

# [COMMITTEE PRINT]

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 3 ation Act of 2005”.

## 4 **CHAPTER 1—PAYMENT FOR** 5 **PRESCRIPTION DRUGS**

### 6 **SEC. 3101. FEDERAL UPPER PAYMENT LIMIT (FUL).**

7 (a) IN GENERAL.—Subsection (e) of section 1927 of  
 8 the Social Security Act (42 U.S.C. 1396r–8) is amended  
 9 to read as follows:

10 “(e) PHARMACY REIMBURSEMENT LIMITS.—

11 “(1) UPPER PAYMENT LIMIT FOR INGREDIENT  
 12 COST OF COVERED OUTPATIENT DRUGS.—

13 “(A) IN GENERAL.—Subject to subpara-  
 14 graph (B), no Federal financial participation  
 15 shall be available for payment for the ingredient

1 cost of a covered outpatient drug in excess of  
2 the upper payment limit for that drug estab-  
3 lished under paragraph (2).

4 “(B) OPTIONAL CARVE OUT.—A State may  
5 elect not to apply subparagraph (A) to payment  
6 for a covered outpatient drug dispensed by any  
7 (or any combination) of the following:

8 “(i) Pharmacies in a nursing facility.

9 “(ii) Pharmacies in hospitals.

10 “(iii) Specialty pharmacies (such as  
11 those dispensing only immunosuppressive  
12 drugs), as defined by the Secretary.

13 “(2) UPPER PAYMENT LIMIT.—

14 “(A) IN GENERAL.—Except as provided in  
15 subparagraph (D), the upper payment limit es-  
16 tablished under this paragraph for the ingre-  
17 dient cost of a—

18 “(i) single source drug, is 106 percent  
19 of the RAMP (as defined in subparagraph  
20 (B)(i)) for that drug; and

21 “(ii) multiple source drug is 120 per-  
22 cent of the volume weighted average  
23 RAMP for that drug (as defined under  
24 subparagraph (C)).

1 “(B) RAMP AND RELATED PROVISIONS.—

2 For purposes of this subsection:

3 “(i) RAMP DEFINED.—The term  
4 ‘RAMP’ means, with respect to a covered  
5 outpatient drug by a manufacturer for a  
6 calendar quarter and subject to clause (ii)  
7 and (iii), the average price paid to a manu-  
8 facturer for the drug in the United States  
9 in the quarter by wholesalers for drugs dis-  
10 tributed to retail pharmacies, after deduct-  
11 ing customary prompt pay discounts and  
12 excluding service fees that are paid by the  
13 manufacturer to an entity and that rep-  
14 resent fair market value for a bona-fide  
15 service provided by the entity and that are  
16 not passed on, in whole in part, to a client  
17 or customer of the entity.

18 “(ii) SALES EXEMPTED FROM COM-  
19 PUTATION.—The RAMP under clause (i)  
20 shall be calculated without regard to—

21 “(I) sales exempt from inclusion  
22 in the determination of best price  
23 under subsection (c)(1)(C)(i); and

24 “(II) such other sales as the Sec-  
25 retary identifies as sales to an entity

1 that are merely nominal in amount  
2 under subsection (c)(1)(C)(ii)(III).

3 “(iii) SALE PRICE NET OF DIS-  
4 COUNTS.—In calculating the RAMP under  
5 clause (i), such AMP shall include any of  
6 the following:

7 “(I) Cash discounts and volume  
8 discounts.

9 “(II) Free goods that are contin-  
10 gent upon any purchase requirement  
11 or agreement.

12 “(III) Sales at a nominal price  
13 that are contingent upon any pur-  
14 chase requirement or agreement.

15 “(IV) Chargebacks, rebates pro-  
16 vided to a pharmacy (not including re-  
17 bates provided under an agreement  
18 under this section), or any other di-  
19 rect or indirect discounts.

20 “(V) Any other price concessions,  
21 which may be based on recommenda-  
22 tions of the Inspector General of the  
23 Department of Health and Human  
24 Services, that would result in a reduc-  
25 tion of the cost to the purchaser.

1                   “(iv) RETAIL PHARMACY.—For pur-  
2                   poses of this subsection, the term ‘retail  
3                   pharmacy’ does not include mail-order only  
4                   pharmacies or pharmacies at nursing facili-  
5                   ties and homes.

6                   “(C) VOLUME WEIGHTED AVERAGE RAMP  
7                   DEFINED.—For purposes of subparagraph (A),  
8                   the volume weighted average RAMP for a cov-  
9                   ered outpatient drug means, with respect to a  
10                  calendar quarter, the RAMP paid to all manu-  
11                  facturers by wholesalers for the drug, weighted  
12                  by volume for retail pharmacies for the entire  
13                  class of drugs with the same chemical composi-  
14                  tion and dosage form. Such weighted average  
15                  shall be a volume-weighted average for all Na-  
16                  tional Drug Codes (NDC) assigned to the drug  
17                  product and shall be computed using the same  
18                  methodology as is used in computing the  
19                  weighted average of average sale prices under  
20                  section 1847A(b)(3).

21                  “(D) EXCEPTION FOR INITIAL SALES PE-  
22                  RIODS.—In the case of a single source drug  
23                  during an initial sales period (not to exceed 2  
24                  calendar quarters) in which data on sales for  
25                  the drug are not sufficiently available from the

1 manufacturer to compute the RAMP or the  
2 weighted average RAMP under subparagraph  
3 (C), the upper payment limit for the ingredient  
4 cost of such drug during such period shall be  
5 the wholesale acquisition cost (as defined in sec-  
6 tion 1847A(c)(6)(B)) for the drug.

7 “(E) UPDATES; DATA COLLECTION.—

8 “(i) FREQUENCY OF DETERMINA-  
9 TION.—The Secretary shall update the  
10 upper payment limits applicable under this  
11 paragraph on at least a quarterly basis,  
12 taking into account the most recent data  
13 collected for purposes of determining such  
14 limits and the Food and Drug Administra-  
15 tion’s most recent publication of ‘Approved  
16 Drug Products with Therapeutic Equiva-  
17 lence Evaluations’.

18 “(ii) COLLECTION OF DATA.—Data on  
19 RAMP is collected under subsection  
20 (b)(3)(A)(iv).

21 “(F) AUTHORITY TO ENTER CON-  
22 TRACTS.—The Secretary may enter into con-  
23 tracts with appropriate entities to determine  
24 sales prices and other data necessary to cal-  
25 culate the upper payment limit for a covered

1           outpatient drug established under this sub-  
2           section and to calculate that payment limit.

3           “(3) DISPENSING FEES.—

4                   “(A) IN GENERAL.—A State which pro-  
5           vides medical assistance for covered outpatient  
6           drugs shall pay a dispensing fee for each cov-  
7           ered outpatient drug for which Federal finan-  
8           cial participation is available in accordance with  
9           this section in accordance with this paragraph.

10                   “(B) DISPENSING FEE PAYMENT FOR  
11           MULTIPLE SOURCE DRUGS.—A State shall es-  
12           tablish a dispensing fee under this title for a  
13           covered outpatient drugs that is a multiple  
14           source drug that is not less than \$8 per pre-  
15           scription (as defined by the Secretary).

16                   “(C) VARIATION IN DISPENSING FEES.—A  
17           State may vary the amount of such dispensing  
18           fees consistent with subparagraph (B) to take  
19           into account the special circumstances of—

20                           “(i) pharmacies serving rural and un-  
21                           derserved areas; and

22                           “(ii) sole community pharmacies.

23           “(4) EFFECT ON STATE MAXIMUM ALLOWABLE  
24           COST LIMITATIONS.—This section shall not super-  
25           sede or affect provisions in effect prior to January

1 1, 1991, or after December 31, 1994, relating to  
2 any maximum allowable cost limitation established  
3 by a State for payment by the State for covered out-  
4 patient drugs, and rebates shall be made under this  
5 section without regard to whether or not payment by  
6 the State for such drugs is subject to such a limita-  
7 tion or the amount of such a limitation.”.

8 (b) CONFORMING AMENDMENTS.—

9 (1) Subsection (b)(3)(D) of such section is  
10 amended—

11 (A) by striking “and” at the end of clause  
12 (ii);

13 (B) by striking the period at the end of  
14 clause (iii) and inserting “, and”; and

15 (C) by inserting after clause (iv) the fol-  
16 lowing new clause:

17 “(iv) to States to carry out this  
18 title.”.

19 (2) Section 1903(i)(10) of such Act (42 U.S.C.  
20 1396b(i)(10)) is amended—

21 (A) in subparagraph (A), by striking  
22 “and” at the end;

23 (B) in subparagraph (B), by striking “or”  
24 at the end and inserting “and”; and

25 (C) by adding at the end the following:

1           “(C) with respect to any amount expended for  
2           the ingredient cost of a covered outpatient drug that  
3           exceeds the upper payment limit for that drug estab-  
4           lished and applied under section 1927(e); or”.

5           (c) EFFECTIVE DATE.—The amendments made by  
6 this section take effect with respect to a State on the later  
7 of—

8           (1) January 1, 2007; or

9           (2) the date that is 6 months after the close of  
10          the first regular session of the State legislature that  
11          begins after the date of the enactment of this Act.

12          (d) GAO STUDY ON DISPENSING FEES.—The Comp-  
13 troller General of the United States shall conduct a study  
14 on the appropriateness in payment levels to pharmacies  
15 for dispensing fees under the medicaid program. Not later  
16 than 1 year after the date of the enactment of this Act,  
17 the Comptroller General shall submit to Congress a report  
18 on such study.

19          (e) IG REPORT ON USE OF RAMP.—Not later than  
20 1 year after the date of the enactment of this Act, the  
21 Inspector General in the Department of Health and  
22 Human Services shall submit to Congress a report on—

23           (1) the appropriateness of using the RAMP,  
24           rather than the average manufacturer price or other  
25           price measures, as the basis for establishing a Fed-

1       eral upper payment limit for reimbursement for cov-  
2       ered outpatient drugs under the medicaid program;  
3       and

4               (2) payment of specialty pharmacies under the  
5       Medicaid program for covered outpatient drugs.

6       **SEC. 3102. COLLECTION AND SUBMISSION OF UTILIZATION**  
7                       **DATA FOR CERTAIN PHYSICIAN ADMINIS-**  
8                       **TERED DRUGS.**

9       (a) IN GENERAL.—Section 1927(a) of the Social Se-  
10      curity Act (42 U.S.C. 1396r–8(a)) is amended by adding  
11      at the end the following new paragraph:

12                   “(7) REQUIREMENT FOR SUBMISSION OF UTILI-  
13                   ZATION DATA FOR CERTAIN PHYSICIAN ADMINIS-  
14                   TERED DRUGS.—

15                   “(A) SINGLE SOURCE DRUGS.—In order  
16                   for payment to be available under section  
17                   1903(a) for a covered outpatient drug that is a  
18                   single source drug or biological that is physician  
19                   administered (as determined by the Secretary),  
20                   and that is administered on or after January 1,  
21                   2006, the State shall provide for the submission  
22                   of such utilization data and coding (such as J-  
23                   codes and National Drug Code numbers) for  
24                   each such drug as the Secretary may specify as  
25                   necessary to identify the manufacturer of the

1 drug in order to secure rebates under this sec-  
2 tion.

3 “(B) MULTIPLE SOURCE DRUGS.—

4 “(i) DEVELOPMENT OF REPORTING  
5 METHODOLOGY.—Not later than January  
6 1, 2007, the Secretary shall develop and  
7 publish a methodology for the submission  
8 of such utilization data and coding (such  
9 as J-codes and National Drug Code num-  
10 bers) for each such drug as the Secretary  
11 may specify as necessary to identify the  
12 manufacturer of each physician adminis-  
13 tered multiple source drug in order to se-  
14 cure rebates under this section.

15 “(ii) IDENTIFICATION OF MOST FRE-  
16 QUENTLY PHYSICIAN ADMINISTERED MUL-  
17 TIPLE SOURCE DRUGS.—Not later than  
18 January 1, 2007, the Secretary shall pub-  
19 lish a list of the 20 physician administered  
20 multiple source drugs that the Secretary  
21 determines have the highest volume of phy-  
22 sician administered dispensing under this  
23 title. The Secretary may modify such list  
24 from year to year to reflect changes in  
25 such volume.

1           “(iii) REQUIREMENT.—In order for  
2           payment to be available under section  
3           1903(a) for a covered outpatient drug that  
4           is a multiple source drug that is physician  
5           administered (as determined by the Sec-  
6           retary), that is on the list published under  
7           clause (ii), and that is administered on or  
8           after January 1, 2008, the State shall pro-  
9           vide for the submission of such utilization  
10          data and coding (such as J-codes and Na-  
11          tional Drug Code numbers) for each such  
12          drug as the Secretary may specify as nec-  
13          essary to identify the manufacturer of the  
14          drug in order to secure rebates under this  
15          section.

16          “(C) HARDSHIP WAIVER.—The Secretary may  
17          delay the application of subparagraph (A) or (B), or  
18          both, in the case of a State to prevent hardship to  
19          States which require additional time to implement  
20          the reporting system required under the respective  
21          subparagraph.”.

