrip-  
15 tion Drug and Medicare Improvements Act of 2003)”  
16 after section 1853(a).

17 (F) Section 1876(k)(4) (42 U.S.C.  
18 1395mm(k)(4)(A)) is amended—

19 (i) in subparagraph (A), by striking “section  
20 1853(a)(3)(B)” and inserting “section  
21 1853(a)(3)(D)”; and

22 (ii) in subparagraph (B), by striking “section  
23 1854(g)” and inserting “section 1854(h)”.

24 (G) Section 1876(k)(4)(C) (42 U.S.C.  
25 1395mm(k)(4)(C)) in amended by inserting “(as in ef-  
26 fect immediately before the enactment of the Prescrip-  
27 tion Drug and Medicare Improvements Act of 2003)”  
28 after “section 1851(e)(6)”.

29 (H) Section 1894(d) (42 U.S.C. 1395eee(d)) is  
30 amended by adding at the end the following new para-  
31 graph:

32 “(3) APPLICATION OF PROVISIONS.—For purposes of  
33 paragraphs (1) and (2), the references to section 1853 and  
34 subsection (a)(2) of such section in such paragraphs shall  
35 be deemed to be references to those provisions as in effect  
36 immediately before the enactment of the Prescription Drug  
37 and Medicare Improvements Act of 2003.”.

1 (2) CONFORMING MEDICARE TERMINOLOGY.—Title  
2 XVIII (42 U.S.C. 1395 et seq.), except for part C of such  
3 title (42 U.S.C. 1395w-21 et seq.), and title XIX (42  
4 U.S.C. 1396 et seq.) are each amended by striking  
5 “Medicare+ Choice” and inserting “MedicareAdvantage”  
6 each place it appears.

7 **SEC. 208. EFFECTIVE DATE.**

8 (a) IN GENERAL.—Except as provided in subsection (b),  
9 the amendments made by this title shall apply with respect to  
10 plan years beginning on and after January 1, 2006.

11 (b) MEDICAREADVANTAGE MSA PLANS.—Notwith-  
12 standing any provision of this title, the Secretary shall apply  
13 the payment and other rules that apply with respect to an MSA  
14 plan described in section 1851(a)(2)(B) of the Social Security  
15 Act (42 U.S.C. 1395w-21(a)(2)(B)) as if this title had not  
16 been enacted.

17 **Subtitle B—Preferred Provider**  
18 **Organizations**

19 **SEC. 211. ESTABLISHMENT OF MEDICAREADVANTAGE**  
20 **PREFERRED PROVIDER PROGRAM OPTION.**

21 (a) ESTABLISHMENT OF PREFERRED PROVIDER PROGRAM  
22 OPTION.—Section 1851(a)(2) is amended by adding at the end  
23 the following new subparagraph:

24 “(D) PREFERRED PROVIDER ORGANIZATION  
25 PLANS.—A MedicareAdvantage preferred provider or-  
26 ganization plan under the program established under  
27 section 1858.”.

28 (b) PROGRAM SPECIFICATIONS.—Part C of title XVIII (42  
29 U.S.C. 1395w-21 et seq.) is amended by inserting after section  
30 1857 the following new section:

31 “PREFERRED PROVIDER ORGANIZATIONS

32 “SEC. 1858. (a) ESTABLISHMENT OF PROGRAM.—

33 “(1) IN GENERAL.—Beginning on January 1, 2006,  
34 there is established a preferred provider program under  
35 which preferred provider organization plans offered by pre-  
36 ferred provider organizations are offered to

1 MedicareAdvantage eligible individuals in preferred pro-  
2 vider regions.

3 “(2) DEFINITIONS.—

4 “(A) PREFERRED PROVIDER ORGANIZATION.—The  
5 term ‘preferred provider organization’ means an entity  
6 with a contract under section 1857 that meets the re-  
7 quirements of this section applicable with respect to  
8 preferred provider organizations.

9 “(B) PREFERRED PROVIDER ORGANIZATION  
10 PLAN.—The term ‘preferred provider organization plan’  
11 means a MedicareAdvantage plan that—

12 “(i) has a network of providers that have  
13 agreed to a contractually specified reimbursement  
14 for covered benefits with the organization offering  
15 the plan;

16 “(ii) provides for reimbursement for all cov-  
17 ered benefits regardless of whether such benefits  
18 are provided within such network of providers; and

19 “(iii) is offered by a preferred provider organi-  
20 zation.

21 “(C) PREFERRED PROVIDER REGION.—The term  
22 ‘preferred provider region’ means—

23 “(i) a region established under paragraph (3);  
24 and

25 “(ii) a region that consists of the entire  
26 United States.

27 “(3) PREFERRED PROVIDER REGIONS.—For purposes  
28 of this part the Secretary shall establish preferred provider  
29 regions as follows:

30 “(A) There shall be at least 10 regions.

31 “(B) Each region must include at least 1 State.

32 “(C) The Secretary may not divide States so that  
33 portions of the State are in different regions.

34 “(D) To the extent possible, the Secretary shall in-  
35 clude multistate metropolitan statistical areas in a sin-  
36 gle region. The Secretary may divide metropolitan sta-  
37 tistical areas where it is necessary to establish regions

1 of such size and geography as to maximize the partici-  
2 pation of preferred provider organization plans.

3 “(E) The Secretary may conform the preferred  
4 provider regions to the service areas established under  
5 section 1860D–10.

6 “(b) ELIGIBILITY, ELECTION, AND ENROLLMENT; BENE-  
7 FITS AND BENEFICIARY PROTECTIONS.—

8 “(1) IN GENERAL.—Except as provided in the suc-  
9 ceeding provisions of this subsection, the provisions of sec-  
10 tions 1851 and 1852 that apply with respect to coordinated  
11 care plans shall apply to preferred provider organization  
12 plans offered by a preferred provider organization.