22          (b) LIMITATION ON PAYMENT.—Section 1903(i)(10)  
23          of such Act (42 U.S.C. 1396b(i)(10)), as amended by sec-  
24          tion 3101(b)(2), is amended—

1 (1) by striking “and” at the end of subpara-  
2 graph (B);

3 (2) by striking “; or” at the end of subpara-  
4 graph (C) and inserting “, and”; and

5 (3) by adding at the end the following new sub-  
6 paragraph:

7 “(D) with respect to covered outpatient drugs  
8 described in section 1927(a)(7), unless information  
9 respecting utilization data and coding on such drugs  
10 that is required to be submitted under such section  
11 is submitted in accordance with such section; or”.

12 **SEC. 3103. IMPROVED REGULATION OF AUTHORIZED GE-**  
13 **NERIC DRUGS AND OTHER DRUGS SOLD**  
14 **UNDER A NEW DRUG APPLICATION AP-**  
15 **PROVED UNDER SECTION 505(C) OF THE FED-**  
16 **ERAL FOOD, DRUG, AND COSMETIC ACT.**

17 (a) INCLUSION WITH OTHER REPORTED AVERAGE  
18 MANUFACTURER AND BEST PRICES.—Section  
19 1927(b)(3)(A) of the Social Security Act (42 U.S.C.  
20 1396r–8(b)(3)(A)) is amended—

21 (1) by striking clause (i) and inserting the fol-  
22 lowing:

23 “(i) not later than 30 days after the  
24 last day of each rebate period under the  
25 agreement—

1                   “(I) on the average manufacturer  
2                   price (as defined in subsection (k)(1))  
3                   for covered outpatient drugs for the  
4                   rebate period under the agreement  
5                   (including for such drugs that are au-  
6                   thorized generic drugs or are any  
7                   other drugs sold under a new drug ap-  
8                   plication approved under section  
9                   505(c) of the Federal Food, Drug,  
10                  and Cosmetic Act); and

11                  “(II) for single source drugs, in-  
12                  novator multiple source drugs, author-  
13                  ized generic drugs, and any other  
14                  drugs sold under a new drug applica-  
15                  tion approved under section 505(c) of  
16                  the Federal Food, Drug, and Cos-  
17                  metic Act, on the manufacturer’s best  
18                  price (as defined in subsection  
19                  (c)(1)(C)) for such drugs for the re-  
20                  bate period under the agreement;”;  
21                  and

22                  (2) in clause (ii), by inserting “(including for  
23                  such drugs that are authorized generic drugs or are  
24                  any other drugs sold under a new drug application

1 approved under section 505(c) of the Federal Food,  
2 Drug, and Cosmetic Act)” after “drugs”.

3 (b) CONFORMING AMENDMENTS.—Section 1927 of  
4 such Act (42 U.S.C. 1396r–8) is amended—

5 (1) in subsection (c)(1)(C)—

6 (A) in clause (i), in the matter preceding  
7 subclause (I), by striking “or innovator multiple  
8 source drug of a manufacturer” and inserting  
9 “, innovator multiple source drug, or authorized  
10 generic drug of a manufacturer, or any other  
11 drug of a manufacturer that is sold under a  
12 new drug application approved under section  
13 505(c) of the Federal Food, Drug, and Cos-  
14 metic Act”; and

15 (B) in clause (ii)—

16 (i) in subclause (II), by striking  
17 “and” at the end;

18 (ii) in subclause (III), by striking the  
19 period at the end and inserting “; and”;  
20 and

21 (iii) by adding at the end the fol-  
22 lowing:

23 “(IV) in the case of a manufac-  
24 turer that approves, allows, or other-  
25 wise permits an authorized generic

1 drug or any other drug of the manu-  
2 facturer to be sold under a new drug  
3 application approved under section  
4 505(c) of the Federal Food, Drug,  
5 and Cosmetic Act, shall be inclusive of  
6 the lowest price for such authorized  
7 generic or other drug available from  
8 the manufacturer during the rebate  
9 period to any wholesaler, retailer, pro-  
10 vider, health maintenance organiza-  
11 tion, nonprofit entity, or governmental  
12 entity within the United States, ex-  
13 cluding those prices described in sub-  
14 clauses (I) through (IV) of clause  
15 (i).”; and

16 (2) in subsection (k)—

17 (A) in paragraph (1)—

18 (i) by striking “The term” and insert-  
19 ing the following:

20 “(A) IN GENERAL.—The term”; and

21 (ii) by adding at the end the fol-  
22 lowing:

23 “(B) INCLUSION OF AUTHORIZED GENERIC  
24 DRUGS.—In the case of a manufacturer that  
25 approves, allows, or otherwise permits an au-

1           thorized generic drug or any other drug of the  
2           manufacturer to be sold under a new drug ap-  
3           plication approved under section 505(c) of the  
4           Federal Food, Drug, and Cosmetic Act, such  
5           term shall be inclusive of the average price paid  
6           for such authorized generic or other drug by  
7           wholesalers for drugs distributed to the retail  
8           pharmacy class of trade, after deducting cus-  
9           tomary prompt pay discounts.”; and

10                       (B) by adding at the end the following:

11                       “(10) AUTHORIZED GENERIC DRUG.—The term  
12           ‘authorized generic drug’ means a listed drug (as  
13           that term is used in section 505(j) of the Federal  
14           Food, Drug, and Cosmetic Act that—

15                       “(A) has been approved under section  
16           505(c) of such Act; and

17                       “(B) is marketed, sold, or distributed di-  
18           rectly or indirectly to retail class of trade under  
19           a different labeling, packaging (other than re-  
20           packaging as the listed drug in blister packs,  
21           unit doses, or similar packaging for use in insti-  
22           tutions), product code, labeler code, trade name,  
23           or trade mark than the listed drug.”.

1           (c) EFFECTIVE DATE.—The amendments made by  
2 this section take effect on the date of the enactment of  
3 this Act.

4 **SEC. 3104. PRESCRIPTION DRUG INNOVATION PAYMENTS.**

5           Section 1903 of the Social Security Act (42 U.S.C.  
6 1396b) is amended by adding at the end the following new  
7 subsection:

8           “(x) PRESCRIPTION DRUG INNOVATION PAY-  
9 MENTS.—

10           “(1) IN GENERAL.—In addition to the pay-  
11 ments provided under subsection (a) and subject to  
12 paragraph (4), the Secretary shall provide for pay-  
13 ments under subsection (a) to qualifying States to  
14 reward States for the introduction of innovative  
15 methods in reducing, in clinically appropriate ways,  
16 expenditures under this title for covered outpatient  
17 drugs, particularly in the categories of greatest drug  
18 utilization. Such methods may include the following:

19           “(A) INCREASING GENERIC UTILIZA-  
20 TION.—Increasing the utilization of generic  
21 drugs through the use of education programs to  
22 educate patients and physicians on the benefits  
23 of such drugs.

1           “(B) MEDICATION RISK MANAGEMENT  
2           PROGRAMS.—The use of medication risk man-  
3           agement programs.

4           “(2) APPLICATION; TERMS AND CONDITIONS.—  
5           No payments shall be made to a State under this  
6           subsection unless the State applied to the Secretary  
7           for such payments in a form, manner, and time  
8           specified by the Secretary. Such payments are made  
9           under such terms and conditions consistent with this  
10          subsection as the Secretary prescribes.

11          “(3) FUNDING.—

12                 “(A) LIMITATION ON FUNDS.—The total  
13                 amount of payments under this subsection shall  
14                 be equal to, and shall not exceed—

15                         “(i) \$50,000,000 for 2006; and

16                         “(ii) \$50,000,000 for 2007.

17           This subsection constitutes budget authority in  
18           advance of appropriations Acts and represents  
19           the obligation of the Secretary to provide for  
20           the payment of amounts provided under this  
21           subsection.

22                 “(B) ALLOCATION OF FUNDS.—The Sec-  
23                 retary shall specify a method for allocating the  
24                 funds made available under this subsection  
25                 among States.

1           “(C) FORM AND MANNER OF PAYMENT.—  
2           Payment to a State under this subsection shall  
3           be made in the same manner as other payments  
4           under section 1903(a). There is no requirement  
5           for State matching funds to receive payments  
6           under this subsection.

7           “(D) NO DOUBLE DIPPING.—Funds pro-  
8           vided under this subsection shall be conditioned  
9           upon the Secretary receives satisfactory assur-  
10          ances that the aggregate Federal expenditures  
11          under such title are not greater than the  
12          amount that would be paid if such payment had  
13          been made.

14          “(E) EXPENDITURES.—For purposes of  
15          this subsection, expenditures for outpatient pre-  
16          scription drugs shall include expenditures for  
17          ingredient costs as well as dispensing fees.”.

## 18           **CHAPTER 2—REFORM OF ASSET**

### 19                   **TRANSFER RULES**

20   **SEC. 3111. LENGTHENING LOOK-BACK PERIOD; CHANGE IN**  
21                   **BEGINNING DATE FOR PERIOD OF INELIGI-**  
22                   **BILITY.**

23           (a) LENGTHENING LOOK-BACK PERIOD FOR ALL  
24   DISPOSALS TO 5 YEARS.—Section 1917(c)(1)(B)(i) of the  
25   Social Security Act (42 U.S.C. 1396p(c)(1)(B)(i)) is

1 amended by inserting “or in the case of any other disposal  
2 of assets made on or after the date of the enactment of  
3 the Medicaid Reconciliation Act of 2005” before “, 60  
4 months”.

5 (b) CHANGE IN BEGINNING DATE FOR PERIOD OF  
6 INELIGIBILITY.—Section 1917(c)(1)(D) of such Act (42  
7 U.S.C. 1396p(c)(1)(D)) is amended—

8 (1) by striking “(D) The date” and inserting  
9 “(D)(i) In the case of a transfer of asset made be-  
10 fore the date of the enactment of the Medicaid Rec-  
11 onciliation Act of 2005, the date”; and

12 (2) by adding at the end the following new  
13 clause:

14 “(ii) In the case of a transfer of asset made on or  
15 after the date of the enactment of the Medicaid Reconcili-  
16 ation Act of 2005, the date specified in this subparagraph  
17 is the first day of a month during or before which assets  
18 have been transferred for less than fair market value and  
19 during which the individual—

20 “(I) is an institutionalized individual (or, at  
21 State option, is a noninstitutionalized individual);

22 “(II) is eligible for medical assistance under the  
23 State plan (or would be so eligible but for the appli-  
24 cation of this subsection); and

1           “(III) is not in any other period of ineligibility  
2           under this subsection.”.

3           (c) EFFECTIVE DATE.—The amendments made by  
4 this section shall apply to transfers made after the date  
5 of the enactment of this Act.

6           (d) AVAILABILITY OF HARDSHIP WAIVERS.—

7           (1) IN GENERAL.—Each State shall provide for  
8 a hardship waiver process in accordance with section  
9 1917(c)(2)(D) of the Social Security Act (42 U.S.C.  
10 1396p(c)(2)(D))—

11           (A) under which an undue hardship exists  
12 when application of the transfer of assets provi-  
13 sion would deprive the individual—

14           (i) of medical care such that the indi-  
15 vidual’s health or life would be endangered;  
16 or

17           (ii) of food, clothing, shelter, or other  
18 necessities of life; and

19           (B) which provides for—

20           (i) notice to recipients that an undue  
21 hardship exception exists;

22           (ii) a timely process for determining  
23 whether an undue hardship waiver will be  
24 granted; and

1 (iii) a process under which an adverse  
2 determination can be appealed.

3 (2) CONSTRUCTION.—Nothing in this section  
4 (or the amendments made by this section) shall be  
5 construed as affecting the application of section  
6 1917(c)(2)(D) of the Social Security Act (42 U.S.C.  
7 1396p(c)(2)(D)) or regulations promulgated or in-  
8 structions issued to carry out such section.

9 (e) TRANSITIONAL COMPENSATION POOL.—

10 (1) IN GENERAL.—The Secretary of Health and  
11 Human Services shall establish by regulation a pro-  
12 gram to provide funds to States (as defined for pur-  
13 poses of title XIX of the Social Security Act) for the  
14 compensation of institutional health care providers  
15 that incur additional bad debt as a direct result of  
16 the implementation of the amendments made by this  
17 section.

18 (2) PROCEDURE.—Funds shall only be made  
19 available under this subsection upon such terms and  
20 conditions, including the approval of an application,  
21 as the Secretary shall specify

22 (3) ALLOCATION OF FUNDS.—The Secretary  
23 shall establish a method for allocating funds avail-  
24 able under paragraph (4) among the qualifying  
25 States. Such method shall take into account the

1 amount of the additional bad debt described in para-  
2 graph (1) for institutional health care providers in  
3 the respective States.

4 (4) FUNDING.—

5 (A) IN GENERAL.—There are hereby au-  
6 thorized and appropriated to carry out this sub-  
7 section, \$30,000,000 for fiscal year 2006 and  
8 \$30,000,000 for fiscal year 2007.

9 (B) AVAILABILITY.—Funds appropriated  
10 under subparagraph (A) for a fiscal year shall  
11 remain available for obligation through the end  
12 of the following fiscal year.

13 (f) ADDITIONAL PROVISIONS ON HARDSHIP WAIV-  
14 ERS.—

15 (1) APPLICATION BY FACILITY.—Section  
16 1917(c)(2) of the Social Security Act (42 U.S.C.  
17 1396p(c)(2)) is amended—

18 (A) by striking the semicolon at the end of  
19 subparagraph (D) and inserting a period; and

20 (B) by adding after and below such sub-  
21 paragraph the following:

22 “The procedures established under subparagraph (D)  
23 shall permit the facility in which the institutionalized indi-  
24 vidual is residing to file an undue hardship waiver applica-

1 tion on behalf of the individual with the consent of the  
2 individual or the legal guardian of the individual.”.

3           (2) **AUTHORITY TO MAKE BED HOLD PAYMENTS**  
4 **FOR HARDSHIP APPLICANTS.**—Such section is fur-  
5 ther amended by adding at the end the following:  
6 “While an application for an undue hardship waiver  
7 is pending under subparagraph (D) in the case of an  
8 individual who is a resident of a nursing facility, if  
9 the application provides a prima facie case of quali-  
10 fication for such a waiver, the State may provide for  
11 payments for nursing facility services in order to  
12 hold the bed for the individual at the facility.”.

13 **SEC. 3112. DISCLOSURE AND TREATMENT OF ANNUITIES**  
14 **AND OF LARGE TRANSACTIONS.**

15           (a) **IN GENERAL.**—Section 1917 of the Social Secu-  
16 rity Act is amended by redesignating subsection (e) as  
17 subsection (f) and by inserting after subsection (d) the fol-  
18 lowing new subsection:

19           “(e)(1) In order to meet the requirements of this sub-  
20 section for purposes of section 1902(a)(18), a State shall  
21 require, as a condition for the provision of medical assist-  
22 ance for services described in subsection (c)(1)(C)(i) (re-  
23 lating to long-term care services) for an individual, the ap-  
24 plication of the individual for such assistance (including

1 any recertification of eligibility for such assistance) shall  
2 disclose the following:

3           “(A) A description of any interest the individual  
4 has in an annuity (or similar financial instrument,  
5 as may be specified by the Secretary), regardless of  
6 whether the annuity is irrevocable or is treated as an  
7 asset.

8           “(B) Full information (as specified by the Sec-  
9 retary) concerning any transaction involving the  
10 transfer or disposal of assets during the previous pe-  
11 riod of 60 months, if the transaction exceeded  
12 \$100,000, without regard to whether the transfer or  
13 disposal was for fair market value. For purposes of  
14 applying the previous sentence under this subsection,  
15 all transactions of \$5,000 or more occurring within  
16 a 12-month period shall be treated as a single trans-  
17 action. The dollar amounts specified in the first and  
18 second sentences of this subparagraph shall be in-  
19 creased, beginning with 2007, from year to year  
20 based on the percentage increase in the consumer  
21 price index for all urban consumers (all items;  
22 United States city average), rounded to the nearest  
23 \$1,000 in the case of the first sentence and \$100 in  
24 the case of the second sentence.

1 Such application or recertification form shall include a  
2 statement that under paragraph (2) the State becomes a  
3 remainder beneficiary under such a annuity by virtue of  
4 the provision of such medical assistance.

5 “(2)(A) In the case of any annuity in which an insti-  
6 tutionalized individual has an interest, if medical assist-  
7 ance is furnished to the individual for services described  
8 in subsection (c)(1)(C)(i), by virtue of the provision of  
9 such assistance the State becomes the remainder bene-  
10 ficiary in the first position for the total amount of such  
11 medical assistance paid on behalf of the individual under  
12 this title.

13 “(B) In the case of disclosure concerning an annuity  
14 under paragraph (1)(A), the State shall notify issuer of  
15 the annuity of the right of the State under subparagraph  
16 (A) as a preferred remainderman interests in the annuity  
17 for medical assistance furnished to the individual. Nothing  
18 in this paragraph shall be construed as preventing such  
19 an issuer from notifying persons with any other remainder  
20 interest of the State’s remainder interest under subpara-  
21 graph (A).

22 “(C) In the case of such an issuer receiving notice  
23 under subparagraph (B), the State may require the issuer  
24 to notify the State when there is a change in the amount  
25 of income or principal being withdrawn from the amount

1 that was being withdrawn at the time of the most recent  
2 disclosure described in paragraph (1)(A). A State shall  
3 take such information into account in determining the  
4 amount of the State's obligations for medical assistance  
5 or in the individual's eligibility for such assistance.

6 “(3)(A) For purposes of subsection (c)(1), a trans-  
7 action described in paragraph (1)(B) shall be deemed as  
8 the transfer of an asset for less than fair market value  
9 unless the individual demonstrates to the satisfaction of  
10 the State that the transfer of the asset was for fair market  
11 value.

12 “(B) The Secretary may provide guidance to States  
13 on categories of arms length transactions (such as the pur-  
14 chase of a commercial annuity) that could be generally  
15 treated as a transfer of asset for fair market value.

16 “(4) Nothing in this subsection shall be construed as  
17 preventing a State from denying eligibility for medical as-  
18 sistance for an individual based on the income or resources  
19 derived from an annuity described in paragraph (1)(A).”.

20 (b) CONFORMING AMENDMENT.—Section  
21 1902(a)(18) of such Act (42 U.S.C. 1396a(a)(18)) is  
22 amended by inserting before the semicolon at the end the  
23 following: “, including the requirements of subsection (e)”.

24 (c) EFFECTIVE DATE.—The amendments made by  
25 this section shall apply to transactions (including the pur-

1 chase of an annuity) occurring on or after the date of the  
2 enactment of this Act.

3 **SEC. 3113. APPLICATION OF “INCOME-FIRST” RULE IN AP-**  
4 **PLYING COMMUNITY SPOUSE’S INCOME BE-**  
5 **FORE ASSETS IN PROVIDING SUPPORT OF**  
6 **COMMUNITY SPOUSE.**

7 (a) IN GENERAL.—Section 1924(d) of the Social Se-  
8 curity Act (42 U.S.C. 1396r–5(d)) is amended by adding  
9 at the end the following new paragraph:

10 “(6) APPLICATION OF ‘INCOME FIRST’ RULE  
11 FOR FUNDING COMMUNITY SPOUSE MONTHLY IN-  
12 COME ALLOWANCE.—For purposes of this subsection  
13 and subsection (e), any transfer or allocation made  
14 from an institutionalized spouse to meet the need of  
15 a community spouse for a community spouse month-  
16 ly income allowance under paragraph (1)(B) shall be  
17 first made from income of the institutionalized  
18 spouse and then only when the income is not avail-  
19 able from the resources of such institutionalized  
20 spouse.”.

21 (b) EFFECTIVE DATE.—The amendment made by  
22 subsection (a) shall apply to transfers and allocations  
23 made on or after the date of the enactment of this Act  
24 by individuals who become institutionalized spouses on or  
25 after such date.

1 **SEC. 3114. DISQUALIFICATION FOR LONG-TERM CARE AS-**  
2 **SISTANCE FOR INDIVIDUALS WITH SUBSTAN-**  
3 **TIAL HOME EQUITY.**

4 (a) IN GENERAL.—Section 1917 of the Social Secu-  
5 rity Act, as amended by section 3112, is further amended  
6 by redesignating subsection (f) as subsection (g) and by  
7 inserting after subsection (e) the following new subsection:

8 “(f)(1) Notwithstanding any other provision of this  
9 title, subject to paragraph (2), in determining eligibility  
10 of an individual for medical assistance with respect to  
11 nursing facility services or other long-term care services,  
12 the individual shall not be eligible for such assistance if  
13 individual’s equity interest in the individual’s home ex-  
14 ceeds \$500,000.

15 “(2) Paragraph (1) shall not apply with respect to  
16 an individual if—

17 “(A) the spouse of such individual, or

18 “(B) such individual’s child who is under age  
19 21, or (with respect to States eligible to participate  
20 in the State program established under title XVI) is  
21 blind or permanently and totally disabled, or (with  
22 respect to States which are not eligible to participate  
23 in such program) is blind or disabled as defined in  
24 section 1614,

25 is lawfully residing in the individual’s home.

1           “(3) Nothing in this subsection shall be construed as  
2 preventing an individual from using a reverse mortgage  
3 or home equity loan to reduce the individual’s total equity  
4 interest in the home.”.

5           (b) EFFECTIVE DATE.—The amendment made by  
6 subsection (a) shall apply to individuals who are deter-  
7 mined eligible for medical assistance with respect to nurs-  
8 ing facility services or other long-term care services based  
9 on an application filed on or after January 1, 2006.

10 **SEC. 3115. TREATMENT OF SPOUSAL ASSIGNMENTS OF**  
11 **RIGHTS FOR INSTITUTIONALIZED SPOUSES**  
12 **RECEIVING MEDICAID LONG-TERM CARE**  
13 **BENEFITS.**

14           (a) IN GENERAL.—Section 1924(c)(3)(A) of the So-  
15 cial Security Act (42 U.S.C. 1396r-5(c)(3)(A)) is amend-  
16 ed by inserting before the semicolon the following: “and  
17 such community spouse makes such resources available for  
18 the cost of such care”.

19           (b) EFFECTIVE DATE.—

20           (1) IN GENERAL.—The amendment made by  
21 subsection (a) shall apply to eligibility for take effect  
22 on January 1, 2006, and shall apply to assignments  
23 of rights of support executed before, on, or after  
24 such date.



1 or type, including through the use of tiered cost-  
2 sharing for prescription drugs) consistent with the  
3 limitations established under this section. Nothing in  
4 this section shall be construed as superseding (or  
5 preventing the application of) section 1916(g).

6 “(2) DEFINITIONS.—In this section:

7 “(A) PREMIUM.—The term ‘premium’ in-  
8 cludes any enrollment fee or similar charge.

9 “(B) COST-SHARING.—The term ‘cost-  
10 sharing’ includes any deduction, deductible, co-  
11 payment, or similar charge.

12 “(b) LIMITATIONS ON EXERCISE OF AUTHORITY.—  
13 Subject to the succeeding provisions of this section—

14 “(1) INDIVIDUALS WITH FAMILY INCOME  
15 BELOW 100 PERCENT OF POVERTY LEVEL.—In the  
16 case of an individual whose family income does not  
17 exceed 100 percent of the Federal poverty level ap-  
18 plicable to a family of the size involved, subject to  
19 the succeeding provisions of this section, the limita-  
20 tions otherwise provided under subsections (a) and  
21 (b) of section 1916 shall continue to apply and no  
22 enrollment fee, premium, or similar charge will be  
23 imposed under the plan, except that subject to the  
24 succeeding provisions of this section, the total an-  
25 nual aggregate amount of cost-sharing imposed for

1 all individuals in the family may not exceed 5 per-  
2 cent of the family income of the family involved for  
3 the year involved.

4 “(2) INDIVIDUALS WITH FAMILY INCOME  
5 ABOVE 100 PERCENT OF POVERTY LEVEL.—In the  
6 case of an individual whose family income exceeds  
7 100 percent of the Federal poverty level applicable  
8 to a family of the size involved, subject to the suc-  
9 ceeding provisions of this section, the total annual  
10 aggregate amount of premiums and cost-sharing im-  
11 posed for all individuals in the family may not ex-  
12 ceed 5 percent of the family income of the family in-  
13 volved for the year involved.

14 “(3) ADDITIONAL LIMITATIONS.—Subject to the  
15 succeeding provisions of this section, no cost-sharing  
16 shall be imposed under this section with respect to  
17 the following:

18 “(A) Services furnished to individuals  
19 under 18 years of age that are required to be  
20 provided medical assistance under section  
21 1902(a)(10)(A)(i), and including services fur-  
22 nished to individuals with respect to whom  
23 adoption or foster care assistance is made avail-  
24 able under part E of title IV without regard to  
25 age.

1           “(B) Preventive services (such as well baby  
2           and well child care and immunizations) pro-  
3           vided to children under 18 years of age regard-  
4           less of family income.

5           “(C) Services furnished to pregnant  
6           women, if such services relate to the pregnancy  
7           or to any other medical condition which may  
8           complicate the pregnancy.

9           “(D) Services furnished to a terminally ill  
10          individual who is receiving hospice care (as de-  
11          fined in section 1905(o)).

12          “(E) Services furnished to any individual  
13          who is an inpatient in a hospital, nursing facil-  
14          ity, intermediate care facility for the mentally  
15          retarded, or other medical institution, if such  
16          individual is required, as a condition of receiv-  
17          ing services in such institution under the State  
18          plan, to spend for costs of medical care all but  
19          a minimal amount of the individual’s income re-  
20          quired for personal needs.

21          “(F) Emergency services (as defined by  
22          the Secretary for purposes of section  
23          1916(a)(2)(D)).

24          “(G) Family planning services and supplies  
25          described in section 1905(a)(4)(C).

1 Nothing in this paragraph shall be construed as pre-  
2 venting a State from exempting additional classes of  
3 individuals or services from cost-sharing under this  
4 section.