13 “(2) SERVICE AREA.—The service area of a preferred  
14 provider organization plan shall be a preferred provider re-  
15 gion.

16 “(3) AVAILABILITY.—Each preferred provider organi-  
17 zation plan must be offered to each MedicareAdvantage eli-  
18 gible individual who resides in the service area of the plan.

19 “(4) AUTHORITY TO PROHIBIT RISK SELECTION.—The  
20 provisions of section 1852(a)(6) shall apply to preferred  
21 provider organization plans.

22 “(5) ASSURING ACCESS TO SERVICES IN PREFERRED  
23 PROVIDER ORGANIZATION PLANS.—

24 “(A) IN GENERAL.—In addition to any other re-  
25 quirements under this section, in the case of a pre-  
26 ferred provider organization plan, the organization of-  
27 fering the plan must demonstrate to the Secretary that  
28 the organization has sufficient number and range of  
29 health care professionals and providers willing to pro-  
30 vide services under the terms of the plan.

31 “(B) DETERMINATION OF SUFFICIENT ACCESS.—  
32 The Secretary shall find that an organization has met  
33 the requirement under subparagraph (A) with respect  
34 to any category of health care professional or provider  
35 if, with respect to that category of provider the plan  
36 has contracts or agreements with a sufficient number

1 and range of providers within such category to provide  
2 covered services under the terms of the plan.

3 “(C) CONSTRUCTION.—Subparagraph (B) shall  
4 not be construed as restricting the persons from whom  
5 enrollees under such a plan may obtain covered bene-  
6 fits.

7 “(c) PAYMENTS TO PREFERRED PROVIDER ORGANIZA-  
8 TIONS.—

9 “(1) PAYMENTS TO ORGANIZATIONS.—

10 “(A) MONTHLY PAYMENTS.—

11 “(i) IN GENERAL.—Under a contract under  
12 section 1857 and subject to paragraph (5), sub-  
13 section (e), and section 1859(e)(4), the Secretary  
14 shall make, to each preferred provider organization,  
15 with respect to coverage of an individual for a  
16 month under this part in a preferred provider re-  
17 gion, separate monthly payments with respect to—

18 “(I) benefits under the original medicare  
19 fee-for-service program under parts A and B in  
20 accordance with paragraph (4); and

21 “(II) benefits under the voluntary pre-  
22 scription drug program under part D in ac-  
23 cordance with section 1858A and the other pro-  
24 visions of this part.

25 “(ii) SPECIAL RULE FOR END-STAGE RENAL  
26 DISEASE.—The Secretary shall establish separate  
27 rates of payment applicable with respect to classes  
28 of individuals determined to have end-stage renal  
29 disease and enrolled in a preferred provider organi-  
30 zation plan under this clause that are similar to the  
31 separate rates of payment described in section  
32 1853(a)(1)(B).

33 “(B) ADJUSTMENT TO REFLECT NUMBER OF EN-  
34 ROLLEES.—The Secretary may retroactively adjust the  
35 amount of payment under this paragraph in a manner  
36 that is similar to the manner in which payment

1 amounts may be retroactively adjusted under section  
2 1853(a)(2).

3 “(C) COMPREHENSIVE RISK ADJUSTMENT METH-  
4 ODOLOGY.—The Secretary shall apply the comprehen-  
5 sive risk adjustment methodology described in section  
6 1853(a)(3)(B) to 100 percent of the amount of pay-  
7 ments to plans under paragraph (4)(D)(ii).

8 “(D) ADJUSTMENT FOR SPENDING VARIATIONS  
9 WITHIN A REGION.—The Secretary shall establish a  
10 methodology for adjusting the amount of payments to  
11 plans under paragraph (4)(D)(ii) that achieves the  
12 same objective as the adjustment described in para-  
13 graph 1853(a)(2)(C).

14 “(2) ANNUAL CALCULATION OF BENCHMARK AMOUNTS  
15 FOR PREFERRED PROVIDER REGIONS.—For each year (be-  
16 ginning in 2006), the Secretary shall calculate a benchmark  
17 amount for each preferred provider region for each month  
18 for such year with respect to coverage of the benefits avail-  
19 able under the original medicare fee-for-service program op-  
20 tion equal to the average of each benchmark amount cal-  
21 culated under section 1853(a)(4) for each  
22 MedicareAdvantage payment area for the year within such  
23 region, weighted by the number of MedicareAdvantage eli-  
24 gible individuals residing in each such payment area for the  
25 year.

26 “(3) ANNUAL ANNOUNCEMENT OF PAYMENT FAC-  
27 TORS.—

28 “(A) ANNUAL ANNOUNCEMENT.—Beginning in  
29 2005, at the same time as the Secretary publishes the  
30 risk adjusters under section 1860D–11, the Secretary  
31 shall annually announce (in a manner intended to pro-  
32 vide notice to interested parties) the following payment  
33 factors:

34 “(i) The benchmark amount for each preferred  
35 provider region (as calculated under paragraph  
36 (2)(A)) for the year.

1                   “(ii) The factors to be used for adjusting pay-  
2                   ments described under—

3                   “(I) the comprehensive risk adjustment  
4                   methodology described in paragraph (1)(C)  
5                   with respect to each preferred provider region  
6                   for the year; and

7                   “(II) the methodology used for adjustment  
8                   for geographic variations within such region es-  
9                   tablished under paragraph (1)(D).

10                   “(B) ADVANCE NOTICE OF METHODOLOGICAL  
11                   CHANGES.—At least 45 days before making the an-  
12                   nouncement under subparagraph (A) for a year, the  
13                   Secretary shall—

14                   “(i) provide for notice to preferred provider or-  
15                   ganizations of proposed changes to be made in the  
16                   methodology from the methodology and assump-  
17                   tions used in the previous announcement; and

18                   “(ii) provide such organizations with an oppor-  
19                   tunity to comment on such proposed changes.

20                   “(C) EXPLANATION OF ASSUMPTIONS.—In each  
21                   announcement made under subparagraph (A), the Sec-  
22                   retary shall include an explanation of the assumptions  
23                   and changes in methodology used in the announcement  
24                   in sufficient detail so that preferred provider organiza-  
25                   tions can compute each payment factor described in  
26                   such subparagraph.

27                   “(4) SECRETARY’S DETERMINATION OF PAYMENT  
28                   AMOUNT FOR BENEFITS UNDER THE ORIGINAL MEDICARE  
29                   FEE-FOR-SERVICE PROGRAM.—The Secretary shall deter-  
30                   mine the payment amount for plans as follows:

31                   “(A) REVIEW OF PLAN BIDS.—The Secretary shall  
32                   review each plan bid submitted under subsection (d)(1)  
33                   for the coverage of benefits under the original medicare  
34                   fee-for-service program option to ensure that such bids  
35                   are consistent with the requirements under this part  
36                   and are based on the assumptions described in section

1 1854(a)(2)(A)(iii) that the plan used with respect to  
2 numbers of enrolled individuals.

3 “(B) DETERMINATION OF PREFERRED PROVIDER  
4 REGIONAL BENCHMARK AMOUNTS.—The Secretary  
5 shall calculate a preferred provider regional benchmark  
6 amount for that plan for the benefits under the original  
7 medicare fee-for-service program option for each plan  
8 equal to the regional benchmark adjusted by using the  
9 assumptions described in section 1854(a)(2)(A)(iii)  
10 that the plan used with respect to numbers of enrolled  
11 individuals.

12 “(C) COMPARISON TO BENCHMARK.—The Sec-  
13 retary shall determine the difference between each plan  
14 bid (as adjusted under subparagraph (A)) and the pre-  
15 ferred provider regional benchmark amount (as deter-  
16 mined under subparagraph (B)) for purposes of  
17 determining—

18 “(i) the payment amount under subparagraph  
19 (D); and

20 “(ii) the additional benefits required and  
21 MedicareAdvantage monthly basic beneficiary pre-  
22 miums.

23 “(D) DETERMINATION OF PAYMENT AMOUNT.—

24 “(i) IN GENERAL.—Subject to clause (ii), the  
25 Secretary shall determine the payment amount to  
26 a preferred provider organization for a preferred  
27 provider organization plan as follows:

28 “(I) BIDS THAT EQUAL OR EXCEED THE  
29 BENCHMARK.—In the case of a plan bid that  
30 equals or exceeds the preferred provider re-  
31 gional benchmark amount, the amount of each  
32 monthly payment to the organization with re-  
33 spect to each individual enrolled in a plan shall  
34 be the preferred provider regional benchmark  
35 amount.

36 “(II) BIDS BELOW THE BENCHMARK.—In  
37 the case of a plan bid that is less than the pre-

1           ferred provider regional benchmark amount,  
2           the amount of each monthly payment to the or-  
3           ganization with respect to each individual en-  
4           rolled in a plan shall be the preferred provider  
5           regional benchmark amount reduced by the  
6           amount of any premium reduction elected by  
7           the plan under section 1854(d)(1)(A)(i).

8           “(ii) APPLICATION OF ADJUSTMENT METH-  
9           ODOLOGIES.—The Secretary shall adjust the  
10          amounts determined under subparagraph (A) using  
11          the factors described in paragraph (3)(A)(ii).

12          “(E) FACTORS USED IN ADJUSTING BIDS AND  
13          BENCHMARKS FOR PREFERRED PROVIDER ORGANIZA-  
14          TIONS AND IN DETERMINING ENROLLEE PREMIUMS.—  
15          Subject to subparagraph (F), in addition to the factors  
16          used to adjust payments to plans described in section  
17          1853(d)(6), the Secretary shall use the adjustment for  
18          geographic variation within the region established  
19          under paragraph (1)(D).

20          “(F) ADJUSTMENT FOR NATIONAL COVERAGE DE-  
21          TERMINATIONS AND LEGISLATIVE CHANGES IN BENE-  
22          FITS.—The Secretary shall provide for adjustments for  
23          national coverage determinations and legislative  
24          changes in benefits applicable with respect to preferred  
25          provider organizations in the same manner as the Sec-  
26          retary provides for adjustments under section  
27          1853(d)(7).

28          “(5) PAYMENTS FROM TRUST FUND.—The payment to  
29          a preferred provider organization under this section shall  
30          be made from the Federal Hospital Insurance Trust Fund  
31          and the Federal Supplementary Medical Insurance Trust  
32          Fund in a manner similar to the manner described in sec-  
33          tion 1853(g).

34          “(6) SPECIAL RULE FOR CERTAIN INPATIENT HOS-  
35          PITAL STAYS.—Rules similar to the rules applicable under  
36          section 1853(h) shall apply with respect preferred provider  
37          organizations.

1           “(7) SPECIAL RULE FOR HOSPICE CARE.—Rules simi-  
2           lar to the rules applicable under section 1853(i) shall apply  
3           with respect to preferred provider organizations.

4           “(d) SUBMISSION OF BIDS BY PPOS; PREMIUMS.—

5           “(1) SUBMISSION OF BIDS BY PREFERRED PROVIDER  
6           ORGANIZATIONS.—

7           “(A) IN GENERAL.—For the requirements on sub-  
8           missions by MedicareAdvantage preferred provider or-  
9           ganization plans, see section 1854(a)(1).

10          “(B) UNIFORM PREMIUMS.—Each bid amount  
11          submitted under subparagraph (A) for a preferred pro-  
12          vider organization plan in a preferred provider region  
13          may not vary among MedicareAdvantage eligible indi-  
14          viduals residing in such preferred provider region.