5 “(5) INDEXING NOMINAL AMOUNTS.—In apply-  
6 ing section 1916 under paragraph (1) with respect  
7 to cost-sharing that is ‘nominal’ in amount—

8 “(A) the Secretary shall phase-in an in-  
9 crease in such amount over a 3 year period (be-  
10 ginning January 1, 2006) so that—

11 “(i) a \$3 nominal amount in 2005  
12 would be increased to be a \$5 nominal  
13 amount in 2008; and

14 “(ii) other nominal amounts would be  
15 increased by a proportional amount (with  
16 appropriate rounding) during such period;  
17 and

18 “(B) the Secretary shall increase such  
19 ‘nominal’ amounts for each subsequent year  
20 (beginning with 2009) by the annual percentage  
21 increase in the medical care component of the  
22 consumer price index for all urban consumers  
23 (U.S. city average) as rounded up in an appro-  
24 priate manner.

1           “(6) DETERMINATIONS OF FAMILY INCOME.—  
2           In applying this subsection, family income shall be  
3           determined in a manner specified by the State for  
4           purposes of this subsection, including the use of  
5           such disregards as the State may provide. Family in-  
6           come shall be determined for such period and at  
7           such periodicity as the State may provide under this  
8           title.

9           “(7) POVERTY LINE DEFINED.—For purposes  
10          of this subsection, the term ‘poverty line’ has the  
11          meaning given such term in section 673(2) of the  
12          Community Services Block Grant Act (42 U.S.C.  
13          9902(2)), including any revision required by such  
14          section.

15          “(8) CONSTRUCTION.—Nothing in this section  
16          shall be construed—

17                 “(A) as preventing a State from further  
18                 limiting the premiums and cost-sharing imposed  
19                 under this section beyond the limitations pro-  
20                 vided under this subsection;

21                 “(B) as affecting the authority of the Sec-  
22                 retary to waive limitations on premiums and  
23                 cost-sharing under this subsection; or

24                 “(C) as affecting any such waiver of re-  
25                 quirements in effect under this title before the

1           date of the enactment of this section with re-  
2           gard to the imposition of premiums and cost-  
3           sharing.

4           “(d) ENFORCEABILITY OF PREMIUMS AND OTHER  
5 COST-SHARING.—

6           “(1) PREMIUMS.—Notwithstanding section  
7 1916(e)(3), a State may, at its option, condition the  
8 provision of medical assistance for an individual  
9 upon prepayment of a premium authorized to be im-  
10 posed under this section, or may terminate eligibility  
11 for such medical assistance on the basis of failure to  
12 pay such a premium. A State may apply the pre-  
13 vious sentence for some or all classes or types of  
14 beneficiaries.

15           “(2) COST-SHARING.—Notwithstanding section  
16 1916(e) or any other provision of law, a State may  
17 permit a provider participating under the State plan  
18 to require, as a condition for the provision of care,  
19 items, or services to an individual entitled to medical  
20 assistance under this title for such care, items, or  
21 services, the payment of any cost-sharing authorized  
22 to be imposed under this section with respect to  
23 such care, items, or services. Nothing in this para-  
24 graph shall be construed as preventing a provider

1 from reducing or waiving the application of such  
2 cost-sharing.”.

3 (b) GAO STUDY OF IMPACT OF PREMIUMS AND  
4 COST-SHARING.—The Comptroller General of the United  
5 States shall conduct a study of the impact of premiums  
6 and cost-sharing under the medicaid program on access  
7 to, and utilization of, services. Not later than January 1,  
8 2008, the Comptroller General shall submit a report to  
9 the Congress on such study.

10 (c) EFFECTIVE DATE.—The amendment made by  
11 subsection (a) shall apply to cost-sharing imposed for  
12 items and services furnished on or after January 1, 2006.

13 **SEC. 3122. SPECIAL RULES FOR COST-SHARING FOR PRE-**  
14 **SCRIPTION DRUGS.**

15 (a) IN GENERAL.—Section 1916A of the Social Secu-  
16 rity Act, as inserted by section 3121, is amended by insert-  
17 ing after subsection (b) the following new subsection:

18 “(c) SPECIAL RULES FOR COST-SHARING FOR PRE-  
19 SCRIPTON DRUGS.—

20 “(1) IN GENERAL.—In order to encourage  
21 beneficiaries to use drugs (in this subsection referred  
22 to as ‘preferred drugs’) identified by the State as the  
23 least (or less) costly effective prescription drugs  
24 within a class of drugs (as defined by the State),

1 with respect to one or more classes of beneficiaries  
2 State may—

3 “(A) provide an increase in cost-sharing  
4 (above the level otherwise permitted under sec-  
5 tion 1916 or subsection (b), but consistent with  
6 paragraphs (2) and (3)) for any beneficiary  
7 with respect to drugs that are not preferred  
8 drugs within a class; and

9 “(B) waive or reduce the cost-sharing oth-  
10 erwise applicable for preferred drugs within  
11 such class.

12 “(2) LIMITATION.—In no case may the increase  
13 in cost-sharing under paragraph (1)(A) with respect  
14 to a non-preferred drug exceed the lesser of the fol-  
15 lowing:

16 “(A) COST DIFFERENTIAL.—The amount  
17 (as estimated from time to time by the State)  
18 by which the amount of payment to the phar-  
19 macy provided by the State under this title for  
20 the non-preferred drug exceeds such amount for  
21 the next lowest cost preferred drug in the same  
22 class.

23 “(B) MULTIPLE OF NOMINAL COST-SHAR-  
24 ING.—In the case of an individual whose family  
25 income is—

1           “(i) below 100 percent of the poverty  
2           line applicable to a family of the size in-  
3           volved, two times the amount of nominal  
4           cost sharing (as otherwise determined  
5           under subsection (b));

6           “(ii) at least 100 percent, but below  
7           150 percent, of the poverty line applicable  
8           to a family of the size involved, three times  
9           the amount of nominal cost sharing (as  
10          otherwise determined under subsection  
11          (b)); or

12          “(iii) at least 150 percent of the pov-  
13          erty line applicable to a family of the size  
14          involved, four times the amount of nominal  
15          cost sharing (as otherwise determined  
16          under subsection (b)).

17          “(3) WAIVER.—In carrying out paragraph (1),  
18          a State shall provide for the application of cost-shar-  
19          ing levels applicable to a preferred drug in the case  
20          of a drug that is not a preferred drug if a physician  
21          certifies that the use of the preferred drug for treat-  
22          ment of the condition is likely to create adverse  
23          health effects.

24          “(4) EXCLUSION AUTHORITY.—Nothing in this  
25          subsection shall be construed as preventing a State

1 from excluding from paragraph (1) specified drugs  
2 or classes of drugs.”.

3 (b) EFFECTIVE DATE.—The amendment made by  
4 subsection (a) shall apply to cost-sharing imposed for  
5 items and services furnished on or after October 1, 2006.

6 **SEC. 3123. EMERGENCY ROOM COPAYMENTS FOR NON-**  
7 **EMERGENCY CARE.**

8 (a) IN GENERAL.—Section 1916A of the Social Secu-  
9 rity Act, as inserted by section 3121 and as amended by  
10 section 3122, is further amended by adding at the end  
11 the following new subsection:

12 “(f) STATE OPTION FOR INCREASE IN COST-SHAR-  
13 ING FOR NON-EMERGENCY CARE FURNISHED IN AN HOS-  
14 PITAL EMERGENCY ROOM.—

15 “(1) IN GENERAL.—Notwithstanding section  
16 1916 or the previous provisions of this section, a  
17 State may, by amendment to its State plan under  
18 this title, provide for an increase in cost-sharing for  
19 non-emergency services furnished to an individual  
20 (within one or more classes of individuals specified  
21 by the State) in a hospital emergency department  
22 under this subsection if the following conditions are  
23 met:

24 “(A) ACCESS TO NON-EMERGENCY ROOM  
25 PROVIDER.—The individual has reasonably

1 available access (as defined by the Secretary) to  
2 an alternate non-emergency services provider  
3 with respect to such services.

4 “(B) NOTICE.—The physician or hospital  
5 must inform the beneficiary after the initial  
6 screening assessment, but before providing the  
7 non-emergency services, of the following:

8 “(i) The hospital may require the pay-  
9 ment of the State specified cost-sharing be-  
10 fore the service can be provided.

11 “(ii) The name and location of an al-  
12 ternate non-emergency services provider  
13 care provider (described in subparagraph  
14 (A)).

15 “(iii) The fact that such alternate  
16 provider can provide the services without  
17 the imposition of the increase in cost-shar-  
18 ing described in clause (i).

19 “(iv) The hospital can provide a refer-  
20 ral to coordinate scheduling of this treat-  
21 ment.

22 Nothing in this section shall be construed as  
23 preventing a State from waiving cost-sharing  
24 otherwise applicable to services described in  
25 clause (iii).

1           “(2) LIMITATION FOR POOREST BENE-  
2           FICIARIES.—In the case of an individual described in  
3           subsection (b)(1), the cost-sharing imposed under  
4           this subsection may not exceed twice the amount de-  
5           termined to be nominal under this section, subject to  
6           the percent of income limitation otherwise applicable  
7           under subsection (b)(1).

8           “(3) APPLICATION TO EXEMPT POPU-  
9           LATIONS.—In the case of an individual who is other-  
10          wise not subject to cost-sharing due to the applica-  
11          tion of subparagraph (B), (C), (D), (H), or (I) of  
12          subsection (b)(4), there may be cost-sharing under  
13          paragraph (1) for care in an amount that does not  
14          exceed a nominal amount (as determined under this  
15          section) so long as no cost-sharing is imposed to re-  
16          ceive such care through an outpatient department or  
17          other alternative health care provider in the area of  
18          the hospital emergency department involved.

19          “(4) CONSTRUCTION.—Nothing in this section  
20          shall be construed—

21                 “(A) to limit a hospital’s obligations with  
22                 respect to screening and stabilizing treatment  
23                 of an emergency medical condition; or

24                 “(B) to modify any obligations under ei-  
25                 ther State or Federal standards relating to the

1 application of a prudent-layperson standard  
2 with respect to payment or coverage of emer-  
3 gency services by any managed care organiza-  
4 tion; or

5 “(C) to prevent a hospital from requiring,  
6 as a condition of providing non-emergency serv-  
7 ices, the payment of any applicable cost-shar-  
8 ing.

9 “(5) DETERMINATION STANDARD.—No hospital  
10 or physician that makes a determination with re-  
11 spect to the imposition of cost-sharing under this  
12 subsection shall be liable in any civil action or pro-  
13 ceeding for such determination absent a finding by  
14 clear and convincing evidence of gross negligence by  
15 the hospital or physician.

16 “(6) DEFINITIONS.—For purposes of this sub-  
17 section:

18 “(A) NON-EMERGENCY SERVICES.—The  
19 term ‘non-emergency services’ means any care  
20 or services furnished in a emergency depart-  
21 ment of a hospital that the hospital or physi-  
22 cian determines do not constitute an appro-  
23 priate medical screening examination or stabi-  
24 lizing examination and treatment screening re-

1           required to be provided by the hospital under sec-  
2           tion 1867.

3                   “(B) ALTERNATE NON-EMERGENCY SERV-  
4           ICES PROVIDER.—The term ‘alternative non-  
5           emergency services provider’ means, with re-  
6           spect to non-emergency services for the diag-  
7           nosis or treatment of a condition, a health care  
8           provider, such as a physician’s office, health  
9           care clinic, community health center, hospital  
10          outpatient department, or similar health care  
11          provider, that provides clinically appropriate  
12          services for such diagnosis or treatment of the  
13          condition within clinically appropriate time of  
14          the provision of such non-emergency services.”.

15          (b) GRANT FUNDS FOR ESTABLISHMENT OF ALTER-  
16          NATE NON-EMERGENCY SERVICES PROVIDERS.—Section  
17          1903 of the Social Security Act (42 U.S.C. 1396b), as  
18          amended by section 3104, is further amended by adding  
19          at the end the following new subsection:

20                   “(y) PAYMENTS FOR ESTABLISHMENT OF ALTER-  
21          NATE NON-EMERGENCY SERVICES PROVIDERS.—

22                   “(1) PAYMENTS.—In addition to the payments  
23          otherwise provided under subsection (a), subject to  
24          paragraph (2), the Secretary shall provide for pay-  
25          ments to States under such subsection for the estab-

1 lishment of alternate non-emergency service pro-  
2 viders (as defined in section 1916A(f)(6)(B)), or  
3 networks of such providers, particularly in rural and  
4 otherwise underserved areas where beneficiaries  
5 under this title may not have regular access to pro-  
6 viders of primary care services.

7 “(2) LIMITATION.—The total amount of pay-  
8 ments under this subsection shall be equal to, and  
9 shall not exceed, \$100,000,000 during the four-year  
10 period beginning with 2006. This subsection con-  
11 stitutes budget authority in advance of appropria-  
12 tions Acts and represents the obligation of the Sec-  
13 retary to provide for the payment of amounts pro-  
14 vided under this subsection.

15 “(3) PREFERENCE.—In providing for payments  
16 to States under this subsection, the Secretary shall  
17 provide preference to States that establish, or pro-  
18 vide for, alternate non-emergency services providers  
19 or networks of such providers in partnership with  
20 local community hospitals.

21 “(4) FORM AND MANNER OF PAYMENT.—Pay-  
22 ment to a State under this subsection shall be made  
23 only upon the filing of such application in such form  
24 and in such manner as the Secretary shall specify.  
25 Payment to a State under this subsection shall be

1       made in the same manner as other payments under  
2       section 1903(a).”.

3       (c) EFFECTIVE DATE.—The amendments made by  
4 this section shall apply to non-emergency services fur-  
5 nished on or after the date of the enactment of this Act.

6 **SEC. 3124. USE OF BENCHMARK BENEFIT PACKAGES.**

7       Title XIX of the Social Security Act is amended by  
8 redesignating section 1936 as section 1937 and by insert-  
9 ing after section 1935 the following new section:

10           “STATE FLEXIBILITY IN BENEFIT PACKAGES

11           “SEC. 1936. (a) STATE OPTION OF PROVIDING  
12 BENCHMARK BENEFITS.—

13                   “(1) AUTHORITY.—

14                           “(A) IN GENERAL.—Notwithstanding any  
15 other provision of this title, a State, at its op-  
16 tion, provide for medical assistance under this  
17 title to individuals within one or more groups of  
18 individuals under the State plan through enroll-  
19 ment in coverage that provides—

20                                   “(i) benchmark coverage described in  
21 subsection (b)(1); or

22                                   “(ii) benchmark equivalent coverage  
23 described in subsection (b)(2).

24                           “(B) LIMITATION.—The State may only  
25 exercise the option under subparagraph (A) for  
26 eligibility categories that had been established

1 before the date of the enactment of this section  
2 and may not apply such for individuals who, on  
3 such date, were enrolled in a group health plan.

4 “(C) OPTION OF WRAP-AROUND BENE-  
5 FITS.—In the case of coverage described in sub-  
6 paragraph (A), a State, at its option, may pro-  
7 vide such wrap-around or additional benefits as  
8 the State may specify.

9 “(D) TREATMENT AS MEDICAL ASSIST-  
10 ANCE.—Payment of premiums for such cov-  
11 erage under this subsection shall be treated as  
12 payment of other insurance premiums described  
13 in the third sentence of section 1905(a).

14 “(2) APPLICATION.—

15 “(A) IN GENERAL.—Except as provided in  
16 subparagraph (B), a State may require that a  
17 full-benefit eligible individual (as defined in  
18 subparagraph (C)) obtain benefits under this  
19 title through enrollment in coverage described  
20 in paragraph (1)(A). A State may apply the  
21 previous sentence to individuals within one or  
22 more categories of such individuals.

23 “(B) LIMITATION ON APPLICATION.—A  
24 State may not require under subparagraph (A)  
25 an individual to obtain benefits through enroll-

1           ment described in paragraph (1)(A) if the indi-  
2           vidual is within one of the following categories  
3           of individuals:

4                   “(i) MANDATORY PREGNANT WOMEN  
5                   AND CHILDREN.—The individual is a preg-  
6                   nant woman or child under 18 years of age  
7                   who is required to be covered under the  
8                   State        plan        under        section  
9                   1902(a)(10)(A)(i).

10                   “(ii) SSI BENEFICIARIES.—The indi-  
11                   vidual is an individual with respect to  
12                   whom supplemental security income bene-  
13                   fits are being paid under title XVI.

14                   “(iii) DUAL ELIGIBLES.—The indi-  
15                   vidual is entitled to benefits under any  
16                   part of title XVIII.

17                   “(iv) TERMINALLY ILL HOSPICE PA-  
18                   TIENTS.—The individual is terminally ill  
19                   and is receiving benefits for hospice care  
20                   under this title.

21                   “(v) ELIGIBLE ON BASIS OF INSTITU-  
22                   TIONALIZATION.—The individual is an in-  
23                   patient in a hospital, nursing facility, in-  
24                   termediate care facility for the mentally re-  
25                   tarded, or other medical institution, if such

1 individual is required, as a condition of re-  
2 ceiving services in such institution under  
3 the State plan, to spend for costs of med-  
4 ical care all but a minimal amount of the  
5 individual's income required for personal  
6 needs.

7 “(vi) MEDICALLY FRAIL AND SPECIAL  
8 MEDICAL NEEDS INDIVIDUALS.—The indi-  
9 vidual is medically frail or otherwise an in-  
10 dividual with special medical needs (as  
11 identified in accordance with regulations of  
12 the Secretary).

13 “(vii) BENEFICIARIES QUALIFYING  
14 FOR LONG-TERM CARE SERVICES.—The in-  
15 dividual qualifies based on medical condi-  
16 tion for medical assistance for long-term  
17 care services under this title.

18 “(C) FULL-BENEFIT ELIGIBLE INDIVID-  
19 UALS.—

20 “(i) IN GENERAL.—For purposes of  
21 this paragraph, subject to clause (ii), the  
22 term ‘full-benefit eligible individual’ means  
23 for a State for a month an individual who  
24 is determined eligible by the State for med-  
25 ical assistance for full benefits under this

1 title for such month under section  
2 1902(a)(10)(A) or under any other cat-  
3 egory of eligibility for medical assistance  
4 for full benefits under this title, as deter-  
5 mined by the Secretary.

6 “(ii) EXCLUSION OF MEDICALLY  
7 NEEDY AND SPEND-DOWN POPULATIONS.—  
8 Such term shall not include an individual  
9 determined to be eligible by the State for  
10 medical assistance under section  
11 1902(a)(10)(C) or by reason of section  
12 1902(f) or otherwise eligible based on a re-  
13 duction of income based on costs incurred  
14 for medical or other remedial care.

15 “(b) BENCHMARK BENEFIT PACKAGES.—

16 “(1) IN GENERAL.—For purposes of subsection  
17 (a)(1), each of the following coverage shall be con-  
18 sidered to be benchmark coverage:

19 “(A) FEHBP-EQUIVALENT CHILDREN’S  
20 HEALTH INSURANCE COVERAGE.—The standard  
21 Blue Cross/Blue Shield preferred provider op-  
22 tion service benefit plan, described in and of-  
23 fered under section 8903(1) of title 5, United  
24 States Code.

1           “(B) STATE EMPLOYEE COVERAGE.—A  
2 health benefits coverage plan that is offered and  
3 generally available to State employees in the  
4 State involved.

5           “(C) COVERAGE OFFERED THROUGH  
6 HMO.—The health insurance coverage plan  
7 that—

8                   “(i) is offered by a health mainte-  
9 nance organization (as defined in section  
10 2791(b)(3) of the Public Health Service  
11 Act), and

12                   “(ii) has the largest insured commer-  
13 cial, non-medicaid enrollment of covered  
14 lives of such coverage plans offered by  
15 such a health maintenance organization in  
16 the State involved.

17           “(2) BENCHMARK-EQUIVALENT COVERAGE.—  
18 For purposes of subsection (a)(1), coverage that  
19 meets the following requirement shall be considered  
20 to be benchmark-equivalent coverage:

21                   “(A) INCLUSION OF BASIC SERVICES.—  
22 The coverage includes benefits for items and  
23 services within each of the following categories  
24 of basic services:

1                   “(i) Inpatient and outpatient hospital  
2                   services.

3                   “(ii) Physicians’ surgical and medical  
4                   services.

5                   “(iii) Laboratory and x-ray services.

6                   “(iv) Well-baby and well-child care,  
7                   including age-appropriate immunizations.

8                   “(v) Other appropriate preventive  
9                   services, as designated by the Secretary.

10                  “(B) AGGREGATE ACTUARIAL VALUE  
11                  EQUIVALENT TO BENCHMARK PACKAGE.—The  
12                  coverage has an aggregate actuarial value that  
13                  is at least actuarially equivalent to one of the  
14                  benchmark benefit packages described in para-  
15                  graph (1).

16                  “(C) SUBSTANTIAL ACTUARIAL VALUE FOR  
17                  ADDITIONAL SERVICES INCLUDED IN BENCH-  
18                  MARK PACKAGE.—With respect to each of the  
19                  following categories of additional services for  
20                  which coverage is provided under the bench-  
21                  mark benefit package used under subparagraph  
22                  (B), the coverage has an actuarial value that is  
23                  equal to at least 75 percent of the actuarial  
24                  value of the coverage of that category of serv-  
25                  ices in such package:

1 “(i) Coverage of prescription drugs.

2 “(ii) Mental health services.

3 “(iii) Vision services.

4 “(iv) Hearing services.

5 “(3) DETERMINATION OF ACTUARIAL VALUE.—

6 The actuarial value of coverage of benchmark benefit  
7 packages shall be set forth in an actuarial opinion  
8 in an actuarial report that has been prepared—

9 “(A) by an individual who is a member of  
10 the American Academy of Actuaries;

11 “(B) using generally accepted actuarial  
12 principles and methodologies;

13 “(C) using a standardized set of utilization  
14 and price factors;

15 “(D) using a standardized population that  
16 is representative of the population involved;

17 “(E) applying the same principles and fac-  
18 tors in comparing the value of different cov-  
19 erage (or categories of services);

20 “(F) without taking into account any dif-  
21 ferences in coverage based on the method of de-  
22 livery or means of cost control or utilization  
23 used; and

24 “(G) taking into account the ability of a  
25 State to reduce benefits by taking into account

1 the increase in actuarial value of benefits cov-  
2 erage offered under this title that results from  
3 the limitations on cost sharing under such cov-  
4 erage.

5 The actuary preparing the opinion shall select and  
6 specify in the memorandum the standardized set and  
7 population to be used under subparagraphs (C) and  
8 (D).”.

9 **CHAPTER 4—EXPANDED ACCESS TO**  
10 **CERTAIN BENEFITS**

11 **SEC. 3131. STATE OPTION OF PROVIDING CASH & COUN-**  
12 **SELING PROGRAMS.**

13 Title XIX of the Social Security Act, as amended by  
14 section 3124, is amended by redesignating section 1937  
15 as section 1938 and by inserting after section 1936 the  
16 following new section:

17 “OPTIONAL USE OF CASH AND COUNSELING PROGRAM IN  
18 CONNECTION WITH PERSONAL CARE SERVICES

19 “SEC. 1937. (a) ESTABLISHMENT OF PROGRAM.—

20 “(1) IN GENERAL.—A State may amend its  
21 State plan under this title to establish and operate,  
22 in connection with its provision of cash and coun-  
23 seling covered services under this title, a cash and  
24 counseling program in accordance with this section.

25 “(2) CASH AND COUNSELING COVERED SERV-  
26 ICES DEFINED.—For purposes of this section, the

1 term ‘cash and counseling covered services’ means  
2 personal care and related services and includes home  
3 or community-based services of the type described in  
4 section 1915(e), services described in section  
5 2110(a)(14), and related support services, such as  
6 personal care and respite care.

7 “(b) CASH AND COUNSELING PROGRAM DEFINED.—

8 “(1) IN GENERAL.—For purposes of this sec-  
9 tion, the term ‘cash and counseling program’ means  
10 a program operated by a State in accordance with  
11 this section under which eligible participants, within  
12 an approved self-directed services plan and budget,  
13 purchase cash and counseling covered services and  
14 permits such participants to hire, supervise, and  
15 manage the individuals providing such services.

16 “(2) PROGRAM PROVISIONS.—

17 “(A) USE OF FISCAL INTERMEDIARY.—

18 Each cash and counseling program shall require  
19 participants to use a fiscal intermediary to ad-  
20 minister payments to providers under the pro-  
21 gram.

22 “(B) USE OF SAVINGS.—Each such pro-  
23 gram shall permit a participant to use—

24 “(i) notwithstanding any other provi-  
25 sion of law, amounts provided under the

1 program for cash payments to legally re-  
2 sponsible relatives (such as a spouse or a  
3 parent); and

4 “(ii) moneys otherwise saved under an  
5 approved self-directed services plan and  
6 budget to purchase items that increase  
7 independence (such as a microwave or an  
8 accessibility ramp).

9 “(C) MONITORING ENROLLMENT AND  
10 COSTS.—Each such program shall monitor and  
11 report quarterly to the Secretary on enrollment  
12 and costs under the program.

13 “(c) ELIGIBLE PARTICIPANTS.—For purposes of this  
14 section, the term ‘eligible participant’ means, with respect  
15 to a cash and counseling program, an individual who—

16 “(1) is eligible for medical assistance under this  
17 title with respect to cash and counseling covered  
18 services (whether under a waiver under section  
19 1915(e) or otherwise) and has an approved self-di-  
20 rected services plan and budget (as defined in sub-  
21 section (d)) in connection with such participation  
22 and does not receive other medical assistance for  
23 such services under this title (than under such plan  
24 and budget) while participating in the cash and  
25 counseling program;

1           “(2) qualifies as a disabled individual under  
2 section 1614(a);

3           “(3) language based on MFI demo language:  
4           “(C) at the time the individual begins participation  
5 in a cash and counseling program, resides in—

6                   “(A) a single-family home owned or leased  
7 by the individual or the individual’s family  
8 member; or

9                   “(B) an apartment with an individual  
10 lease, lockable access and egress, and living,  
11 sleeping, and cooking areas over which the oc-  
12 cupant has domain and control; and

13           “(4) voluntarily elects to participate in the cash  
14 and counseling program.