15          “(C) APPLICATION OF FEHBP STANDARD; PROHI-  
16          BITION ON PRICE GOUGING.—Each bid amount sub-  
17          mitted under subparagraph (A) for a preferred provider  
18          organization plan must reasonably and equitably reflect  
19          the cost of benefits provided under that plan.

20          “(D) REVIEW.—The Secretary shall review the ad-  
21          justed community rates (as defined in section  
22          1854(g)(3)), the amounts of the MedicareAdvantage  
23          monthly basic premium and the MedicareAdvantage  
24          monthly beneficiary premium for enhanced medical  
25          benefits filed under this paragraph and shall approve or  
26          disapprove such rates and amounts so submitted. The  
27          Secretary shall review the actuarial assumptions and  
28          data used by the preferred provider organization with  
29          respect to such rates and amounts so submitted to de-  
30          termine the appropriateness of such assumptions and  
31          data.

32          “(E) AUTHORITY TO LIMIT NUMBER OF PLANS IN  
33          A REGION.—If there are bids for more than 3 preferred  
34          provider organization plans in a preferred provider re-  
35          gion, the Secretary shall accept only the 3 lowest-cost  
36          credible bids for that region that meet or exceed the

1 quality and minimum standards applicable under this  
2 section.

3 “(2) MONTHLY PREMIUMS CHARGED.—The amount of  
4 the monthly premium charged to an individual enrolled in  
5 a preferred provider organization plan offered by a pre-  
6 ferred provider organization shall be equal to the sum of  
7 the following:

8 “(A) The MedicareAdvantage monthly basic bene-  
9 ficiary premium, as defined in section 1854(b)(2)(A) (if  
10 any).

11 “(B) The MedicareAdvantage monthly beneficiary  
12 premium for enhanced medical benefits, as defined in  
13 section 1854(b)(2)(C) (if any).

14 “(C) The MedicareAdvantage monthly obligation  
15 for qualified prescription drug coverage, as defined in  
16 section 1854(b)(2)(B) (if any).

17 “(3) DETERMINATION OF PREMIUM REDUCTIONS, RE-  
18 DUCED COST-SHARING, ADDITIONAL BENEFITS, AND BENE-  
19 FICIARY PREMIUMS.—The rules for determining premium  
20 reductions, reduced cost-sharing, additional benefits, and  
21 beneficiary premiums under section 1854(d) shall apply  
22 with respect to preferred provider organizations.

23 “(4) PROHIBITION OF SEGMENTING PREFERRED PRO-  
24 VIDER REGIONS.—The Secretary may not permit a pre-  
25 ferred provider organization to elect to apply the provisions  
26 of this section uniformly to separate segments of a pre-  
27 ferred provider region (rather than uniformly to an entire  
28 preferred provider region).

29 “(e) PORTION OF TOTAL PAYMENTS TO AN ORGANIZA-  
30 TION SUBJECT TO RISK FOR 2 YEARS.—

31 “(1) NOTIFICATION OF SPENDING UNDER THE  
32 PLAN.—

33 “(A) IN GENERAL.—For 2007 and 2008, the pre-  
34 ferred provider organization offering a preferred pro-  
35 vider organization plan shall notify the Secretary of the  
36 total amount of costs that the organization incurred in  
37 providing benefits covered under parts A and B of the

1 original medicare fee-for-service program for all enroll-  
2 ees under the plan in the previous year.

3 “(B) CERTAIN EXPENSES NOT INCLUDED.—The  
4 total amount of costs specified in subparagraph (A)  
5 may not include—

6 “(i) subject to subparagraph (C), administra-  
7 tive expenses incurred in providing the benefits de-  
8 scribed in such subparagraph; or

9 “(ii) amounts expended on providing enhanced  
10 medical benefits under section 1852(a)(3)(D).

11 “(C) ESTABLISHMENT OF ALLOWABLE ADMINIS-  
12 TRATIVE EXPENSES.—For purposes of applying sub-  
13 subparagraph (B)(i), the administrative expenses incurred  
14 in providing benefits described in subparagraph (A)  
15 under a preferred provider organization plan may not  
16 exceed an amount determined appropriate by the Ad-  
17 ministrator.

18 “(2) ADJUSTMENT OF PAYMENT.—

19 “(A) NO ADJUSTMENT IF COSTS WITHIN RISK  
20 CORRIDOR.—If the total amount of costs specified in  
21 paragraph (1)(A) for the plan for the year are not  
22 more than the first threshold upper limit of the risk  
23 corridor (specified in paragraph (3)(A)(iii)) and are not  
24 less than the first threshold lower limit of the risk cor-  
25 ridor (specified in paragraph (3)(A)(i)) for the plan for  
26 the year, then no additional payments shall be made by  
27 the Secretary and no reduced payments shall be made  
28 to the preferred provider organization offering the plan.

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

31 “(i) IN GENERAL.—If the total amount of  
32 costs specified in paragraph (1)(A) for the plan for  
33 the year are more than the first threshold upper  
34 limit of the risk corridor for the plan for the year,  
35 then the Secretary shall increase the total of the  
36 monthly payments made to the preferred provider  
37 organization offering the plan for the year under

1 subsection (c)(1)(A) by an amount equal to the  
2 sum of—

3 “(I) 50 percent of the amount of such  
4 total costs which are more than such first  
5 threshold upper limit of the risk corridor and  
6 not more than the second threshold upper limit  
7 of the risk corridor for the plan for the year (as  
8 specified under paragraph (3)(A)(iv)); and

9 “(II) 10 percent of the amount of such  
10 total costs which are more than such second  
11 threshold upper limit of the risk corridor.