15           “(d) APPROVED SELF-DIRECTED SERVICES PLAN  
16 AND BUDGET.—For purposes of this section, the term ‘ap-  
17 proved self-directed services plan and budget’ means, with  
18 respect to a participant, the establishment of a plan and  
19 budget for the provision of cash and counseling covered  
20 services through self-direction consistent with this fol-  
21 lowing requirements:

22                   “(1) SELF-DIRECTION.—The participant (or, in  
23 the case of a participant who is a minor child, the  
24 participant’s parent or guardian) exercises choice  
25 and control over the budget, planning, and purchase

1 of cash and counseling covered services, including  
2 the amount, duration, and scope, provider, and loca-  
3 tion of service provision.

4 “(2) ASSESSMENT OF NEEDS.—There is an as-  
5 sessment of the needs, strengths, and preferences of  
6 the participant for such services.

7 “(3) SERVICE PLAN.—A plan for such services  
8 (and supports for such services) for the participant  
9 has been developed and approved by the State based  
10 on such assessment through a person-centered proc-  
11 ess that—

12 “(A) builds upon the participant’s capacity  
13 to engage in activities that promote community  
14 life and that respects the participant’s pref-  
15 erences, choices, and abilities; and

16 “(B) involves families, friends, and profes-  
17 sionals in the planning or delivery of services or  
18 supports as desired or required by the partici-  
19 pant.

20 “(4) SERVICE BUDGET.—A budget for such  
21 services and supports for the participant has been  
22 developed and approved by the State based on such  
23 assessment and plan and on a methodology that uses  
24 valid, reliable cost data, is open to public inspection,

1 and includes a calculation of the expected cost of  
2 such services if those services were not self-directed.

3 “(5) APPLICATION OF QUALITY ASSURANCE  
4 AND RISK MANAGEMENT.—There are appropriate  
5 quality assurance and risk management techniques  
6 used in establishing and implementing such plan and  
7 budget that recognize the roles and sharing of re-  
8 sponsibilities in obtaining services in a self-directed  
9 manner and assure the appropriateness of such plan  
10 and budget based upon the participant’s resources  
11 and capabilities.”.

12 **SEC. 3132. EXTENSION OF TRANSITIONAL MEDICAL ASSIST-**  
13 **ANCE (TMA) AND ABSTINENCE EDUCATION**  
14 **PROGRAM.**

15 (a) TMA EXTENSION.—

16 (1) IN GENERAL.—Section 1925(f) of the Social  
17 Security Act (42 U.S.C. 1396r-6(f)) is amended by  
18 striking “September 30, 2003” and inserting “De-  
19 cember 31, 2006”.

20 (2) CONFORMING AMENDMENT.—Section  
21 1902(e)(1)(B) of such Act (42 U.S.C.  
22 1396a(e)(1)(B)) is amended by striking “September  
23 30, 2003” and inserting “the last date (if any) on  
24 which section 1925 applies under subsection (f) of  
25 that section or otherwise”.

1 (b) ABSTINENCE EDUCATION.—Section 510(d) of the  
2 Social Security Act (42 U.S.C. 710(d)) is amended by  
3 striking “2003” and inserting “2006 and an additional  
4 \$12,500,000 for the first calendar quarter in fiscal year  
5 2007”.

6 **SEC. 3133. EXPANSION OF STATE LONG-TERM CARE PART-**  
7 **nership PROGRAM.**

8 (a) IN GENERAL.—Section 1917(b) of the Social Se-  
9 curity Act (42 U.S.C. 1396p(b)) is amended—

10 (1) in paragraph (1)(C)(ii), by inserting “or  
11 which has a State plan amendment that provides for  
12 a qualified State long-term care insurance partner-  
13 ship (as defined in clause (iii))” after “1993,”; and

14 (2) by adding at the end of paragraph (1)(C)  
15 the following new clauses:

16 “(iii) For purposes of this paragraph, the term  
17 ‘qualified State long-term care insurance partner-  
18 ship’ means a State plan amendment under this title  
19 that provides for the disregard of any assets or re-  
20 sources in an amount equal to the insurance benefit  
21 payments that are made under a long-term care in-  
22 surance policy (including a certificate issued under a  
23 group insurance contract), if the following require-  
24 ments are met:

1           “(I) The policy covers an insured who was  
2 a resident of such State when coverage first be-  
3 came effective under the policy.

4           “(II) The policy is a qualified long-term  
5 care insurance policy (as defined in section  
6 7702(b) of the Internal Revenue Code of 1986)  
7 issued on or after the date of approval of the  
8 plan amendment.

9           “(III) If the policy does not provide some  
10 level of inflation protection, the insured was of-  
11 fered, before the policy was sold, a long-term  
12 care insurance policy that provides some level of  
13 inflation protection.

14           “(IV) The State plan amendment provides  
15 for some level of agent training for the sale of  
16 long-term care insurance policies under the  
17 partnership.

18           “(V) The issuer of the policy provides reg-  
19 ular reports to the Secretary that include, in ac-  
20 cordance with regulations of the Secretary (pro-  
21 mulgated after consultation with the States),  
22 notification regarding when all benefits provided  
23 under the policy have been paid and the amount  
24 of such benefits paid, when the policy otherwise  
25 terminates, and such other information as the

1 Secretary determines may be appropriate to the  
2 administration of such partnerships.

3 “(VI) The State does not impose any re-  
4 quirement affecting the terms or benefits of  
5 such a policy unless the State imposes such re-  
6 quirement on long-term care insurance policies  
7 without regard to whether the policy is covered  
8 under the partnership or is offered in connec-  
9 tion with such a partnership.

10 In the case of a long-term care insurance policy  
11 which is exchanged for another such policy, sub-  
12 clause (I) shall be applied based on the coverage of  
13 the first such policy that was exchanged.

14 “(iv) The Secretary—

15 “(I) as appropriate, shall provide copies of  
16 the reports described in clause (iii)(VII) to the  
17 State involved; and

18 “(II) shall promote the education of con-  
19 sumers regarding qualified State long-term care  
20 insurance partnerships.”.

21 (b) CONSTRUCTION.—Nothing in the amendments  
22 made by subsection (a) shall be construed as affecting the  
23 treatment of long-term care insurance policies that are or  
24 were provided under a State plan amendment described

1 in section 1916(b)(1)(C)(ii) of the Social Security Act that  
2 was approved as of May 15, 1993.

3 (c) **EFFECTIVE DATE.**—A State plan amendment  
4 that provides for a qualified State long-term care insur-  
5 ance partnership under the amendments made by sub-  
6 section (a) may provide that such amendment is effective  
7 for long-term care insurance policies issued on or after a  
8 date, specified in the amendment, that is not earlier than  
9 the date of the enactment of this Act.

10 (d) **STANDARDS FOR RECIPROCAL RECOGNITION**  
11 **AMONG PARTNERSHIP STATES.**—In order to permit port-  
12 ability in long-term care insurance policies purchased  
13 under State long-term care insurance partnerships, the  
14 Secretary may develop, in consultation with the States and  
15 the National Association of Insurance Commissioners, uni-  
16 form standards for reciprocal recognition of such policies  
17 among States with qualified State long-term care insur-  
18 ance partnerships.

19 **SEC. 3134. HEALTH OPPORTUNITY ACCOUNTS.**

20 Title XIX of the Social Security Act, as amended by  
21 sections 3124 and 3131, is amended—

22 (1) by redesignating section 1938 as section  
23 1939; and

24 (2) by inserting after section 1937 the following  
25 new section:

1                   “HEALTH OPPORTUNITY ACCOUNTS

2                   “SEC. 1938. (a) AUTHORITY.—

3                   “(1) IN GENERAL.—Notwithstanding any other  
4                   provision of this title, the Secretary shall establish a  
5                   demonstration program under which States may pro-  
6                   vide under their State plans under this title (includ-  
7                   ing such a plan operating under a statewide waiver  
8                   under section 1115) in accordance with this section  
9                   for the provision of alternative benefits consistent  
10                  with subsection (c) for eligible population groups in  
11                  one or more geographic areas of the State specified  
12                  by the State. An amendment under the previous sen-  
13                  tence is referred to in this section as a ‘State dem-  
14                  onstration program’.

15                  “(2) INITIAL DEMONSTRATION.—The dem-  
16                  onstration program under this section shall begin on  
17                  January 1, 2006. During the first 5 years of such  
18                  program, the Secretary shall not approve more than  
19                  10 State demonstration programs, with each State  
20                  demonstration program covering one or more geo-  
21                  graphic areas specified by the State. After such 5-  
22                  year period—

23                  “(A) unless the Secretary finds, taking  
24                  into account cost-effectiveness, quality of care,  
25                  and other criteria that the Secretary specifies,

1           that a State demonstration program previously  
2           implemented has been unsuccessful, such a  
3           demonstration program may be extended or  
4           made permanent in the State; and

5           “(B) unless the Secretary finds, taking  
6           into account cost-effectiveness, quality of care,  
7           and other criteria that the Secretary specifies,  
8           that all State demonstration program previously  
9           implemented were unsuccessful, other States  
10          may implement State demonstration programs.

11          “(3) APPROVAL.—The Secretary shall not ap-  
12          prove a State demonstration program under para-  
13          graph (1) unless the program includes the following:

14               “(A) Creating patient awareness of the  
15               high cost of medical care.

16               “(B) Providing incentives to patients to  
17               seek preventive care services.

18               “(C) Reducing inappropriate use of health  
19               care services.

20               “(D) Enabling patients to take responsi-  
21               bility for health outcomes.

22               “(E) Providing enrollment counselors and  
23               ongoing education activities.

1           “(F) Providing transactions involving  
2           health opportunity accounts to be conducted  
3           electronically and without cash.

4           “(G) Providing access to negotiated pro-  
5           vider payment rates consistent with this section.

6           Nothing in this section shall be construed as pre-  
7           venting a State demonstration program from pro-  
8           viding incentives for patients obtaining appropriate  
9           preventive care (as defined for purposes of section  
10          223(c)(2)(C) of the Internal Revenue Code of 1986),  
11          such as additional account contributions for an indi-  
12          vidual demonstrating healthy prevention practices.

13          “(4)           NO           REQUIREMENT           FOR  
14          STATEWIDENESS.—Nothing in this section or any  
15          other provision of law shall be construed to require  
16          that a State must provide for the implement of a  
17          State demonstration program on a Statewide basis.

18          “(5) REPORTS.—The Secretary shall periodi-  
19          cally submit to Congress reports regarding the suc-  
20          cess of State demonstration programs.

21          “(b) ELIGIBLE POPULATION GROUPS.—

22          “(1) IN GENERAL.—A State demonstration pro-  
23          gram under this section shall specify the eligible  
24          population groups consistent with paragraph (2).

1           “(2) ELIGIBILITY LIMITATIONS DURING INITIAL  
2 DEMONSTRATION PERIOD.—During the initial 5  
3 years of the demonstration program under this sec-  
4 tion, a State demonstration project shall not apply  
5 to any of the following individuals:

6           “(A) Individuals who are 65 years of age  
7 or older.

8           “(B) Individuals who are disabled, regard-  
9 less of whether or not their eligibility for med-  
10 ical assistance under this title is based on such  
11 disability.

12           “(C) Individuals who are eligible for med-  
13 ical assistance under this title only because they  
14 are (or were within previous 60 days) pregnant.

15           “(D) Individuals who have been eligible for  
16 medical assistance for a continuous period of  
17 less than 3 months.

18           “(3) LIMITATIONS.—

19           “(A) STATE OPTION.—This subsection  
20 shall not be construed as preventing a State  
21 from further limiting eligibility to individuals  
22 who are likely to be eligible for medical assist-  
23 ance for a period of one year or longer.

24           “(B) ON ENROLLEES IN MEDICAID MAN-  
25 AGED CARE ORGANIZATIONS.—Insofar as the

1 State provides for eligibility of individuals who  
2 are enrolled in medicaid managed care organi-  
3 zations, such individuals may participate in the  
4 State demonstration project only if the State  
5 provides assurances satisfactory to the Sec-  
6 retary that the following conditions are met  
7 with respect to any such organization:

8 “(i) In no case may the number of  
9 such individuals enrolled in the organiza-  
10 tion who participate in the project exceed  
11 5 percent of the total number of individ-  
12 uals enrolled in such organization.

13 “(ii) The proportion of enrollees in  
14 the organization who so participate is not  
15 significantly disproportionate to the pro-  
16 portion of such enrollees in other such or-  
17 ganizations who participate.

18 “(iii) The State has provided for an  
19 appropriate adjustment in the per capita  
20 payments to the organization to account  
21 for such participation, taking into account  
22 differences in the likely use of health serv-  
23 ices between enrollees who so participate  
24 and enrollees who do not so participate.

1           “(4) VOLUNTARY PARTICIPATION.—An eligible  
2 individual shall be enrolled in a State demonstration  
3 project only if the individual voluntarily enrolls.  
4 Such an enrollment shall be effective for a period of  
5 12 months, but may be extended for additional peri-  
6 ods of 12 months each with the consent of the indi-  
7 vidual.

8           “(c) ALTERNATIVE BENEFITS.—

9           “(1) IN GENERAL.—The alternative benefits  
10 provided under this section shall consist, consistent  
11 with this subsection, of at least—

12           “(A) coverage for medical expenses in a  
13 year for items and services for which benefits  
14 are otherwise provided under this title after an  
15 annual deductible described in paragraph (2)  
16 has been met; and

17           “(B) contribution into a health opportunity  
18 account.

19 Nothing in subparagraph (A) shall be construed as  
20 preventing a State from providing for coverage of  
21 preventive care (referred to in subsection (a)(3))  
22 within the alternative benefits without regard to the  
23 annual deductible.

24           “(2) ANNUAL DEDUCTIBLE.—The amount of  
25 the annual deductible described in paragraph (1)(A)

1 shall be at least 100 percent, but no more than 110  
2 percent, of the annualized amount of contributions  
3 to the health opportunity account under subsection  
4 (d)(2)(A)(i), determined without regard to any limi-  
5 tation described in subsection (d)(2)(C)(ii).

6 “(3) ACCESS TO NEGOTIATED PROVIDER PAY-  
7 MENT RATES.—

8 “(A) FEE-FOR-SERVICE ENROLLEES.—In  
9 the case of an individual who is participating in  
10 a State demonstration project and who is not  
11 enrolled with a medicaid managed care organi-  
12 zation, the State shall provide that the indi-  
13 vidual may obtain demonstration project med-  
14 icaid services from—

15 “(i) any participating provider under  
16 this title at the same payment rates that  
17 would be applicable to such services if the  
18 deductible described in paragraph (1)(A)  
19 was not applicable; or

20 “(ii) any provider at payment rates  
21 that do not exceed 125 percent of the pay-  
22 ment rate that would be applicable to such  
23 services furnished by a participating pro-  
24 vider under this title if the deductible de-

1           scribed in paragraph (1)(A) was not appli-  
2           cable.

3           “(B) TREATMENT UNDER MEDICAID MAN-  
4           AGED CARE PLANS.—In the case of an indi-  
5           vidual who is participating in a State dem-  
6           onstration project and is enrolled with a med-  
7           icaid managed care organization, the State shall  
8           enter into an arrangement with the organiza-  
9           tion under which the individual may obtain  
10          demonstration project medicaid services from  
11          any provider under such organization at pay-  
12          ment rates that do not the payment rate that  
13          would be applicable to such services if the de-  
14          ductible described in paragraph (1)(A) was not  
15          applicable.

16          “(C) COMPUTATION.—The payment rates  
17          described in subparagraphs (A) and (B) shall  
18          be computed without regard to any cost-sharing  
19          that would be otherwise applicable under sec-  
20          tion 1916.

21          “(D) DEFINITIONS.—For purposes of this  
22          paragraph:

23                 “(i) The term ‘demonstration project  
24                 medicaid services’ means, with respect to  
25                 an individual participating in a State dem-

1                   onstration project, services for which the  
2                   individual would be provided medical as-  
3                   sistance under this title but for the appli-  
4                   cation of the deductible described in para-  
5                   graph (1)(A).

6                   “(ii) The term ‘participating provider’  
7                   means—

8                   “(I) with respect to an individual  
9                   described in subparagraph (A), a  
10                  health care provider that has entered  
11                  into a participation agreement with  
12                  the State for the provision of services  
13                  to individuals entitled to benefits  
14                  under the State plan; or

15                  “(II) with respect to an indi-  
16                  vidual described in subparagraph (B)  
17                  who is enrolled in a medicaid man-  
18                  aged care organization, a health care  
19                  provider that has entered into an ar-  
20                  rangement for the provision of serv-  
21                  ices to enrollees of the organization  
22                  under this title.

23                  “(4) NO EFFECT ON SUBSEQUENT BENEFITS.—  
24                  Except as provided under paragraphs (1) and (2),  
25                  alternative benefits for an eligible individual shall

1 consist of the benefits otherwise provided to the indi-  
2 vidual, including cost-sharing relating to such bene-  
3 fits.

4 “(5) OVERRIDING COST-SHARING AND COM-  
5 PARABILITY REQUIREMENTS FOR ALTERNATIVE  
6 BENEFITS.—The provisions of this title relating to  
7 cost-sharing for benefits (including section 1916)  
8 shall not apply with respect to benefits to which the  
9 annual deductible under paragraph (1)(A) applies.  
10 The provisions of section 1902(a)(10)(B) (relating  
11 to comparability) shall not apply with respect to the  
12 provision of alternative benefits (as described in this  
13 subsection).

14 “(6) TREATMENT AS MEDICAL ASSISTANCE.—  
15 Subject to subparagraphs (D) and (E) of subsection  
16 (d)(2), payments for alternative benefits under this  
17 section (including contributions into a health oppor-  
18 tunity account) shall be treated as medical assist-  
19 ance for purposes of section 1903(a).

20 “(7) USE OF TIERED DEDUCTIBLE AND COST-  
21 SHARING.—

22 “(A) IN GENERAL.—A State—

23 “(i) may vary the amount of the an-  
24 nual deductible applied under paragraph  
25 (1)(A) based on the income of the family

1 involved so long as it does not favor fami-  
2 lies with higher income over those with  
3 lower income; and

4 “(ii) may vary the amount of the max-  
5 imum out-of-pocket cost-sharing (as de-  
6 fined in subparagraph (B)) based on the  
7 income of the family involved so long as it  
8 does not favor families with higher income  
9 over those with lower income.

10 “(B) MAXIMUM OUT-OF-POCKET COST-  
11 SHARING.—For purposes of subparagraph  
12 (A)(ii), the term ‘maximum out-of-pocket cost-  
13 sharing’ means, for an individual or family, the  
14 amount by which the annual deductible level ap-  
15 plied under paragraph (1)(A) to the individual  
16 or family exceeds the balance in the health op-  
17 portunity account for the individual or family.

18 “(8) CONTRIBUTIONS BY EMPLOYERS.—Noth-  
19 ing in this section shall be construed as preventing  
20 an employer from providing health benefits coverage  
21 consisting of the coverage described in paragraph  
22 (1)(A) to individuals who are provided alternative  
23 benefits under this section.

24 “(d) HEALTH OPPORTUNITY ACCOUNT.—

1           “(1) IN GENERAL.—For purposes of this sec-  
2           tion, the term ‘health opportunity account’ means an  
3           account that meets the requirements of this sub-  
4           section.

5           “(2) CONTRIBUTIONS.—

6           “(A) IN GENERAL.—No contribution may  
7           be made into a health opportunity account  
8           except—

9                   “(i) contributions by the State under  
10                   this title; and

11                   “(ii) contributions by other persons  
12                   and entities, such as charitable organiza-  
13                   tions.

14           “(B) STATE CONTRIBUTION.—A State  
15           shall specify the contribution amount that shall  
16           be deposited under subparagraph (A)(i) into a  
17           health opportunity account.

18           “(C) LIMITATION ON ANNUAL STATE CON-  
19           TRIBUTION PROVIDED AND PERMITTING IMPO-  
20           SITION OF MAXIMUM ACCOUNT BALANCE.—

21                   “(i) IN GENERAL.—A State—

22                           “(I) may impose limitations on  
23                           the maximum contributions that may  
24                           be deposited under subparagraph

1 (A)(i) into a health opportunity ac-  
2 count in a year;

3 “(II) may limit contributions into  
4 such an account once the balance in  
5 the account reaches a level specified  
6 by the State; and

7 “(III) subject to clauses (ii) and  
8 (iii) and subparagraph (D)(i), may  
9 not provide contributions described in  
10 subparagraph (A)(i) to a health op-  
11 portunity account on behalf of an in-  
12 dividual or family to the extent the  
13 amount of such contributions (includ-  
14 ing both State and Federal shares)  
15 exceeds, on an annual basis, \$2,500  
16 for each individual (or family mem-  
17 ber) who is an adult and \$1,000 for  
18 each individual (or family member)  
19 who is a child.

20 “(ii) INDEXING OF DOLLAR LIMITA-  
21 TIONS.—For each year after 2006, the dol-  
22 lar amounts specified in clause (i)(III)  
23 shall be annually increased by the Sec-  
24 retary by an percentage that reflects the  
25 annual percentage increase in the medical

1 care component of the consumer price  
2 index for all urban consumers.

3 “(iii) BUDGET NEUTRAL ADJUST-  
4 MENT.—A State may provide for dollar  
5 limitations in excess of those specified in  
6 clause (i)(III) (as increased under clause  
7 (ii)) for specified individuals if the State  
8 provides assurances satisfactory to the Sec-  
9 retary that contributions otherwise made  
10 to other individuals will be reduced in a  
11 manner so as to provide for aggregate con-  
12 tributions that do not exceed the aggregate  
13 contributions that would otherwise be per-  
14 mitted under this subparagraph.

15 “(D) LIMITATIONS ON FEDERAL MATCH-  
16 ING.—

17 “(i) STATE CONTRIBUTION.—A State  
18 may contribute under subparagraph (A)(i)  
19 amounts to a health opportunity account in  
20 excess of the limitations provided under  
21 subparagraph (C)(i)(III), but no Federal  
22 financial participation shall be provided  
23 under section 1903(a) with respect to con-  
24 tributions in excess of such limitations.

1                   “(ii) NO FFP FOR PRIVATE CONTRIBU-  
2                   TIONS.—No Federal financial participation  
3                   shall be provided under section 1903(a)  
4                   with respect to any contributions described  
5                   in subparagraph (A)(ii) to a health oppor-  
6                   tunity account.

7                   “(E) APPLICATION OF DIFFERENT MATCH-  
8                   ING RATES.—The Secretary shall provide a  
9                   method under which, for expenditures made  
10                  from a health opportunity account for medical  
11                  care for which the Federal matching rate under  
12                  section 1903(a) exceeds the Federal medical as-  
13                  sistance percentage, a State may obtain pay-  
14                  ment under such section at such higher match-  
15                  ing rate for such expenditures.

16                  “(3) USE.—

17                         “(A) GENERAL USES.—

18                                 “(i) IN GENERAL.—Subject to the  
19                                 succeeding provisions of this paragraph,  
20                                 amounts in a health opportunity account  
21                                 may be used for payment of such health  
22                                 care expenditures as the State specifies.

23                                 “(ii) GENERAL LIMITATION.—In no  
24                                 case shall such account be used for pay-  
25                                 ment for health care expenditures that are

1 not payment of medical care (as defined by  
2 section 213(d) of the Internal Revenue  
3 Code of 1986).

4 “(iii) STATE RESTRICTIONS.—In ap-  
5 plying clause (i), a State may restrict pay-  
6 ment for—

7 “(I) providers of items and serv-  
8 ices to providers that are licensed or  
9 otherwise authorized under State law  
10 to provide the item or service and may  
11 deny payment for such a provider on  
12 the basis that the provider has been  
13 found, whether with respect to this  
14 title or any other health benefit pro-  
15 gram, to have failed to meet quality  
16 standards or to have committed one  
17 or more acts of fraud or abuse; and

18 “(II) items and services insofar  
19 as the State finds they are not medi-  
20 cally appropriate or necessary.

21 “(iv) ELECTRONIC WITHDRAWALS.—  
22 The State demonstration program shall  
23 provide for a method whereby withdrawals  
24 may be made from the account for such  
25 purposes using an electronic system and

1 shall not permit withdrawals from the ac-  
2 count in cash.

3 “(B) MAINTENANCE OF HEALTH OPPOR-  
4 TUNITY ACCOUNT AFTER BECOMING INELI-  
5 GIBLE FOR PUBLIC BENEFIT.—

6 “(i) IN GENERAL.—Notwithstanding  
7 any other provision of law, if an account  
8 holder of a health opportunity account be-  
9 comes ineligible for benefits under this title  
10 because of an increase in income or  
11 assets—

12 “(I) no additional contribution  
13 shall be made into the account under  
14 paragraph (2)(A)(i);

15 “(II) subject to clause (iii), the  
16 balance in the account shall be re-  
17 duced by 25 percent; and

18 “(III) subject to the succeeding  
19 provisions of this subparagraph, the  
20 account shall remain available to the  
21 account holder for withdrawals under  
22 the same terms and conditions as if  
23 the account holder remained eligible  
24 for such benefits.

1           “(ii) SPECIAL RULES.—Withdrawals  
2 under this subparagraph from an  
3 account—

4           “(I) shall be available for the  
5 purchase of health insurance coverage;  
6 and

7           “(II) may, subject to clause (iv),  
8 be made available (at the option of  
9 the State) for such additional expendi-  
10 tures (such as job training and tuition  
11 expenses) specified by the State (and  
12 approved by the Secretary) as the  
13 State may specify.

14           “(iii) EXCEPTION FROM 25 PERCENT  
15 SAVINGS TO GOVERNMENT FOR PRIVATE  
16 CONTRIBUTIONS.—Clause (i)(II) shall not  
17 apply to the portion of the account that is  
18 attributable to contributions described in  
19 paragraph (2)(A)(ii). For purposes of ac-  
20 counting for such contributions, with-  
21 draws from a health opportunity account  
22 shall first be attributed to contributions  
23 described in paragraph (2)(A)(i).

24           “(iv) CONDITION FOR NON-HEALTH  
25 WITHDRAWALS.—No withdrawal may be

1           made from an account under clause (ii)(II)  
2           unless the accountholder has participated  
3           in the program under this section for at  
4           least 1 year.