12 “(C) REDUCTION IN PAYMENT IF COSTS BELOW  
13 LOWER LIMIT OF RISK CORRIDOR.—If the total amount  
14 of costs specified in paragraph (1)(A) for the plan for  
15 the year are less than the first threshold lower limit of  
16 the risk corridor for the plan for the year, then the  
17 Secretary shall reduce the total of the monthly pay-  
18 ments made to the preferred provider organization of-  
19 fering the plan for the year under subsection (c)(1)(A)  
20 by an amount (or otherwise recover from the plan an  
21 amount) equal to—

22 “(i) 50 percent of the amount of such total  
23 costs which are less than such first threshold lower  
24 limit of the risk corridor and not less than the sec-  
25 ond threshold lower limit of the risk corridor for  
26 the plan for the year (as specified under paragraph  
27 (3)(A)(ii)); and

28 “(ii) 10 percent of the amount of such total  
29 costs which are less than such second threshold  
30 lower limit of the risk corridor.

31 “(3) ESTABLISHMENT OF RISK CORRIDORS.—

32 “(A) IN GENERAL.—For 2006 and 2007, the Sec-  
33 retary shall establish a risk corridor for each preferred  
34 provider organization plan. The risk corridor for a plan  
35 for a year shall be equal to a range as follows:

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

4                   “(I) the target amount described in sub-  
5 paragraph (B) for the plan; minus

6                   “(II) an amount equal to 5 percent of  
7 such target amount.

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

11                   “(I) the target amount described in sub-  
12 paragraph (B) for the plan; minus

13                   “(II) an amount equal to 10 percent of  
14 such target amount.

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

18                   “(I) such target amount; and

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

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

24                   “(I) such target amount; and

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

27                   “(B) TARGET AMOUNT DESCRIBED.—The target  
28 amount described in this paragraph is, with respect to  
29 a preferred provider organization plan offered by a pre-  
30 ferred provider organization in a year, an amount equal  
31 to the sum of—

32                   “(i) the total monthly payments made to the  
33 organization for enrollees in the plan for the year  
34 under subsection (c)(1)(A); and

35                   “(ii) the total MedicareAdvantage basic bene-  
36 ficiary premiums collected for such enrollees for the  
37 year under subsection (d)(2)(A).

1           “(4) PLANS AT RISK FOR ENTIRE AMOUNT OF EN-  
2           HANCED MEDICAL BENEFITS.—A preferred provider orga-  
3           nization that offers a preferred provider organization plan  
4           that provides enhanced medial benefits under section  
5           1852(a)(3)(D) shall be at full financial risk for the provi-  
6           sion of such benefits.

7           “(5) NO EFFECT ON ELIGIBLE BENEFICIARIES.—No  
8           change in payments made by reason of this subsection shall  
9           affect the amount of the MedicareAdvantage basic bene-  
10          ficiary premium that a beneficiary is otherwise required to  
11          pay under the plan for the year under subsection (d)(2)(A).

12          “(6) DISCLOSURE OF INFORMATION.—The provisions  
13          of section 1860D–16(b)(7), including subparagraph (B) of  
14          such section, shall apply to a preferred provider organiza-  
15          tion and a preferred provider organization plan in the same  
16          manner as such provisions apply to an eligible entity and  
17          a Medicare Prescription Drug plan under part D.

18          “(f) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS  
19          FOR PREFERRED PROVIDER ORGANIZATIONS.—A preferred  
20          provider organization shall be organized and licensed under  
21          State law as a risk-bearing entity eligible to offer health insur-  
22          ance or health benefits coverage in each State within the pre-  
23          ferred provider region in which it offers a preferred provider or-  
24          ganization plan.

25          “(g) INAPPLICABILITY OF PROVIDER-SPONSORED ORGANI-  
26          ZATION SOLVENCY STANDARDS.—The requirements of section  
27          1856 shall not apply with respect to preferred provider organi-  
28          zations.

29          “(h) CONTRACTS WITH PREFERRED PROVIDER ORGANI-  
30          ZATIONS.—The provisions of section 1857 shall apply to a pre-  
31          ferred provider organization plan offered by a preferred pro-  
32          vider organization under this section.”.

33          (c) PREFERRED PROVIDER TERMINOLOGY DEFINED.—  
34          Section 1859(a) is amended by adding at the end the following  
35          new paragraph:

36                  “(3) PREFERRED PROVIDER ORGANIZATION; PRE-  
37          ferred provider organization plan; preferred pro-

1 VIDER REGION.—The terms ‘preferred provider organiza-  
2 tion’, ‘preferred provider organization plan’, and ‘preferred  
3 provider region’ have the meaning given such terms in sec-  
4 tion 1858(a)(2).”.

5 **Subtitle C—Other Managed Care**  
6 **Reforms**

7 **SEC. 221. EXTENSION OF REASONABLE COST CON-**  
8 **TRACTS.**

9 (a) FIVE-YEAR EXTENSION.—Section 1876(h)(5)(C) (42  
10 U.S.C. 1395mm(h)(5)(C)) is amended by striking “2004” and  
11 inserting “2009”.

12 (b) APPLICATION OF CERTAIN MEDICARE+ CHOICE RE-  
13 QUIREMENTS TO COST CONTRACTS EXTENDED OR RENEWED  
14 AFTER 2003.—Section 1876(h) (42 U.S.C. 1395mm(h)(5)), as  
15 amended by subsection (a), is amended—

16 (1) by redesignating paragraph (5) as paragraph (6);  
17 and

18 (2) by inserting after paragraph (4) the following new  
19 paragraph:

20 “(5) Any reasonable cost reimbursement contract with an  
21 eligible organization under this subsection that is extended or  
22 renewed on or after the date of enactment of the Prescription  
23 Drug and Medicare Improvements Act of 2003 for plan years  
24 beginning on or after January 1, 2004, shall provide that the  
25 following provisions of the Medicare+ Choice program under  
26 part C (and, on and after January 1, 2006, the provisions of  
27 the MedicareAdvantage program under such part) shall apply  
28 to such organization and such contract in a substantially simi-  
29 lar manner as such provisions apply to Medicare+ Choice orga-  
30 nizations and Medicare+ Choice plans (or, on and after Janu-  
31 ary 1, 2006, MedicareAdvantage organizations and  
32 MedicareAdvantage plans, respectively) under such part:

33 “(A) Paragraph (1) of section 1852(e) (relating to the  
34 requirement of having an ongoing quality assurance pro-  
35 gram) and paragraph (2)(B) of such section (relating to  
36 the required elements for such a program).

1           “(B) Section 1852(j)(4) (relating to limitations on  
2 physician incentive plans).

3           “(C) Section 1854(c) (relating to the requirement of  
4 uniform premiums among individuals enrolled in the plan).

5           “(D) Section 1854(g), or, on and after January 1,  
6 2006, section 1854(h) (relating to restrictions on imposi-  
7 tion of premium taxes with respect to payments to organi-  
8 zations).

9           “(E) Section 1856(b) (regarding compliance with the  
10 standards established by regulation pursuant to such sec-  
11 tion, including the provisions of paragraph (3) of such sec-  
12 tion relating to relation to State laws).

13           “(F) Section 1852(a)(3)(A) (regarding the authority  
14 of organizations to include supplemental health care bene-  
15 fits and, on and after January 1, 2006, enhanced medical  
16 benefits under the plan subject to the approval of the Sec-  
17 retary).

18           “(G) The provisions of part C relating to timelines for  
19 benefit filings, contract renewal, and beneficiary notifica-  
20 tion.

21           “(H) Section 1854(e), or, on and after January 1,  
22 2006, section 1854(f) (relating to proposed cost-sharing  
23 under the contract being subject to review by the Sec-  
24 retary).”.

25           (c) PERMITTING DEDICATED GROUP PRACTICE HEALTH  
26 MAINTENANCE ORGANIZATIONS TO PARTICIPATE IN THE MEDI-  
27 CARE COST CONTRACT PROGRAM.—Section 1876(h)(6) of the  
28 Social Security Act (42 U.S.C. 1395mm(h)(6)), as redesignated  
29 and amended by subsections (a) and (b), is amended—

30           (1) in subparagraph (A), by striking “After the date  
31 of the enactment” and inserting “Except as provided in  
32 subparagraph (C), after the date of the enactment”;

33           (2) in subparagraph (B), by striking “subparagraph  
34 (C)” and inserting “subparagraph (D)”;

35           (3) by redesignating subparagraph (C) as subpara-  
36 graph (D); and

1 (4) by inserting after subparagraph (B), the following  
2 new subparagraph:

3 “(C) Subject to paragraph (5) and subparagraph (D), the  
4 Secretary shall approve an application to enter into a reason-  
5 able cost contract under this section if—

6 “(i) the application is submitted to the Secretary by  
7 a health maintenance organization (as defined in section  
8 1301(a) of the Public Health Service Act) that, as of Janu-  
9 ary 1, 2004, and except as provided in section  
10 1301(b)(3)(B) of such Act, provides at least 85 percent of  
11 the services of a physician which are provided as basic  
12 health services through a medical group (or groups), as de-  
13 fined in section 1302(4) of such Act; and

14 “(ii) the Secretary determines that the organization  
15 meets the requirements applicable to such organizations  
16 and contracts under this section.”.

17 **SEC. 222. SPECIALIZED MEDICARE+CHOICE PLANS FOR**  
18 **SPECIAL NEEDS BENEFICIARIES.**

19 (a) TREATMENT AS COORDINATED CARE PLAN.—Section  
20 1851(a)(2)(A) (42 U.S.C. 1395w-21(a)(2)(A)) is amended by  
21 adding at the end the following new sentence: “Specialized  
22 Medicare+ Choice plans for special needs beneficiaries (as de-  
23 fined in section 1859(b)(4)) may be any type of coordinated  
24 care plan.”.

25 (b) SPECIALIZED MEDICARE+ CHOICE PLAN FOR SPECIAL  
26 NEEDS BENEFICIARIES DEFINED.—Section 1859(b) (42  
27 U.S.C. 1395w-28(b)) is amended by adding at the end the fol-  
28 lowing new paragraph:

29 “(4) SPECIALIZED MEDICARE+ CHOICE PLANS FOR  
30 SPECIAL NEEDS BENEFICIARIES.—

31 “(A) IN GENERAL.—The term ‘specialized  
32 Medicare+ Choice plan for special needs beneficiaries’  
33 means a Medicare+ Choice plan that exclusively serves  
34 special needs beneficiaries (as defined in subparagraph  
35 (B)).

1           “(B) SPECIAL NEEDS BENEFICIARY.—The term  
2           ‘special needs beneficiary’ means a Medicare+ Choice  
3           eligible individual who—

4                   “(i) is institutionalized (as defined by the Sec-  
5                   retary);

6                   “(ii) is entitled to medical assistance under a  
7                   State plan under title XIX; or

8                   “(iii) meets such requirements as the Sec-  
9                   retary may determine would benefit from enroll-  
10                  ment in such a specialized Medicare+ Choice plan  
11                  described in subparagraph (A) for individuals with  
12                  severe or disabling chronic conditions.”.

13           (c) RESTRICTION ON ENROLLMENT PERMITTED.—Section  
14           1859 (42 U.S.C. 1395w-28) is amended by adding at the end  
15           the following new subsection:

16                   “(f) RESTRICTION ON ENROLLMENT FOR SPECIALIZED  
17                   MEDICARE+ CHOICE PLANS FOR SPECIAL NEEDS BENE-  
18                   FICIARIES.—In the case of a specialized Medicare+ Choice plan  
19                   (as defined in subsection (b)(4)), notwithstanding any other  
20                   provision of this part and in accordance with regulations of the  
21                   Secretary and for periods before January 1, 2008, the plan  
22                   may restrict the enrollment of individuals under the plan to in-  
23                   dividuals who are within 1 or more classes of special needs  
24                   beneficiaries.”.