5                   “(v) NO REQUIREMENT FOR CONTINU-  
6                   ATION OF COVERAGE.—An account holder  
7                   of a health opportunity account, after be-  
8                   coming ineligible for medical assistance  
9                   under this title, is not required to purchase  
10                  high-deductible or other insurance as a  
11                  condition of maintaining or using the ac-  
12                  count.

13                   “(4) ADMINISTRATION.—A State may coordi-  
14                  nate administration of health opportunity accounts  
15                  through the use of a third party administrator and  
16                  reasonable expenditures for the use of such adminis-  
17                  trator shall be reimbursable to the State in the same  
18                  manner as other administrative expenditures under  
19                  section 1903(a)(7).

20                   “(5) TREATMENT.—Amounts in, or contributed  
21                  to, a health opportunity account shall not be counted  
22                  as income or assets for purposes of determining eli-  
23                  gibility for benefits under this title.

24                   “(6) UNAUTHORIZED WITHDRAWALS.—A State  
25                  may establish procedures—

1           “(A) to penalize or remove an individual  
2           from the health opportunity account based on  
3           nonqualified withdrawals by the individual from  
4           such an account; and

5           “(B) to recoup costs that derive from such  
6           nonqualified withdrawals.”.

7           **CHAPTER 5—OTHER PROVISIONS**

8           **SEC. 3141. INCREASE IN MEDICAID PAYMENTS TO CERTAIN**  
9           **INSULAR AREAS.**

10          Section 1108(g) of the Social Security Act (42 U.S.C.  
11          1308(g)) is amended—

12           (1) in paragraph (2), by inserting “and subject  
13           to paragraph (3)” after “subsection (f)”; and

14           (2) by adding at the end the following new  
15           paragraph:

16           “(3) FISCAL YEAR 2006 AND 2007 FOR CERTAIN  
17           INSULAR AREAS.—The amounts otherwise deter-  
18           mined under this subsection for the Virgin Islands,  
19           Guam, the Northern Mariana Islands, and American  
20           Samoa for fiscal year 2006 and fiscal year 2007  
21           shall be increased by the following amounts:

22           “(A) For the Virgin Islands, \$2,500,000  
23           for fiscal year 2006 and \$5,000,000 for fiscal  
24           year 2007.

1           “(B) For Guam, \$2,500,000 for fiscal year  
2           2006 and \$5,000,000 for fiscal year 2007.

3           “(C) For the Northern Mariana Islands,  
4           \$1,000,000 for fiscal year 2006 and \$2,000,000  
5           for fiscal year 2007.

6           “(D) For American Samoa, \$2,000,000 for  
7           fiscal year 2006 and \$4,000,000 for fiscal year  
8           2007.

9           Such amounts shall not be taken into account in ap-  
10          plying paragraph (2) for fiscal year 2007 but shall  
11          be taken into account in applying such paragraph  
12          for fiscal year 2008 and subsequent fiscal years.”.

13 **SEC. 3142. MANAGED CARE ORGANIZATION PROVIDER TAX**  
14 **REFORM.**

15          (a) IN GENERAL.—Section 1903(w)(7)(A)(viii) of the  
16          Social Security Act (42 U.S.C. 1396b(w)(7)(A)(viii)) is  
17          amended to read as follows:

18                 “(viii) Services of managed care organiza-  
19                 tions (including health maintenance organiza-  
20                 tions, preferred provider organizations, and  
21                 such other similar organizations as the Sec-  
22                 retary may specify by regulation).”.

23          (b) EFFECTIVE DATE.—

1           (1) IN GENERAL.—Subject to paragraph (2),  
2           the amendment made by subsection (a) shall be ef-  
3           fective as of the date of the enactment of this Act.

4           (2) GRANDFATHER.—In the case of a State  
5           that has had approved as of the date of the enact-  
6           ment of this Act a provider tax on services described  
7           in section 1903(w)(7)(A)(viii) of the Social Security  
8           Act, as amended by subsection (a), such amendment  
9           shall be effective as of October 1, 2007.

10 **SEC. 3143. MEDICAID TRANSFORMATION GRANTS.**

11           (a) IN GENERAL.—Section 1903 of the Social Secu-  
12           rity Act (42 U.S.C. 1396b), as amended by section 3104,  
13           is amended by adding at the end the following new sub-  
14           section:

15           “(y) MEDICAID TRANSFORMATION PAYMENTS.—

16           “(1) IN GENERAL.—In addition to the pay-  
17           ments provided under subsection (a), subject to  
18           paragraph (4), the Secretary shall provide for pay-  
19           ments under subsection (a) to States for the adop-  
20           tion of innovative methods to improve the effective-  
21           ness and efficiency in providing medical assistance  
22           under this title.

23           “(2) PERMISSIBLE USES OF FUNDS.—The fol-  
24           lowing are examples of innovative methods for which  
25           funds provided under this subsection may be used:

1           “(A) Methods for reducing patient error  
2 rates.

3           “(B) Methods for improving rates of collec-  
4 tion from estates of amounts owed under this  
5 title.

6           “(C) Methods for reducing fraud and  
7 abuse under the program under this title.

8           “(3) APPLICATION; TERMS AND CONDITIONS.—  
9 No payments shall be made to a State under this  
10 subsection unless the State applied to the Secretary  
11 for such payments in a form, manner, and time  
12 specified by the Secretary. Such payments are made  
13 under such terms and conditions consistent with this  
14 subsection as the Secretary prescribes.

15           “(4) FUNDING.—

16           “(A) LIMITATION ON FUNDS.—The total  
17 amount of payments under this subsection shall  
18 be equal to, and shall not exceed—

19                   “(i) \$50,000,000 for 2006; and

20                   “(ii) \$50,000,000 for 2007.

21           This subsection constitutes budget authority in  
22 advance of appropriations Acts and represents  
23 the obligation of the Secretary to provide for  
24 the payment of amounts provided under this  
25 subsection.

1           “(B) ALLOCATION OF FUNDS.—The Sec-  
2           retary shall specify a method for allocating the  
3           funds made available under this subsection  
4           among States.

5           “(C) FORM AND MANNER OF PAYMENT.—  
6           Payment to a State under this subsection shall  
7           be made in the same manner as other payments  
8           under section 1903(a). There is no requirement  
9           for State matching funds to receive payments  
10          under this subsection.

11          “(D) NO DOUBLE DIPPING.—Funds pro-  
12          vided under this subsection shall be conditioned  
13          upon the Secretary receives satisfactory assur-  
14          ances that the aggregate Federal expenditures  
15          under such title are not greater than the  
16          amount that would be paid if such payment had  
17          been made.”.

18 **SEC. 3144. ENHANCING THIRD PARTY RECOVERY.**

19          (a) CLARIFICATION OF RIGHT OF RECOVERY  
20          AGAINST ANY THIRD PARTY LEGALLY RESPONSIBLE FOR  
21          PAYMENT OF A CLAIM FOR A HEALTH CARE ITEM OR  
22          SERVICE.—Section 1902(a)(25) of the Social Security Act  
23          (42 U.S.C. 1396a(a)(25)) is amended—

24                  (1) in subparagraph (A), in the matter pre-  
25          ceding clause (i)—

1 (A) by inserting “, including self-insured  
2 plans” after “health insurers”; and

3 (B) by striking “and health maintenance  
4 organizations” and inserting “health mainte-  
5 nance organizations, pharmacy benefit man-  
6 agers, or other parties that are, by statute, con-  
7 tract, or agreement, legally responsible for pay-  
8 ment of a claim for a health care item or serv-  
9 ice”; and

10 (2) in subparagraph (G)—

11 (A) by inserting “a self-insured plan,”  
12 after “1974,”; and

13 (B) by striking “and a health maintenance  
14 organization” and inserting “a health mainte-  
15 nance organization, a pharmacy benefit man-  
16 ager, or other party that is, by statute, con-  
17 tract, or agreement, legally responsible for pay-  
18 ment of a claim for a health care item or serv-  
19 ice”.

20 (b) REQUIREMENT FOR THIRD PARTIES TO PROVIDE  
21 THE STATE WITH COVERAGE ELIGIBILITY AND CLAIMS  
22 DATA.—Section 1902(a)(25) of such Act (42 U.S.C.  
23 1396a(a)(25)) is amended—

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

1           (2) in subparagraph (H), by adding “and” after  
2           the semicolon at the end; and

3           (3) by inserting after subparagraph (H), the  
4           following:

5                   “(I) that the State shall provide assur-  
6                   ances satisfactory to the Secretary that the  
7                   State has in effect laws requiring health insur-  
8                   ers, including self-insured plans, group health  
9                   plans (as defined in section 607(1) of the Em-  
10                  ployee Retirement Income Security Act of  
11                  1974), service benefit plans, health maintenance  
12                  organizations, pharmacy benefit managers, or  
13                  other parties that are, by statute, contract, or  
14                  agreement, legally responsible for payment of a  
15                  claim for a health care item or service, as a  
16                  condition of doing business in the State, to—

17                           “(i) provide eligibility and claims pay-  
18                           ment data with respect to an individual  
19                           who is eligible for, or is provided, medical  
20                           assistance under the State plan, upon the  
21                           request of the State;

22                           “(ii) accept the subrogation of the  
23                           State to any right of an individual or other  
24                           entity to payment from the party for an

1 item or service for which payment has been  
2 made under the State plan;

3 “(iii) respond to any inquiry by the  
4 State regarding a claim for payment for  
5 any health care item or service submitted  
6 not later than 3 years after the date of the  
7 provision of such health care item or serv-  
8 ice; and

9 “(iv) agree not to deny a claim sub-  
10 mitted by the State solely on the basis of  
11 the date of submission of the claim;”.

12 (c) EFFECTIVE DATE.—

13 (1) IN GENERAL.—Except as provided in para-  
14 graph (2), the amendments made by this section  
15 take effect on January 1, 2006.

16 (2) DELAYED EFFECTIVE DATE FOR CHAP-  
17 TER.—in the case of a State plan under title XIX  
18 of the Social Security Act which the Secretary deter-  
19 mines requires State legislation in order for the plan  
20 to meet the additional requirements imposed by the  
21 amendments made by this section, the State plan  
22 shall not be regarded as failing to comply with the  
23 requirements of such Act solely on the basis of its  
24 failure to meet these additional requirements before  
25 the first day of the first calendar quarter beginning

1 after the close of the first regular session of the  
2 State legislature that begins after the date of enact-  
3 ment of this Act. For purposes of the previous sen-  
4 tence, in the case of a State that has a 2-year legis-  
5 lative session, each year of the session shall be con-  
6 sidered to be a separate regular session of the State  
7 legislature.

8 **Subtitle B—Katrina Health Care**  
9 **Relief**

【to be provided】

**Subtitle C—Katrina and Rita**  
**Energy Relief**

**SEC. 3301. HURRICANES KATRINA AND RITA ENERGY RE-  
LIEF.**

(a) FINDINGS.—The Congress finds the following:

(1) Hurricanes Katrina and Rita severely disrupted crude oil and natural gas production in the Gulf of Mexico. The Energy Information Administration estimates that as a result of these two hurricanes, the amount of shut in crude oil production nearly doubled to almost 1,600,000 barrels per day, and the amount of natural gas production shut in also doubled to about 8,000,000,000 cubic feet per day. The hurricanes also initially shut down most of the crude oil refinery capacity in the Gulf of Mexico

region. These disruptions led to significantly higher prices for crude oil, refined oil products, and natural gas.

(2) These production and supply disruptions are expected to lead to significantly higher heating costs for consumers this winter. The Energy Information Administration projects an increase in residential natural gas heating expenditures of 32 percent to 61 percent over last winter, with the Midwest seeing the largest increase. Winter heating oil expenditures are projected to increase by 30 percent to 41 percent over last winter, again with the Midwest seeing the largest increase. Propane expenditures for home heating are projected to increase 20 percent to 36 percent over last winter, with the Midwest seeing the largest projected increase. Expenditures for home heating using electricity are expected to increase by 2 percent to 9 percent over last winter, with the South seeing the largest increase. Overall, average home heating expenditures this winter are projected to increase about 33 percent, assuming a normal winter. These significant increases in home heating costs this winter will particularly harm low-income consumers. The Low-Income Home Energy Assistance Program is designed to assist these low

income consumers in this situation. Accordingly, Congress seeks a one-time only supplement to the Low-Income Home Energy Assistance Program fund to assist low income consumers with the additional home heating expenditures that they will face this winter as a result of Hurricanes Katrina and Rita.

(b) RELIEF.—In addition to amounts otherwise made available, there shall be directly available to the Secretary of Health and Human Services for a 1-time only obligation and expenditure \$1,000,000,000 for fiscal year 2006 for allocation under section 2604(a) through (d) of the Low-Income Home Energy Assistance Act of 1981 (42 U.S.C. 8623(a) through (d)), for the sole purpose of providing assistance to offset the anticipated higher energy costs caused by Hurricane Katrina and Hurricane Rita.

(c) SUNSET.—The provisions of this section shall terminate, be null and void, and have no force and effect whatsoever after September 30, 2006. No monies provided for under this section shall be available after such date.