25           (d) REPORT TO CONGRESS.—Not later than December 31,  
26           2006, the Secretary shall submit to Congress a report that as-  
27           sesses the impact of specialized Medicare+ Choice plans for spe-  
28           cial needs beneficiaries on the cost and quality of services pro-  
29           vided to enrollees. Such report shall include an assessment of  
30           the costs and savings to the medicare program as a result of  
31           amendments made by subsections (a), (b), and (c).

32           (e) EFFECTIVE DATES.—

33                   (1) IN GENERAL.—The amendments made by sub-  
34                   sections (a), (b), and (c) shall take effect on the date of  
35                   enactment of this Act.

36                   (2) DEADLINE FOR ISSUANCE OF REQUIREMENTS FOR  
37                   SPECIAL NEEDS BENEFICIARIES; TRANSITION.—No later

1 than 1 year after the date of enactment of this Act, the  
2 Secretary shall issue final regulations to establish require-  
3 ments for special needs beneficiaries under section  
4 1859(b)(4)(B)(iii) of the Social Security Act, as added by  
5 subsection (b).

6 **SEC. 223. PAYMENT BY PACE PROVIDERS FOR MEDI-**  
7 **CARE AND MEDICAID SERVICES FURNISHED**  
8 **BY NONCONTRACT PROVIDERS.**

9 (a) MEDICARE SERVICES.—

10 (1) MEDICARE SERVICES FURNISHED BY PROVIDERS  
11 OF SERVICES.—Section 1866(a)(1)(O) (42 U.S.C.  
12 1395cc(a)(1)(O)) is amended—

13 (A) by striking “part C or” and inserting “part C,  
14 with a PACE provider under section 1894 or 1934,  
15 or”;

16 (B) by striking “(i)”;

17 (C) by striking “and (ii)”;

18 (D) by striking “members of the organization”  
19 and inserting “members of the organization or PACE  
20 program eligible individuals enrolled with the PACE  
21 provider,”.

22 (2) MEDICARE SERVICES FURNISHED BY PHYSICIANS  
23 AND OTHER ENTITIES.—Section 1894(b) (42 U.S.C.  
24 1395eee(b)) is amended by adding at the end the following  
25 new paragraphs:

26 “(3) TREATMENT OF MEDICARE SERVICES FURNISHED  
27 BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—

28 “(A) APPLICATION OF MEDICARE+ CHOICE RE-  
29 QUIREMENT WITH RESPECT TO MEDICARE SERVICES  
30 FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER  
31 ENTITIES.—Section 1852(k)(1) (relating to limitations  
32 on balance billing against Medicare+ Choice organiza-  
33 tions for noncontract physicians and other entities with  
34 respect to services covered under this title) shall apply  
35 to PACE providers, PACE program eligible individuals  
36 enrolled with such PACE providers, and physicians and  
37 other entities that do not have a contract establishing

1 payment amounts for services furnished to such an in-  
2 dividual in the same manner as such section applies to  
3 Medicare+ Choice organizations, individuals enrolled  
4 with such organizations, and physicians and other enti-  
5 ties referred to in such section.

6 “(B) REFERENCE TO RELATED PROVISION FOR  
7 NONCONTRACT PROVIDERS OF SERVICES.—For the pro-  
8 vision relating to limitations on balance billing against  
9 PACE providers for services covered under this title  
10 furnished by noncontract providers of services, see sec-  
11 tion 1866(a)(1)(O).

12 “(4) REFERENCE TO RELATED PROVISION FOR  
13 SERVICES COVERED UNDER TITLE XIX BUT NOT UNDER  
14 THIS TITLE.—For provisions relating to limitations on  
15 payments to providers participating under the State  
16 plan under title XIX that do not have a contract with  
17 a PACE provider establishing payment amounts for  
18 services covered under such plan (but not under this  
19 title) when such services are furnished to enrollees of  
20 that PACE provider, see section 1902(a)(66).”.

21 (b) MEDICAID SERVICES.—

22 (1) REQUIREMENT UNDER STATE PLAN.—Section  
23 1902(a) (42 U.S.C. 1396a(a)) is amended—

24 (A) in paragraph (64), by striking “and” at the  
25 end;

26 (B) in paragraph (65), by striking the period at  
27 the end and inserting “; and”; and

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

30 “(66) provide, with respect to services covered  
31 under the State plan (but not under title XVIII) that  
32 are furnished to a PACE program eligible individual  
33 enrolled with a PACE provider by a provider partici-  
34 pating under the State plan that does not have a con-  
35 tract with the PACE provider that establishes payment  
36 amounts for such services, that such participating pro-  
37 vider may not require the PACE provider to pay the

1 participating provider an amount greater than the  
2 amount that would otherwise be payable for the service  
3 to the participating provider under the State plan for  
4 the State where the PACE provider is located (in ac-  
5 cordance with regulations issued by the Secretary).”.

6 (2) REFERENCE IN MEDICAID STATUTE.—Section  
7 1934(b) (42 U.S.C. 1396u-4(b)) is amended by adding at  
8 the end the following new paragraphs:

9 “(3) TREATMENT OF MEDICARE SERVICES FURNISHED  
10 BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—

11 “(A) APPLICATION OF MEDICARE+ CHOICE RE-  
12 QUIREMENT WITH RESPECT TO MEDICARE SERVICES  
13 FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER  
14 ENTITIES.—Section 1852(k)(1) (relating to limitations  
15 on balance billing against Medicare+ Choice organiza-  
16 tions for noncontract physicians and other entities with  
17 respect to services covered under title XVIII) shall  
18 apply to PACE providers, PACE program eligible indi-  
19 viduals enrolled with such PACE providers, and physi-  
20 cians and other entities that do not have a contract es-  
21 tablishing payment amounts for services furnished to  
22 such an individual in the same manner as such section  
23 applies to Medicare+ Choice organizations, individuals  
24 enrolled with such organizations, and physicians and  
25 other entities referred to in such section.

26 “(B) REFERENCE TO RELATED PROVISION FOR  
27 NONCONTRACT PROVIDERS OF SERVICES.—For the pro-  
28 vision relating to limitations on balance billing against  
29 PACE providers for services covered under title XVIII  
30 furnished by noncontract providers of services, see sec-  
31 tion 1866(a)(1)(O).

32 “(4) REFERENCE TO RELATED PROVISION FOR  
33 SERVICES COVERED UNDER THIS TITLE BUT NOT  
34 UNDER TITLE XVIII.—For provisions relating to limita-  
35 tions on payments to providers participating under the  
36 State plan under this title that do not have a contract  
37 with a PACE provider establishing payment amounts

1 for services covered under such plan (but not under  
2 title XVIII) when such services are furnished to enroll-  
3 ees of that PACE provider, see section 1902(a)(66).”.

4 (c) EFFECTIVE DATE.—The amendments made by this  
5 section shall apply to services furnished on or after January 1,  
6 2004.

7 **SEC. 224. INSTITUTE OF MEDICINE EVALUATION AND**  
8 **REPORT ON HEALTH CARE PERFORMANCE**  
9 **MEASURES.**

10 (a) EVALUATION.—

11 (1) IN GENERAL.—Not later than the date that is 2  
12 months after the date of enactment of this Act, the Sec-  
13 retary of Health and Human Services shall enter into an  
14 arrangement under which the Institute of Medicine of the  
15 National Academy of Sciences (in this section referred to  
16 as the “Institute”) shall conduct an evaluation of leading  
17 health care performance measures and options to imple-  
18 ment policies that align performance with payment under  
19 the medicare program under title XVIII of the Social Secu-  
20 rity Act (42 U.S.C. 1395 et seq.).

21 (2) SPECIFIC MATTERS EVALUATED.—In conducting  
22 the evaluation under paragraph (1), the Institute shall—

23 (A) catalogue, review, and evaluate the validity of  
24 leading health care performance measures;

25 (B) catalogue and evaluate the success and utility  
26 of alternative performance incentive programs in public  
27 or private sector settings; and

28 (C) identify and prioritize options to implement  
29 policies that align performance with payment under the  
30 medicare program that indicate—

31 (i) the performance measurement set to be  
32 used and how that measurement set will be up-  
33 dated;

34 (ii) the payment policy that will reward per-  
35 formance; and

1 (iii) the key implementation issues (such as  
2 data and information technology requirements) that  
3 must be addressed.

4 (3) SCOPE OF HEALTH CARE PERFORMANCE MEAS-  
5 URES.—The health care performance measures described in  
6 paragraph (2)(A) shall encompass a variety of perspectives,  
7 including physicians, hospitals, health plans, purchasers,  
8 and consumers.

9 (4) CONSULTATION WITH MEDPAC.—In evaluating the  
10 matters described in paragraph (2)(C), the Institute shall  
11 consult with the Medicare Payment Advisory Commission  
12 established under section 1805 of the Social Security Act  
13 (42 U.S.C. 1395b–6).

14 (b) REPORT.—Not later than the date that is 18 months  
15 after the date of enactment of this Act, the Institute shall sub-  
16 mit to the Secretary of Health and Human Services, the Com-  
17 mittees on Ways and Means and Energy and Commerce of the  
18 House of Representatives, and the Committee on Finance of  
19 the Senate a report on the evaluation conducted under sub-  
20 section (a)(1) describing the findings of such evaluation and  
21 recommendations for an overall strategy and approach for  
22 aligning payment with performance in the original medicare  
23 fee-for-service program under parts A and B of title XVIII of  
24 the Social Security Act, the Medicare+ Choice program under  
25 part C of such title, and any other programs under such title  
26 XVIII.

27 (c) AUTHORIZATION OF APPROPRIATIONS.—There are au-  
28 thorized to be appropriated \$1,000,000 for purposes of con-  
29 ducting the evaluation and preparing the report required by  
30 this section.

31 **SEC. 225. EXPANDING THE WORK OF MEDICARE QUAL-**  
32 **ITY IMPROVEMENT ORGANIZATIONS TO IN-**  
33 **CLUDE PARTS C AND D.**

34 (a) APPLICATION TO MEDICARE MANAGED CARE AND  
35 PRESCRIPTION DRUG COVERAGE.—Section 1154(a)(1) (42  
36 U.S.C. 1320c–3(a)(1)) is amended by inserting “,  
37 Medicare+ Choice organizations and MedicareAdvantage orga-

1 nizations under part C, and prescription drug card sponsors  
2 and eligible entities under part D” after “under section 1876”.

3 (b) PRESCRIPTION DRUG THERAPY QUALITY IMPROVE-  
4 MENT.—Section 1154(a) (42 U.S.C. 1320c-3(a)) is amended  
5 by adding at the end the following new paragraph:

6 “(17) The organization shall execute its responsibil-  
7 ities under subparagraphs (A) and (B) of paragraph (1) by  
8 offering to providers, practitioners, prescription drug card  
9 sponsors and eligible entities under part D, and  
10 Medicare+ Choice and MedicareAdvantage plans under part  
11 C quality improvement assistance pertaining to prescription  
12 drug therapy. For purposes of this part and title XVIII,  
13 the functions described in this paragraph shall be treated  
14 as a review function.”.

15 (c) EFFECTIVE DATE.—The amendments made by this  
16 section shall apply on and after January 1, 2004.